AUG 2 2 2014

PRINTED: 08/01/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDER/SUPPLIER/CLIA (X2) MULTIPLE CON			(X3) DATE COMP	
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	NG			•
		345434	B. WING			1	, 1 <u>7/2014 </u>
MANE OF C	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
MAME OF E	NOVIDEN ON OUT TELET			321	EAST CARVER STREET		
CARVER	LIVING CENTER			טס	RHAM, NC 27704		
0(4) ID	SHMMARY ST	FATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECT		(X5) COMPLETIO
(X4) ID PREFIX TAG	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
					Credible Allegation of Complian	ce for 157	7/17/14
F 000	INITIAL COMMENTS	3	F	000	The facility provides the following		
, 000			1	to show that all the residents at C			
	The Division of Nool	Ith Service Regulation			from the discrepancies identified		11
	(DHSR), Nursing Ho				continue to build on this QA pro		' "
	Cortification Section	conducted a recertification			that policies are followed and de	veloned OA	
	and complaint invest	igation health survey on			programs initiated and further ed	veropea, Q11	
	07/10/14. The surve	y team went back to the			guidance is provided as needed.	dication and	ŀ
	facility on 07/16/14 to	o 7/17/14 to gather additional			RESIDENT IDENTIFIED		
	information that led t	to the decision that the facility			At the time this IJ was announce	4 R263-]
	had substandard qua	had substandard quality of care at the immediate			*Had a C-diff re-culture on 7/9		
	jeopardy level. A partial extended survey was					717 During the	
	conducted on 7/16/1	4 through 07/17/14 and an			survey *MD was aware of the loose st	ools 7/9/14	
	exit conference was	held with the facility on				0013 777114	
		diate jeopardy began on			during the survey *The Potassium errors have be	an recolved ac	
	6/23/14 and was ren			157	7/14/14 with correct orders. T		
F 15	1	FY OF CHANGES	,	137	notified of errors on 7/16/14 a		
SS=	J (INJURY/DECLINE/	ROOW, ETC)					
	A facility may at immo	diately inform the resident;			changes in the current treatme *The MD is aware of R 263 co		
	A facility must infine	dent's physician; and if		1		numon and 13	
	known notify the res	sident's legal representative			monitoring closely. IDENTIFYING OTHER RESIDENTIFYING	OLD AT DIC	J
	or an interested fam	illy member when there is an		-	1. A 100% Bowel Movement		
	accident involving th	ne resident which results in		1	from 7/10-7/16/14 to identify:		
	injury and has the p	otential for requiring physician		1	are exhibiting persistent diarrh		
	intervention; a signif	ficant change in the resident's			facility printed out the CNA bo		
	physical, mental, or	psychosocial status (i.e., a		ĺ	charting from the Electronic cl		
	deterioration in heal	th, mental, or psychosocial		1	was completed at 9:03pm on 7.		
	status in either life the	hreatening conditions or			was completed by the Nurse M		
	clinical complication	s); a need to alter treatment			* From this audit R1,		
	significantly (i.e., a i	need to discontinue an	-	1	identified as having a		3
	existing form of trea	itment due to adverse commence a new form of			loose stools. The facil		
	trootmont): or a dec	ision to transfer or discharge	ļ	İ	MD of these loose sto		and .
	the resident from th	e facility as specified in		l	orders for C-diff cult		1
	§483.12(a).	a teaming as apparent in		ļ	V	nea were obtain	Ĩ
1	3-100.12(0).				as a safety measure.	nlated for the to	
	The facility must als	so promptly notify the resident			2. A 100% lab audit was com		
1	and, if known, the re	esident's legal representative			30 days to ensure all labs were orders that were received were		
	or interested family	member when there is a			administered as ordered. The M		
i	10	_	E .	- 1			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG			
		345434	B. WING			C 07/17/2014	
		040404		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER				1 EAST CARVER STREET		
CARVER L	IVING CENTER			1	JRHAM, NC 27704		
				L -	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 157	change in room or rospecified in §483.15 resident rights under regulations as specifithis section. The facility must recithe address and pholegal representative This REQUIREMENT by: Based on record renurse practitioner in notify or consult with practitioner that a restools which resulte treatment for 1 of 2 Clostridium Difficile physician of missed resident with a critic 5.3 reference range. The immediate jeop Resident #263 had	commate assignment as (e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. It is not met as evidenced view, staff, physician and terviews, the facility failed to in the physician or nurse sident had persistent loose d in a 17 day delay in medical residents reviewed for (C-Diff) and failed to notify the doses of potassium for 1 of 1 all potassium level of 2.3 [3.5 -1] (Resident #263).	F	157	out all lab orders from the Electronic C system to validate this. This was comp nurse managers on 7/16/14 at 9:10 pm * From this audit no further medica in relationship to lab results were The facility did note that 13 labs w per orders in the last 30 days. The notified of these errors and new or obtained. 3. A 100% in house resident audit wa to ascertain if all changes of Condition by nursing and the MD was aware. Th completed from 7/14/14-7/16/14 by th This was completed on 7/16/14 @ 10 * From this audit there were 19 cha that the facility could not find Mi The MD was notified of all chang by the nurse managers. Upon no MD had no new orders or interv these residents. 4. A 100% MD order audit was com 7/10/14-7/16/14 to ensure that all new into the Electronic Charting System a process was started on 7/16/14 by the This audit was completed on 7/17/14 * From this audit 4 med errors were	tion errors observed. were not drawn MD was ders were s completed 's were identified is audit was e Nurse Managers. :37 PM. anges of condition D notification. ges on 7/16/14 tification the entions for upleted from orders were entered s ordered. This nurse managers. @ 3;35pm. re noted. The	
		nd neither the physician nor er was contacted for			error for R4- the Metformin was		
	quidance. The imm	ediate jeopardy was removed			to be held on 7/16/14 and was ac		
	on 7/17/14 at 8:47 t	om when the facility provided			(MD notified and no new receive		
	and implemented a	n acceptable credible			2 tabs ordered and 1 tab was trai		
	allegation of compli	ance. The facility will remain			changed to 2 tabs), R6 Facility f		
	out of compliance a	it a scope and severity of D			Fosamax weekly as ordered for		
	(no actual harm wit	h the potential for more than			stated to start Fosamax weekly),		
	minimal harm) that	is not immediate jeopardy to			order of Dry gauze and TAO wa		
1	ensure monitoring	systems put in place are			times a week and it was transcri		
	effective. Findings	included:			(MD stated to change to 3 times	weekiy). None	
	Lovi Comple Geriet	ric Dosage Handbook, 17th	-		of these residents suffered any i	i citecis icissed	
1	Lexi-Comp's Gena	are posage transpoors trai			to these errors.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE 9 COMPL	ETED	
		345434	B. WING			07/1	7/2014
NAME OF DE	ROVIDER OR SUPPLIER	1	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
stranc Ot €1	(0.1.521) 0.1.501) 5.5.1		321 EAST CARVER STREET		1 EAST CARVER STREET		
CARVER L	IVING CENTER			שם	JRHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 157	cation (causes a pos (located or occur with essential for conduct heart, brain and skel cardiac, skeletal and maintenance of norm acid-base balance, cand gastric (stomach Resident #263 was a 4/28/14. Diagnoses infectious diarrhea), potassium), hyperter weakness), ventricul placed in the ventric cerebral spinal fluid) (area that has becar blood vessels in the (difficult swallowing) general muscle wea Minimum Data Set of Resident #263 had a problems. Decision moderately impaired A review of the lab r facility on 6/12/14 for read "clostridium difficult was further indicated back and verified wis 8:55 am." A review of the physical review of the physical "Flagyl 500 mg for clostridium difficil medication administicated to set of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for clostridium difficil medication administical past dose of Flagyl 500 mg for c	"potassium is the major litive charge) of intracellular him the cell) fluid and is ion of nerve impulses in etal muscle; contraction of smooth muscles; hal renal (kidney) function, carbohydrate metabolism, h) secretion." admitted into the facility on included C-Diff (a type of diarrhea, hypokalemia (low hison, debility (physical lostomy (an external catheter les of the brain to drain clamped, cerebral aneurysm me weakened causing the brain to bulge), dysphagia, difficulty walking and kness. The admission completed on 5/9/14 indicated short and long term memory making was listed as difficile toxin result positive. It dithat the report was "Read the director of nursing at sician order dated 6/12/14 by mouth three times daily life for 10 days." The tration record (MAR) reflected gyl was administered on	F	157	PROCESSES IMPLEMENTED TO PREFURTHER OCCURRENCES 1. In-servicing for the nursing staff and assistants was started on 7/16/14 by the NAt this point 84 nursing staff and nursing of 138 have been in-serviced. No member staff or nursing assistants will be able to wantil they are in serviced. *The facility's Change of Conditional the requirements of MD notifical includes; residents that are expenses that loose stools and have levels and other critical/abnorm. *The facility's Medication transwhich would include the proper of potassium. a. STARTED ON 7/16/14 AND AT THIS TIME. 2. The Nurse Managers were in-serviced Vice President on 7/17/14 on the followints and the residents that have exhibit loose stools have been communicated that all residents that have exhibit loose stools have been communicated that all new orders have any resident that is having contour or 3 loose stools in a 24 hour profification for proper intervents. Review of all new orders to was properly transcribed into the Charting System and that the retreatment promptly. The Norreceiving the lab/C-difficule enter it into the ECS lab tracking Managers will ensure this is contained.	nursing urse Mana assistants of the nur vork the fle ation Policy ation whice critical po al labs. scription pe transcript O ONGOIN d by the Rang: QA Meetin On report to bited persi- nicated to to ve been car I Record to inuous dia period has a tions. crisure that the Electror esident rec- urse respor- ture order ong. The Nu	out sing cor y and tassium clicy con G egional red out, ensure that rhea MD the order cic eived sible will use
l .	6/21/14 at 10:00 pm	n. Flagyl is an antibiotic that is			their morning QA review.		1

Facility ID: 923077

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STATEMENT OF DEFICIENCIES			l, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			0.114140			C 07/17/2014	
		345434	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	07/17/2014	
NAME OF P	ROVIDER OR SUPPLIER			I			
040000	LIVING CENTER				1 EAST CARVER STREET		
CARVER	LIVING CENTER			DL	JRHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETO RIATE DATE	ON
					Review of the lab tracking sheet to ensu	re that all	
F 157	Continued From pag	<u> </u>	F	157	C-diff cultures were obtained as ordered		
F 107					responsible for receiving the lab order v	vill enter it	
	used to treat a bacte	nar intection.			into The ECS lab tracking.		
	A review of the physic	ician order dated 6/23/14 in		1	* The 2nd shift Supervisor will ensure t	hat all labs/	
	nert read "Recheck s	stool for clostridium difficile			C-diff cultures obtained are received, d	stributed to the	
	secondary to persist	ent diarrhea."			appropriate responsible nurse, the MD i		
	3600ridary to poroter				new orders are transcribed and impleme		
	A review of the bowe	el elimination pattern record		ļ	* The Morning Nurses QA will review	all these	
	revealed the following			-	completed labs/C-diff cultures the follo	wing morning	
					to ensure the 2nd shift Supervisor comp	leted the	
	· 6/26/14 "three la	arge loose stools"			assigned task.		
	6/29/14 "two medium loose stools"				* The Lab Company and all Critical La		
	6/30/14 "two lar	ge loose stools"			called to the DON/designee. The DON	designee	
	7/5/14 "one med	dium loose stool"]		will ensure that the MD is notified and	ensure that any	
		dium loose stools, one large			new orders are carried out.		
	loose stool"	va lagge stoci"			* Properly managing the facility staff to	ensure proper	
	· 7/7/14 "one larg				resident care is provided.		
	1/8/14 One sm	all 10036 31001	İ		Monitoring for compliance will be at M	forning	
	A rovious of a critical	lab result, reported to the			Nurses QA Meeting, all areas listed in	#2 will be	
	nursing facility by th	e lab provider on 7/8/14 at			completed by the Nursing Managemen	Team. The	
	6:16 am to Nurse #7	7 in part read "Critical	- 1		new QA meeting was started on 7/17/1	4 and	
	potassium 2.3." Phy	sician #1 was indicated as			monitored by the RVP. During this me	eting any	
	notified with a new o	order received on 7/8/14 at	Ì		discrepancies identified will be docum	ented,	
	6:18 am by Nurse #	7.			investigated, and corrected as required	From any	
			Į		discrepancies identified further educati	on or	
ļ	A review of a physic	ian telephone order dated			disciplinary action will occur with the		
	7/8/14 received by	Nurse #7 in part read			responsible for discrepancies. If trend	are noted	
	"potassium 20 meq	every day."			from discrepancies the QA process wil	l be revised	
		hits (CLARR) temperary multiplication			by the QA Committee. These new QA	programs	
	The medication adn	ninistration record (MAR) did			will be a permanent practice of the fac	lity. This	
	not reflect potassiul	n 20 meq was administered d when the nursing facility			process will be followed by the QA Co	mmittee for	
	on 7/6/14 as ordere	tical potassium level of 2.3 on			compliance and revised as required.		
	7/8/14 at 6:16 am b	v the lab provider.	-		discrepancies and trends are identified		
	1/0/14 at 0. 10 att b	2 min ma binings	1		QA audits further educational training		
	A review of the purs	se's notes dated 7/9/14 at 8:46	-		provided. The facility will contact and	l setup	
	om revealed a stoo	I sample was obtained for	- 1		in-servicing on medication errors and	ranscription	
	C-Diff.	•			errors with the pharmacist. The facility	will involve	
1	1				***************************************	ļ <u></u>	

Facility ID: 923077

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		(X3) DATE SURVEY COMPLETED				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG _)
		345434	B, WNG			l l	7/2014
NAME OF P	ROVIDER OR SUPPLIER			!	TREET ADDRESS, CITY, STATE, ZIP CODE		
				l	21 EAST CARVER STREET		
CARVER	LIVING CENTER			D	URHAM, NC 27704	. 1	
(X4) ID PREFIX TAG	(FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	A review of the MA by mouth (15 millilili 7/9/14 at 9:00 am. A review of the nur 07/09/14 did not reinterventions to mathe physician or nufor guidance. A review of the borevealed the follow 7/10/14 "two life toose stools" A review of the lab facility on 7/10/14 read "Clostridium Critical results call with unit manager Due to the critical facility on 7/10/14 positive C-Diff, the 125 mg by mouth 14 days. Vancomy bacterial infection: A review of the Matablet was administrative of the Matablet was administrative of the physical potassium chlorid daily." The MAR review of the MAR review of the physical potassium chlorid daily." The MAR review of the MAR review of the physical potassium chlorid daily." The MAR review of the physical potassium chlorid daily." The MAR review of the physical potassium chlorid daily." The MAR review of the physical potassium chlorid daily."	R revealed potassium 20 meq ters) was administered on sess' notes from 6/23/14 to effect any facility care anage loose stools/diarrhea or arse practitioner was consulted well elimination pattern recording: arge loose stools, two medium or report received by the nursing from the lab provider at in part difficile toxin result positive. Led to, read back and verified #1 at 8:20 am." Iab reported to the nursing by the lab provider related to a physician ordered Vancomycin four times a day for C-Diff for yorin is an antibiotic used to treat	F	157	the Medical Director in the facility proorder to seek guidance and support. member of the Corporate Office Stat on site weekly for at least the next 3 assist in support, training, and monit this plan. Compliance is 7/17/14	A f will be) days to	

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	HPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		0.5.0	B. WING			C 7/17/2014		
		345434	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		11112014		
	ROVIDER OR SUPPLIER		:	321 EAST CARVER STREET DURHAM, NC 27704	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 157	Continued From pa	age 5	F	157				
	facility from the lab read "potassium 2 reflected potassiur once at 9:00 am of a review of the lab facility on 7/14/14 provider reported to "potassium 2.2 critical A review of the phrat 3:00 pm read "gothen increase potamouth twice daily reflected on 7/14/1 administered "pm" meq (2 tablets) was 5:00 pm. A review of the lab facility from the lab read "potassium 2	ysician order dated 7/14/14 pm live potassium 40 meq now, lesium chloride to 40 meq by for low potassium." The MAR 14 potassium 40 meq was 15 and on 7/15/14, potassium 20 16 as administered at 9:00 am and 17 oreport received by the nursing 18 provider on 7/16/14 in part 19 14/15/14.						
	In an interview on stated per review the electronic records, the been attempted of the period of the control of the period of th	a 20 meq (2 tablets) was 00 am and 4:00 pm. 7/9/14 at 11:42 am, Nurse #2 of Resident #263's chart and ord she did not see in the hat another stool sample had or collected to date; ordered to he physician on 6/23/14. UM #1 e was responsible for orsing unit as the "unit indicated a stool sample have been completed as ordered showever she could not find pecimen had been completed or						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345434	B. WING _			C 07/17/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	017	1772014	
CADVED	IVING CENTED			321 EAST CARVER STREET				
CARVER	LIVING CENTER			DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 157	obtain either.		F1	57		Birth of Advisory Lab Propagation and the Advisory Advisory Lab Propagation and the Advisory		
	sample ordered on 6/ obtained as ordered to continued C-Diff, due medical treatment con In an interview on 7/9 and Nurse #4 both ac residents' bowel elimit basis as part of their of indicated they were a had completed previot C-diff and the resident stools after completio 6/21/14. They both in the physician via telep continued loose stool second stool sample.	d he expected the stool 23/14 to have been o reevaluate the resident for to persistent diarrhea, so uld have been initiated. /14 at 4:21 pm, Nurse #3 knowledged they reviewed nation pattern on a daily daily routine. Both nurses ware that Resident #263 us antibiotics (ABT) for t continued to have loose n of the ABT (Flagyl) on dicated they did not contact othone regarding the s, nor had they obtained a Nurse #3 and #4 stated						
	worked throughout the In an interview on 7/1 acknowledged she sign 6/23/14, which directed C-Diff "secondary to #4 indicated she was was needed but she con her shift because the movement. She further up regarding the ordestool specimen had but In an interview on 7/1 the presence of the distated her role was to	0/14 at 2:05 pm, Nurse #4 gned the physician order on ed to recheck the stool for persistent diarrhea." Nurse aware that a stool sample did not obtain a stool sample here was no bowel er stated she did not follow r because she assumed the een obtained. 0/14 at 5:07 pm, UM #1 in rector of nursing (DON)						

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	DETTI OF HOME		NG			C
		345434	B. WING		TA LOODEGO GITY OTHER 710 CODE	[0:	7/17/2014
	ROVIDER OR SUPPLIER			321 E	ET ADDRESS, CITY, STATE, ZIP CODE AST CARVER STREET HAM, NC 27704		
		THE PERIOD OF DELICITIONS	IĐ	7	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 157	Continued From page carried out as ordered was aware Resident course of antibiotics 6/21/14) due to cont She stated it was an ordered to be obtain obtained until 7/9/14 expected all orders ordered by the physical reflect such, if the stobtained. In an interview on 7 acknowledged she of 6/26/14 from 7am-7 the resident having amount and she obtained in a stool stools. She could be the physician regard the resident was alred in an interview on 7 stated on 7/8/14 Restool that was "water mucous and slimy."	ge 7 ed, UM #1 acknowledged she t #263 had completed a to treat C-Diff (completed on tinued diarrhea/loose stools. n oversight the stool sample hed on 6/23/14 was not the DON added she to have been obtained as dician and the clinical record to tool sample was unable to be //16/14 at 10:52 am, Nurse #6 worked with Resident #263 on typm. She stated she recalled loose stools, moderate served loose stools in the te stated NA (nursing assistant) the the resident was having procluded she did not contact ding the loose stools because ready on contact isolation and have running stool to me." //16/14 at 11:26 am, NA #8 tesident #263 had a loose small tery, greenish color, with 'She stated she reported her 3 before she documented as	F	157	DEFICIENCY)		
	who worked on 6/2 observed Resident brownish, and sme notified Nurse #6 o 6/30/14 of her finding						
1	In an interview on 7	7/16/14 at 12:54 pm, Nurse #7					<u> </u>

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345434	B, WING		0	C 7/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 321 EAST CARVER STREET DURHAM, NC 27704	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 157	acknowledged on 7,7pm-7am. She state worked with Reside resident's stools had could not recall any concluded she did related to the foul of the foul o	/8/14 she worked from ed on occasions she had nt #263 and recalled the ving a strong foul odor but specific dates. She not contact the physician	F1	57		
	medical director inc aware by the facility persistent diarrhea; resident had a histo completed a course (Flagyl). He stated resident to be given due to a critical pot medication was no expected the medic administered to the ordered, considerir of the resident critic expected the potas administered on 7/	7/16/14 at 1:53 pm, the dicated he was not made by staff the resident was having a however he was aware the cory of loose stools and had be of antibiotics for 10 days on 7/8/14, he ordered for the potassium 20 meg every day cassium level, however the stadministered. He stated he coation to have been be resident on 7/8/14 as ang the facility staff was aware call lab result. He indicated he coation to have been solution are a critical level and the				

Facility ID: 923077

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR' COMPLETE				
		345434	B. WING		07/17/2	014
	PROVIDER OR SUPPLIER	<u> </u>	321	EET ADDRESS, CITY, STATE, ZIP CO EAST CARVER STREET RHAM, NC 27704	DDE	<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) MPLETION DATE
F 157	resident could have as an abnormal her potassium to be a 7/14/14, he indica aggressive treatm was ordered to be twice daily (total or potassium level or director, he stated the low potassium continued loose so an interview on stated any abnorm persistent diarrher would expect the and the physician. In an interview or practitioner stated once (6/23/14) Recontinued diarrher know who contact ordered for the resistent would expect the and the physician ordered for the resistent would expect the resistent with an an interview of informed unit manager resistent #263 he stools/diarrhea, fishe would have or intervention to he stools/diarrhea. In an interview of indicated her expending to have the orders to ensistent to the orders to ensistent with the orders to ensist	re had cardiac problems such eart rhythm, while awaiting the dministered on 7/9/14. On ted the resident required more ent in which potassium 40 mg given "now" and then to 40 mg of 80 mg daily) because the ontinued to drop. As the medical of factors which contributed to haver "Fluid loss as a result of	F 157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		345434	B. WING		l l	17/2014
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP 321 EAST CARVER STREET DURHAM, NC 27704	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGA PEREDENAED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 157	stated per her review MAR did not reflect to administered as order the MAR reflected possible administered until 7% added potassium 20 administered on 7/10 daily and the MAR resided potassium 20 administered once estated the order to intranscribed into the exproperly, so the order DON concluded her manager to have chuthe orders to ensure transcribed properly. In an interview on 7% administrator stated ensuring physician of correctly as ordered an order, the receiving ensuring the order is transcribed into the correctly. She added responsible for follow to ensure all new ordered. In an interview on 7% who worked 7pm-7% lab result dated 7/8% notified by the lab pas indicated on the medical director as 7/8/14 at 6:18 am, a medical director on	of the physician orders, the hat potassium 20 meq was pred on 7/8/14. She indicated obtassium 20 meq was not 9/14 at 9:00 am. The DON meq was also ordered to be 0, 7/11, 7/12, 7/13/14 twice effected the medication was ach day at 9:00 am. She increase potassium was not electronic computer system or was not carried out. The expectation was for the unit ecked the carbon copies of the physician orders were	F	157		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		345434	B. WING _			07/17/2014	
	ROVIDER OR SUPPLIER	1	•	STREET ADDRESS, CITY, STATE, ZIP COD 321 EAST CARVER STREET DURHAM, NC 27704	E		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	1 SHOULD BE	(X5) COMPLETION DATE	
F 157	stated that she woorder into the electroster indicated on 7/8/14 are physician. Nurse worked on 7/8/14 care of Resident indicated she was (Nurse #3) aware level/order received. The administrato jeopardy on 7/16, provided the folic 17, 2014 at 8:25 "RESIDENT IDE At the time this Identity in the survey of the electroster in the electroster in the provided the folic 17, 2014 at 8:25 "RESIDENT IDE At the time this Identity in the electroster in the provided the current treatroster in the monitoring close in the electroster in the monitoring close in the electroster in the monitoring close in the electroster in the electroster in the monitoring close in the electroster in the monitoring close in the electroster in the el	as suppose to transcribe the ctronic computer system for the q to be administered on 7/8/14, takenly scheduled it to be 7/9/14. Nurse #7 indicated she repotassium to Resident sordered nor did she notify the #7 concluded Nurse #3 who from 7am-7pm took over the #263 after her. Nurse #7 so not sure if she made her of the critical potassium red. The was notified of the immediate for the critical potassium red. The was notified allegation on July pm for F 157 as follows: NTIFIED Was announced R 263-re-culture on 7/9/10 During the pare of the loose stools 7/9/10 for the purpose of the critical potassium red. The was announced R 263-re-culture on 7/9/10 During the pare of the loose stools 7/9/10 for the loose stools 7/9/10	F1	157			

Facility ID: 923077

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
		345434	B. WING			7/17/2014		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 321 EAST CARVER STREET DURHAM, NC 27704	P GODE			
(X4) ID PREFIX TAG	FACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 157	9:03 pm on 7/16/14 the Nurse Managers From this audit as having a long his facility notified the M 7/16/14 and orders obtained as a safety 2. A 100% lab aud 30 days to ensure a orders that were red administered as orders that were red administered as orders that were red administered as orders that were red administered as orders that were red administered as orders that were red administered as orders in the last 30 these errors and ned 3. A 100% in hou completed to ascer Condition's were id was aware. This a 7/14/14-7/16/14 by was completed on From this audit condition that the fa notification. The MI on 7/16/14 by the r notification the MD interventions for the 4. A 100% MD of 7/10/14-7/16/14 to were entered into the as ordered. This pi by the nurse manal continue and will be	This task was completed by s. R1, R2 and R3 were identified story of loose stools. The MD of these loose stools on for C-diff cultures were y measure. dit was completed for the last all labs were obtained and any ceived were transcribed and dered. The Managers printed om the Electronic Charting his. This was completed by s on 7/16/14 at 9:10 pm. It is no further medication errors to results were observed. The is 13 labs were not drawn per indicated down the Electronic Charting his. The MD was notified of ew orders were obtained. Se resident audit was tain if all changes of entified by nursing and the MD audit was completed from the Nurse Managers. This 7/16/14 @ 10:37 PM. It there were 19 changes of eacility could not find MD D was notified of all changes ourse managers. Upon had no new orders or ese residents. In the Electronic Charting System rocess was started on 7/16/14 gers. This process will e completed on 7/16/14 by the This audit was completed on	F	157				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		345434	B. WING_		07/17/2014
,	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 321 EAST CARVER STREET DURHAM, NC 27704	CODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 157	These error for R4 be held on 7/16/14 notified and no new tabs ordered and changed to 2 tabs. Fosamax weekly a stated to start Fosorder of Dry gauze a week and it was stated to change to these residents sutthese errors. PROCESSES IMFFURTHER OCCU 1. In-servicing for assistants was stated managers. At this nursing assistants in-serviced. No minursing assistants until they are in seven the requirements includes; resident persistent loose s potassium levels a potassium. The facility's which would incluse potassium. STARTED OTHIS TIME. The Nurse M Regional Vice Prefollowing: The Facility's Meeting which will	it 4 med errors were noted. - the Metformin was ordered to and was administered (MD w received), R5 had multi 2 it ab was transcribed (MD), R6 Facility failed to give as ordered for 2 weeks (MD amax weekly), R7 treatment and TAO was ordered 3 times transcribed as daily (MD to 3 times weekly). None of ffered any Ill effects related to the nursing staff and nursing tred on 7/16/14 by the Nurse point 84 nursing staff and out of 138 have been the most of the nursing staff or will be able to work the floor erviced. Change of Condition Policy and the state are experiencing tools and have critical and other critical/abnormal labs. Medication transcription policy de the proper transcription of N 7/16/14 AND ONGOING AT anagers were in-serviced by the esident on 7/17/14 on the	F	157	

NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER SUMMARY STATEMENT OF DEPICIENCIES (RACH DEPICIENCY MAYS TREPER OF DURILL REGULATIONY OR LAS DESCRIPTION ON THE PROCESSO DEPULL REGULATIONY OR LAS DESCRIPTION ON THE PROCESSO DEPUCTION OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	COMPLETED	
CARVER LIVING CENTER SUMMARY STATEMENT OF DEFIDIENCIES PRECEDED BY PULL REGULATORY OR LIST DEPRECEDED BY PULL REGULATORY OR LIST DEPRECEDED BY PULL PREFIX TAB PRETIX TAB PROTITE TAB PROTITE TAB PRETIX TAB PRETIX TAB PRO			345434	B. WING				
PREFIX TAG F 157 Continued From page 14 ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out. O Review of the 24 hour Bowel Record to ensure that any resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. O Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse seponsible for receiving the lab/C-diff culture order will enter into it into the ECS lab tracking, o The 24 shift Supervisor will enter into it into the ECS lab tracking. O Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter into it into the ECS lab tracking. O The 24 shift Supervisor will ensure that all labs/C-diff cultures been obtained as ordered. The Nurse responsible for received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. O The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task. O The Lab Company and all Critical Labs will be called to the DON/designee. The DON/designee will ensure that the MD is notified and ensure that any new orders are carried out. O Properly managing the facility staff to ensure proper resident care is provided. The Completion date is 7/17/14."	• • • • • • • • • • • • • • • • • • • •				321	EAST CARVER STREET		
ensure that all residents that have exhibited persistent loose stools have been communicated to the MD and that all new orders have been carried out. O Review of the 24 hour Bowel Record to ensure that any resident that is having continuous diarrhea or 3 loose stools in a 24 hour period has MD notification for proper interventions. O Review of all new orders to ensure that the order was properly transcribed into the Electronic Charting System and that the resident received the treatment promptly. The Nurse responsible for receiving the lab/C-diff culture order will enter into it into the ECS lab tracking. The Nurse Managers will ensure this is completed during their morning QA review. O Review of the lab tracking sheet to ensure that all C-diff cultures were obtained as ordered. The Nurse responsible for receiving the lab order will enter into it into the ECS lab tracking. O The 2nd shift Supervisor will ensure that all labs/C-diff cultures order shifted are received, distributed to the appropriate responsible nurse, the MD is notified and new orders are transcribed and implemented. O The Morning Nurses QA will review all these completed labs/C-diff cultures the following morning to ensure the 2nd shift Supervisor completed the assigned task. O The Lab Company and all Critical Labs will be called to the DON/designee will ensure that the MD is notified and ensure that any new orders are carried out. O Properly managing the facility staff to ensure proper resident care is provided. The Completion date is 7/17/14."	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
1 0- 7/47/0044 of 9/26 pm, the electric supposition 1	F 157	ensure that all reside persistent loose stoot to the MD and that a carried out. o Review of the 2 ensure that any residiarrhea or 3 loose is MD notification for poor Review of all neorder was properly to Charting System and the treatment promptor receiving the labilitor it into the ECS I Managers will ensure their morning QA recorder and implemented in the MD is notified a and implemented. o The Morning Noompleted labs/C-dimorning to ensure the completed the assignormal to the DON/C will ensure that the any new orders are o Properly manaproper resident care.	ents that have exhibited ols have been communicated all new orders have been all new orders have been all new orders have been all new orders have been as stools in a 24 hour period has roper interventions. Beworders to ensure that the ranscribed into the Electronic at that the resident received only. The Nurse responsible all racking. The Nurse re this is completed during view. Best bracking sheet to ensure that see this is completed during view. Best bracking sheet to ensure the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order the ECS lab tracking. In the lab order that all obtained are received, oppropriate responsible nurse, and new orders are transcribed the lab order transcribed. In the lab order that lab o	F	157			

STATEMENT OF DEFICIENCIES AND BLAN OF CORRECTION AND BLAN OF CORRECTION DESTRICTION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLI		
AND PLAN OF	CORRECTION	INCIALICIOMICAL MORPHY	A. BUILD	NG		С	
		345434	B. WING			07/1	7/2014
	NOVIDER OR SUPPLIER			321	REET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	Continued From pag was validated. Staff nurses and nursing a had implemented the should take related to persistent, continued critical potassium lever pattern, 3) physician sample or specimen condition policy, 5) for report and 6) process new orders in the elemedications and lab 483.10(e), 483.75(l) PRIVACY/CONFIDE. The resident has the confidentiality of his records. Personal privacy incomedical treatment, we communications, permeetings of family a does not require the room for each resident release of personal individual outside the the resident's right and clinical records. The resident's right and clinical records.	e 15 Interviews with licensed assistants revealed the facility of following actions one to 1) physician notification of those stools or diarrhea, wel, 2) changes in stools order received for stool to be obtained, 4) change in wenty-four hour condition is for entering or transcribing actronic charting system for its. (4) PERSONAL ENTIALITY OF RECORDS in right to personal privacy and or her personal and clinical actions are received for stool to be obtained, and resident groups, but this in paragraph (e)(3) of this to the provide a private ent. In paragraph (e)(3) of this to the provide and clinical records to any the facility. It refuse release of personal does not apply when the ed to another health care if release is required by law.		157	The resident has the right to personal pronfidentiality of his or her personal arrecords. RESIDENT IDENTIFIED 1. R2 and R167 suffered no ill effectiation and no non medical person view medical information. INDENTIFYING OTHER RESIDENT 1. All residents were at risk for this PROCESSES IMPLEMENTED TO PERTHER OCCURRENCES 1. Licensed Nurses were in-service Medical Records Coordinator on 8/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	ats from this wed their IS AT RISE citation. REVENT ed by 2014 on the that all resident in stepping a serviced by the followient - Discloss	ent medical way the ng:
	contained in the res	sident's records, regardless of			Workstation Use		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					•	C		
		345434	B. WING			07/1	17/2014	
	ROVIDER OR SUPPLIER			32	REET ADDRESS, CITY, STATE, ZIP CODE 1 EAST CARVER STREET JRHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 164	the form or storage release is required by healthcare institution contract; or the residence of the residence of the residence of the residence of the residents' residents reviewed for administration (Residents reviewed for administration (MAR) was observed viewable/readable with Residents and diagnothe medication cart again computer screen still medical information cart. The MAR screens reviewed for a medical information cart at 8:50 am. On 7/10/14 at 9:50 at not aware that I left visible on the computer of the medicart." On 7/10/14 at 4:07 promite for the medicart."	nethods, except when y transfer to another r; law; third party payment	F		*C. Employees must sign the "Empacknowledgement - Workstation to statement. 4. Monitoring will be completed by Mec Records Clerk, Nursing Managers, and Guardian Angel. Forms will be discus in Morning QA. Administrator will mon review forms weekly x4 weeks and mo after and report findings to monthly QA Committee. 5. Compliance 8/20/14	Jse" Iical I Assigned sed daily itor and nthly ther		

Facility ID: 923077

CENTER	3 LOV MEDIOVIVE &	IVILDIOAID OLIVIOLO				(VO) E 175	01/01/51/
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SI COMPLE	
			, 200120				;
		345434	B. WING			07/	17/2014
NAME OF P	ROVIDER OR SUPPLIER	-			REET ADDRESS, CITY, STATE, ZIP CODE		
CARVER I	LIVING CENTER				EAST CARVER STREET RHAM, NC 27704		
					PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 164	Continued From page privacy of the resider times during med passcreen or logging off the med cart. 2. During a medication 7/10/14 at 9:03 am, I medication cart with opened and complete medical information of the computer screen resident's room, commedication cart. The from the resident doctorant. Nurse #10 return 9:05 am and the resident's not medication cart. In diagnoses was still viscreen. Nurse #10 le 9:08 am and re-enter again and administer medication) with the readable to anyone preturned to the medication with the resident's medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the medication of the computation of the medication of the medication of the computation of the medication of the medication of the medication of the computation of the medication of the medication of the medication of the computation of the medication of the medicati	e 17 Ints' medical information at all ass, by closing the computer prior to walking away from the prior to walking away from the street of the electronic MAR observed all viewable/readable with for Resident #167 visible on and the pletely out of sight of the facility staff was observed or walking by the medication and to the medication cart at dent's medical information as of medications and isible on the computer of from the medication cart at red Resident #167's room ared Zofran (nausea		164	DEFICIENCY)		
	screen or logging off	f prior to walking away from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE: COMPI	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			
		345434	B, WING			07 <i>i</i>	7/2014
*****	ROVIDER OR SUPPLIER	070404			TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDER OR SUPPLIER			1	21 EAST CARVER STREET		
CARVER I	LIVING CENTER			ם	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	483.13(a) RIGHT TO PHYSICAL RESTRA The resident has the physical restraints im discipline or convenie treat the resident's m This REQUIREMEN' by: Based on observation record review, the falleast restrictive device regarding the medical restraint for 1 of 1 reviewed for physical included: Resident #203 was a with a diagnosis of discipline or disciplination of a trunk restraint. In an observation on #203 was observed lap buddy applied to is a padded trunk refront of a wheelchair wheelchair at the armesident from standin In an interview with a nursing assistant #1	BE FREE FROM INTS right to be free from any posed for purposes of ence, and not required to pedical symptoms. It is not met as evidenced ons, staff interviews and cility failed to attempt the error provide documentation at justification for the physical sident (resident #203). I restraints. Findings admitted the facility 5/31/13 ementia. The most recent MDS) was a significant 63/3/14 and indicated resident gritive impairment, required a for transfers and was coded. 17/7/14 at 11:40 AM, resident sitting in a wheelchair with a her wheel chair. (A lap buddy straint that fits across the and is secured to the morest. It prevents the ing unassisted.) 10 7/7/14 at 12:00 PM, stated that resident #203		221		at has the ats impose ence, and as. ent and can at RISK 10% audit to list of all the elist	ent ented.
	could not remove the wheelchair. The NA	e lap buddy from her stated resident #203 would ut the lap buddy in place.			The Restorative Nurse will complet QA and present to the IDT before any reimplemented.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILD	NG		1	
		345434	B. WING			07/1	; 17/2014
	TOTALDED OF OTHER TEC	V70707		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER			1	1 EAST CARVER STREET		
CARVER L	IVING CENTER			1	JRHAM, NC 27704		
i	0(111140)(0)	TATEMENT OF DEFICIENCIES	ID	' Т	PROVIDER'S PLAN OF CORRECTION		(X5)
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							8/20/14
E 004	Continued From pag	a 19	F	221	2. The IDT will review all the component	ents to ensu	re
F 221	Continued From pag	C V	•		compliance before the restraint is imple	emented.	
	In an intendey on 7/	9/14 at 2:45 PM, nurse #1		ł	3. All facility restraints will have the Q		
	etated resident #203	had the lap buddy when she			completed at least monthly and turned		
	was first admitted in	to the secured unit. She			Monthly QA committee for review wer	ekly x4 and	}
	recalled it was arour	nd 6 months ago resident			then monthly and report findings to mo		
	#203 was brought of	ut and placed on the hallway.			Committee.		
	Nurse #1 stated the	rapy recently changed her			4. Compliance date 8/20/14		
	wheelchair to one th	at was tilted but the lap buddy		Ì]
İ	was not discontinue	d and it did not fit her . The lap buddy was now too					
	large for the current	wheelchair. She stated they		Ì			
	had tried alarms on	resident #203 but they did not					
	stop her falls. Nurse	#1 confirmed resident #203		ĺ			1
	last fall was 6/21/14	at 6:20 PM and occurred in	ļ				
	resident #203's roor	n. She apparently removed	İ				
	her lap buddy and for	ell from the wheelchair. The					
	only other tall in the	last 6 months was on 4/23/14 sident #203 was discovered		!			
	on her mat beside h	ner bed. Nurse #1 stated she					
	had not seen reside	int #203 attempted to remove					
	the lap buddy but he	ad heard reports that she was					
	able to remove it.						
[UNIA -10.55 DEA ESE HO					
	In an interview on 7	/9/14 at 2:55 PM, NA #2			Į.		
1	stated she had work	ked with resident #203 for a ng as she could remember,			1		
	resident #203 had t	he lap buddy. Resident #203					
	was first admitted to	o the secured unit and had the			1		
	lap buddy when she	e was back there. It had never					
	been discontinued	since resident #203 was			†		
	admitted as long as	she could remember.					
	Resident #203 was	observed at the nurse station.			-		
	NA#2 requested re	esident 203 remove her lap					
	buddy but the resid	lent did not respond to the attempt at removal of the					
	command with any device.	anditiple at removal or me					
	device.				1		
	In an interview on	7/9/14 at 3: 23 PM, the					
	rehabilitation direct	or stated he screened resident					<u> </u>

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C (X3) DATE SU COMPLET		ETED				
		345434	B. WING				7/2014
NAME OF PROVID				32	REET ADDRESS, CITY, STATE, ZIP CODE 1 EAST CARVER STREET JRHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
#20 fun buckers he or viscos he or viscos he or viscos which the as year of ratte door the ln a me buckers he or viscos he	ctional status and ddy continued. He ident #203 was pure if her whether her wheel cause the lap buddy eelchair she was collap buddy had be long as he had be ar ago. In interview on 7/5 dical director stated to her wheelch facility to have trivially buddy and do continued need. In interview on 7/5 dical director stated to her wheelch facility to have trivially buddy and do continued need. In interview on 7/5 his restraint reductions are straint reductions at the electric facility to have trivially buddy and do continued need. In interview on 7/5 his restraint reductions are resident has the needules, and health interests, assess eract with member ide and outside the	and no change in her recommended the lap recalled at some point at into a tilted wheelchair but wheelchair was changed out chair seat just simply tilted by was not the best fit for the currently sitting in. He stated en in use for resident #203 en working at the facility a working at the facility a working at the facility a working the continued need for the currently sitting the continued need for working the continued need for w		221	The facility does ensure that each resident's to get out of bed and eat meals are honored RESIDENT IDENTIFIED 1. R63 was provided a shower on 7/11/14 IDENTIFYING OTHER RESIDENTS AT 1. The Social Service Department and or Activity Department will interview each also oriented resident on their choice of dining a rising time. This will be communicated to a staff via the KARDEX system by 8/11/14.	RISK The ert and	8/20/14

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE ((X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	NG		
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	- ALVERT OF OUR DIVINI	040404	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				1 EAST CARVER STREET	
CARVER I	LIVING CENTER				URHAM, NC 27704	
					PROVIDER'S PLAN OF CORRECTION	N (X5)
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F 242	Continued From page 21			242	PROCESSES IMPLEMENTED TO PR FURTHER OCCURRENCES	EVENT
					1. The Nursing staff were in-serviced b	y Adarania ¢.
	This DEOLUDEMEN	T is not met as evidenced			on 8/11/14 on the following:	
	by:	To not mot do ottavas a			* The facility's new shower sl	ieet
		ons, staff interviews and			* The facility's new shower p	rocess
	record review, the fa	cility failed offer or attempt to			* Shower sheets will be turne	d into the
	shower as scheduled	for 1 of 1 resident (resident			Wound Nurse daily for prope	r tracking.
	# 63) reviewed for ch	noices. Findings included:			2. Nursing Management was in-service	
		1 itt. it to the facilities on			Corporate Clinical/OPS on 8/1/14 on th	
	Resident #63 was at	dmitted to the facility on ted 3/8/12 with cumulative	1		*The Wound Nurse/designee	4
	diagnoses of encent	nalopathy and pseudobublar			the Shower sheets daily while in the fa	
	affect (unexplainable	e emotional episodes). The			* These will be matched again	
	quarterly Minimum D	Data Set (MDS) dated 5/24/14			shower sheet to ensure that showers we	
	indicated resident #6	33 had severe cognitive			* Any discrepancies observed	
	impairment and requ	ired total assistance for			in education/teachable moments of emp	L.
		care plan last updated			3. Each department manager has been	
		at resident #63 required	1		resident care area. (Guardian Angel Ro	
	assistance with all o	f her activities of daily living			manager will conduct daily random rou	
	(ADL) to include ba	thing and showering.			observations. During these rounds each	
	A review of the hally	vay shower list indicated that			will ask an alert and oriented resident	
	resident #63 was to	receive a shower every			their shower routine. Each	iootit
	Monday and Thursd				I .	Agouranaa
					Manager will complete the new Quality	Assurance
	In an observation or	7/7/14 at 1:00 PM, resident			Monitoring tool.	int for
		n the dining room clean and	ļ		4. Showers will be added to the Topic	
		was dressed for season and			discussion at each Resident Council M	eenng.
	no odor was noted.		1		MONITORING	
	In an observation or	7/0/14 at 10:00 AM resident			1. The new shower system will be a p	ermanent
	her room. She appeared clean and there was no odor noted. In an interview on 7/9/14 at 3:00 PM, nursing any discrepancies during to the any discrepancies during the any discrepanc					
					2. The Wound Nurse/Designee will co	
			any discrepancies during the Morning			
					At that time the IDT will revise the pla	
					3. These Quality Assurance tools will	
	assistant (NA) #4 st	ated resident #63 was			daily at the Daily Quality Assurance c	ž –
}	assigned a shower	every Monday and Thursday			meeting for completeness and accuracy	
i	I on first shift and a b	ed bath the other days. She	1		4 Any discrepancies will be identified	and the

	F DEFICIENCIES CORRECTION	INCUTICIOATION MULIPER.			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345434	B. WING_			l .	7/2014
	ROVIDER OR SUPPLIER			32	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E XIE	(X5) COMPLETION DATE
F 242	stated she did not ba because resident #63 the third shift NA alre in the mornings. In an interview on 7/3 worked third shift with resident gets up early bed bath before getti chair. NA #5 stated s #63 on third shift and to shower her on her shift. A review of the ADL of All 1/1/14 to present review a shower on stated. There were a of showers from 4/1/1 in another interview of stated she did not shift today because s showered the resident in an interview on 7/1 Director of Nursing s should have shower assigned shower day resident a shower ar responses. If resident attempts, the response	the resident #63 on first shift augually gets up so early, ady had her up and dressed 10/14 at 9:10 AM, NA #5 who have resident #63 stated the y and she always gave her a ng her up into her wheel he never showered resident would expect that first shift assigned shower days and records for bathing from ealed resident #63 did not any shift for the time frame also no documented refusals 14 to present. The Trio/14 at 2:20 PM, NA #4 ower resident #63 on first she assumed third shift int on third shift last night. 10/14 at 2:40 PM, the tated the 1st shift staff ed resident #63 on the ys or at least offered the id documented her at #63 refused the shower sible party should have been	F	242	Quality Assurance process will be modificated. Ongoing staff education, disciplicated and revision of the Quality Assurance process may be concurred to discrepancies noted. 5. This Quality Assurance process will educate at that time the Quality Assurance commercies the process weekly x 4 and there a monthly to ensure compliance. The Quality Assurance process will be revised as determined by the Quality Assurance conformation. The facility will conduct at least monthly Quality Assurance meetings with the Medicated to present findings and to seek good The Administrator is responsible for commercial transfer of the substantial complication.	nary action occess will ontinue ined and ittee will after ity nmittee. They dical quidance. upliance.	8/20/14
F 279 SS=D	COMPREHENSIVE A facility must use th	(1) DEVELOP	F	279	The facility does use the results of the ass to develop, review and revise the resident comprehensive plan of care.		8/20/14

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The state of the s		ULTIPLE CONSTRUCTION LDING		SURVEY LETED
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CARVER I	IVING CENTER			DI	URHAM, NC 27704		
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F 279	Continued From page comprehensive plan of the facility must dever plan for each resident objectives and timeta medical, nursing, and needs that are identificanceds that are identificanceds that are identificanceds that are identificanced in the facility of the facility of the facility of the facility of a known contracture (resident #160) reviee Findings included:	of care. elop a comprehensive care that includes measurable bles to meet a resident's imental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's hysical, mental, and ing as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment It is not met as evidenced ons, staff interviews and cility failed to develop a plan based on the assessed tion, restorative nursing or prevent a further worsening re for 1 of 4 resident's wed for range of motion.		279		tracture ted 11/14 to RISK herapy to ents identification and a VENT FU by the owing: sure that Admission Quarterly dentified is put into ed Therap and a care	eRTHER
	4/27/12 with cumulat hemiplegia, vascular quarterly Minimu 6/7/14 indicated resid cognitive impairment impairment in range	dementia and seizures. The ım Data Set (MDS) dated dent #160 had severe and was coded for of motion on one side. The			admission and on each resident MDS schedule to ensure that th has been screened by therapy n documented and a formalized p implemented as recommended. 2. These QA tools will be revie	s quarterly e resident eeds are lan is wed at the	
	annual MDS dated 9	ror to captured the			Morning QA meeting for comp	leteness d	hily

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) ĐATE COMP	
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	A	345434	B. WING_	6.	TREET ADDRESS, CITY, STATE, ZIP CODE	071	17/2014
	ROVIDER OR SUPPLIER			32	21 EAST CARVER STREET URHAM, NC 27704		
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F 279	but it was not care pla a factor in relation to his act ivies of daily li with a known contract plan for restorative not prevent worsening of ln an observation on #160 was lying in bed the elbow lying acros was in a fist position. A review of restorative receiving ROM and sonot appear on the list director of nursing state over the restorative presponsible for ROM in a group interview of three restorative aide #160 was not receiving ROM or splinting. In an observation on resident #160 was obwash cloth in his left stated she washed read clean dry wash clot the nurse told her too told anything about Romally does the ROM contractures. In a telephone interviting MDS nurse stated.	are Assessment Area (CAA) anned but only mentioned as his need for assistance with ving and pain associated ture. Also, there was no care ursing services of splinting to the contracture. 7/7/14 at 10:58 AM, resident d with his left arm flexed at s his chest. The left hand e nursing list for residents plinting, resident #160 did . On 7/9/14 at 12:12 PM, the ated the MDS nurse was urogram which was and splinting on 7/9/14 at 3:05 PM the as confirmed that resident ang any passive ROM, active	F	279	3. Findings will be reported to monthly QA Committee and if further discrepancies cot to be identified this plan will be revised by The Restorative is responsible for compliant The facility will be in substantial compliant 8/20/2014.	ntinue the IDT. nce	
		nd restorative or splinting					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	001101110011011	(X3) DATE SURVEY COMPLETED
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F 279	In an interview on 7/stated there should have splinting services to resident #160's contributions.	ne 25 ased on the evaluation. 10/14 at 5:00 PM, the DON have been restorative or prevent worsening of racture based on the annual he risk of potential worsening	F 279		8/20/14
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or other incapacitated under participate in plannin changes in care and A comprehensive ca within 7 days after the comprehensive asse interdisciplinary team physician, a register for the resident, and disciplines as determined, to the extent prothe resident, the resident, the resident provised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive; and revised by a team of the extent prother incomprehensive assets in the extent prother incomprehensive assets	e right, unless adjudged rwise found to be the laws of the State, to ag care and treatment or a treatment. The plan must be developed the completion of the essment; prepared by an another appropriate staff in the plan in the plan the participation of ident's family or the resident's needs, and periodically reviewed am of qualified persons after	F 280	1. Resident #203 had a proper restraint assessment by therapy completed on 8 MDS care plan updates in process will completed by 8/20/14. Lap Buddy has removed. 2. The Restorative Team conducted a 1 audit of all Residents and gathered a comprehensive list of all restraints. The Residents identified had a comprehens audit completed to ensure that all aspet the restraint process have been completed by 8/20/14. 3. To prevent further occurrences the Restorative team was in serviced on 7/by the Corporate Clinical/OPS VP on the following: The facility policy on restraint need to properly assess each resident a restraint is implemented, the need to attempt the least restrictive intervention before a restraint reduction plan in place a proper order which includes medical necessity, and a care plan with specific interventions that are resident specific.	be been 00% e sive cts of eted 231/14 he ts, the before need to e, have
	by: Based on observati record review, the fa	IT is not met as evidenced ion, staff interviews and acility failed to care plan a esident (resident #203)		Facility has implemented, "No restraint applied without the IDT review". The ID review each restraint before it is applie ensure that all components of the policipresent.	OT will d to

	O TOT MEDIONICE G	I	1				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 280	reviewed for physical included: Resident #203 was a with a diagnosis of de Minimum Data Set (Naignificant change da #203 had severe cog extensive assistance for a trunk restraint. (CAA) stated 6/3/14 i required the lap budd #203 was unable to ron command. A care A review of the care pathe comprehensive sassessment dated 6/plan for the lap buddy for a restraint. The fathe lap buddy except presence on 10/11/13 falls from her wheelch in an observation on #203 was observed swheelchair with a lap chair. (A lap buddy is fits across the front of secured to the wheel prevents the resident in an interview with of nursing assistant #1 scould not remove the chair. The NA stated and fall without the lap stated the lap buddy	dmitted the facility 5/31/13 ementia. The most recent MDS) was a comprehensive sted 6/3/14 indicated resident nitive impairment, required for transfers and was coded The Care Assessment Area ndicated resident #203 by to prevent rising. Resident emove the device at will or plan was to be developed. Dolan updated at the time of ignificant change 2/14 did not include a care by with interventions specific all care plan did not include for a mention of it's and 11/11/13 involving a hair. 7/7/14 at 11:40 AM, resident sitting in the dining room in a buddy applied to her wheel a padded trunk restraint that	F.	280	continued. 4. Monitoring will be accomplished by the Restorative Nurse completing the restrand present it to the IDT before any restimplemented. The IDT will review all the components to ensure compliance beforestraint is implemented. All facility rest will have a QA audit completed and presto Morning QA daily for 4 weeks and mand findings reviewed at the Monthly Committee. 5. Compliance will be 8/20/14	eint QA straint is he ore the raints esented onthly th	8/20/14 en

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	And the second s		STREET ADDRESS, CITY, STATE, ZIP C 321 EAST CARVER STREET DURHAM, NC 27704				
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F 280	resident in the bed. In an interview on 7/S of nursing (DON) stal in use for resident #2 been employed at the lap buddy should be repositioned at least the resident during man the lap buddy was called specific interventions. In an interview on 7/S #203 was observed a requested resident 20 the resident did not reany attempt at remove In an interview on 7/S rehabilitation director #203 in April and four functional status and buddy continued. He be care planned and continued need. In a telephone intervitie MDS nurse stated she must have lead and stated she must have lead to 1/2 administrator stated telling the staff how time the staff how	he was going to lay the 1/14 at 12:12 PM, the director led the lap buddy had been 03 as long as she had had a facility. The DON stated the removed and the resident levery 2 hours and taken off leals. She stated she thought re planned with all the 1/14 at 2:55 PM, resident at the nurse station. NA #2 1/203 remove her lap buddy but lespond to the command with leal of the device. 1/14 at 3: 23 PM, the 1/214 stated he screened resident	F	280				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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				3:	21 EAST CARVER STREET		1
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F 281 F 281 SS=D	PROFESSIONAL STA	ICES PROVIDED MEET	1	281 281	Resident #203 had a proper restrain assessment and care plan completed. order obtained on 7/17/14 to d/c lap but	Physician	
	must meet professior	al standards of quality.			with chair alarm and monitor for fall prevention. 2. The Restorative team conducted a	100%	
	by: Based on observation record review, the factorial obtain an physician of for 1 of 1 residents (rephysical restraints. Fither facility policy datasets)	rder for a physical restraint esident #203) reviewed for ndings included: led 2/5/14 indicated a written	TO VICTORIAN AND AND AND AND AND AND AND AND AND A		audit of all residents to gather a compilist of all restraints. This was completed. The residents identified had a compress audit completed to ensure that all asperstraint process have been completed. Completion will be 8/20/14. 3. To prevent further occurrences the Restorative team was in-serviced on the by the Corporate Clinical/OPS VP on the complete compile to the component of the componen	ed 8/8/14 hensive ects of th d.	
	restraint. Resident #203 was an 5/31/13 with a diagnorecent Minimum Data change dated 6/3/14 #203's mental status resident required extetransfers and was contact.	dmitted into the facility on sis of dementia. The most Set was a significant which indicated resident was severely impaired. The ensive assistance with ded for a trunk restraint.			following: Facility policy on restraints, to properly assess each resident before are implemented, the need to attempt least restrictive intervention before a resist implemented, the need to have a replan, the need to have a proper order includes medical necessity, and the necesser Plan the restraint with resident spinterventions. The facility has implemented the policy	the need re restrain the estraint duction which eed to ecific	nts
	documentation reveal physical restraint. In an observation on #203 was observed in wheelchair with a lap chair. (A lap buddy is fits across the front of secured to the wheelchair.	ed no physician's order for a 7/7/14 at 11:40 AM, resident a the dining room sitting in a buddy applied to her wheel a padded trunk restraint that			"No restraint can be applied without the review". The IDT will review each rest before it is applied to ensure all composite policy are present. 4. The Restorative Nurse will ensure and will complete the restraint QA and it to the IDT before any restraint is imposite IDT will review all components to compliance before the restraint is imposite in the IDT will review all components to compliance before the restraint is imposite in the IDT will review all components to complete and reviewed at Daily QA are completed and reviewed at Daily QA are	raint complianc present lemented ensure emented. it	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	CONSTRUCTION	(X3) DATE	
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	ROVIDER OR SUPPLIER		3:	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	assistant #1 stated the remove the lap buddy. NA stated resident #2 without the lap buddy. In an interview on 7/5 of nursing (DON) stated been in use for resident had been employed a unable to locate the variable variable to locate the variable variable to locate the variable variable to locate the variable variable to locate the variable varia	7/14 at 12:00 PM, nursing that resident #203 could not by from her wheel chair. The 203 would stand and fall or in place. 7/14 at 12:12 PM, the director the the physical restraint had ent #203 as long as she had at the facility but she was written order for the device. 7/14 at 2:45 PM, nurse #1 had the lap buddy when she to the secured unit. She do 6 months ago when ansferred from the secure the hallway. Nurse #1 stated sident #203 attempted to by but had heard reports that the entire that he screened resident at the stated he screened resident at the lap buddy was in this employment a year ago. The determinant of the entire was an order for the entire that the was an order for the entire that the was an order for the entire that the determinant of the entire that the second had a lap thair, he would have given a ter for the device.	F 281	and monthly afterwards. Findings to be presented to monthly QA Committee. 5. Compliance 8/20/14	oe .	8/20/14
	physician order supp	orting why a physical				

		MEDIO/ND CENTIONS				1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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CARVER	LIVING CENTER			D	URHAM, NC 27704		
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F 281 F 309 SS=J	Continued From page restraint was necesse 483.25 PROVIDE CA HIGHEST WELL BEI	ary for any resident. RE/SERVICES FOR		281 309	1. Resident #263 had a C-Diff re-culture 7/9/14 during the survey. MD was made of loose stools on 7/9/14 during survey.	le aware . The	7/17/14
	provide the necessar or maintain the highe mental, and psychos	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment			Potassium errors have been resolved a 7/14/14 with correct orders. The MD w notified of errors on 7/16/14 and had ga changes in the current treatment plan. is aware of resident #263 condition and monitoring closely. 2. A 100% bowel movement audit was completed from 7/10-7/16/14 to identify residents that are exhibiting persistent.	vas ave no The MD I is	
	by: Based on record rev nurse practitioner into manage the care of a or re-check a stool sa physician for persiste a 17 day delay in me physician was not no continued loose stoo low blood pressures (loss of bodily fluids), potassium level. The administer potassium for a critical potassium reference range) for reviewed for Clostrid (Resident #263). The immediate jeopa a stool specimen was the physician to rech persistent diarrhea. To	ls, the resident experienced and a fluid volume deficit which lead to a low facility also failed to a sordered by the physician level of 2.3 (3.5 - 5.3 to f2 residents' records			loose stools. The facility printed out the bowel movement charting from the ele charting system. This audit was compl 9:03 pm on 7/16/14. This task was cor by Nurse Managers. From this audit 3 were identified as having a long history stools. The facility notified MD on 7/16 orders for C-diff cultures were obtained precautionary measure. A 100% lab at completed for the last 30 days to ensur were obtained and any orders that we received were transcribed and adminis ordered. The Managers printed out all orders from the Electronic Charting Sysvalidate the orders. This was complete 7/16/14 at 9:10 pm. From this audit no medication errors in relationship to lab were found. The facility did note that 1 were not drawn per orders in the last 3: The MD was notified of these errors at orders were obtained. A 100% in house audit was completed to ascertain if all 6:	e CNA ctronic eted at inpleted resident y of loose 6/14 and l as a udit was re all labs re tered as I lab stem to ed on further results 3 labs 0 days, nd new e Resider	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
		045494	B. WING	_		(·
		345434	B. AAIIAG			07/	17/2014
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
CADVEDI	LIVING CENTER			32	21 EAST CARVER STREET		
CARVER	LIVING CENTER			Đ	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					continued.		
F 309	out of compliance at a (no actual harm with minimal harm) that is ensure monitoring systeffective. Findings incomplete infectious diarrhea), compossion infectious diarrhea), compossion, hyperten weakness), ventricular placed in the ventricle cerebral spinal fluid) of (area that has became blood vessels in the blood vessels	nce. The facility will remain a scope and severity of D the potential for more than not immediate jeopardy to stems put in place are cluded: dmitted into the facility on necluded C-Diff (a type of diarrhea, hypokalemia (low sion, debility (physical postomy (an external catheter es of the brain to drain clamped, cerebral aneurysm e weakened causing the prain to bulge), dysphagia difficulty walking and ness. The admission simpleted on 5/9/14 indicated nort and long term memory making was listed as a Dosage Handbook, 17th potassium is the major tive charge) of intracellular in the cell) fluid and is on of nerve impulses in the muscle; contraction of	F	309	continued. the MD was made aware. This audit we completed from 7/14-7/16/14 by the Not Managers this was completed on 7/16 10:37 pm. From this audit there were changes in condition that the facility confind the MD notification. The MD was of all changes on 7/16/14 by the Nurse Managers. Upon notification the MD in new orders or interventions for these RA 100% MD order audit was completed 7/10-7/16/14 to ensure that all orders the entered into the Electronic System as This audit was completed on 7/17/14 a From this audit 4 medication errors we These errors were for, Metformin was ton 7/16/14 and was administered. MD and no new order given. Multi tab order to 2 tabs. Facility failed to give Fosams weekly as ordered for 2 weeks. MD chorder to start Fosamax weekly. Treatmorder for Dry Gauze and TAO was ordered for Dry Gauze and TAO was ordered for Dry Gauze and TAO was ordered to 3 times a week and it was transcribed and Changed order to 3 times weekly. The Residents suffered any ill effects reto these errors. 3. In-servicing for the nursing staff and assistants was started on 7/16/14 by N Managers. In services included, Facility	orse 3/14 at 19 uld not notified ad no desidents if from were ordered. t 3:35 pn re noted to be held red for order ax anged nent ered as daily. None of elated nursing urse	1.
		al renal (kidney) function,			Change in Condition Policy and the		ł
		arbohydrate metabolism,			requirements of MD notification which i	ncludes;	
	and gastric (stomach)	secretion."			Resident's that are experiencing persis		e
		MARK Autoto Company			stools and have critical potassium leve		
		2014 admission monthly	1		other critical/abnormal labs. The facility		
		aled Resident #263 was not			Medication transcription policy was rev		ŀ
		on admission into the			with nurses to include proper transcript		
	facility. Medications to pressure included:	nat related to heart/blood		-	potassium and other medications. The		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345434	B. WING			1	17/2014
NAME OF P	ROVIDER OR SUPPLIER			ŞT	REET ADDRESS, CITY, STATE, ZIP CODE		
				32	1 EAST CARVER STREET		
CARVER	LIVING CENTER			DI	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 309	Continued From page Aspirin 325 milli Lisinopril 5 mg I A review of the lab refacility from the lab refacility from the lab refacility on 6/12/14 from the	gram (mg) by mouth daily by mouth daily by mouth daily seport received by the nursing provider on 5/13/14 revealed 3.6. seport received by the nursing both the lab provider in part ficile toxin result positive." It do that the report was "Read the director of nursing at the director of nursing at the director of nursing at the provider times daily the for 10 days." The retire the second (MAR) reflected		3309	continued Managers were in serviced by the Reg Vice President on 7/17/14 on the follow the facility's new morning nurses QA meeting to include: review of 24 hour condition report to ensure that all Residents that have exhibited persiste loose stools have been communicated the MD and new orders have been ca out. Review the 24 hour Bowel Recor ensure that any Resident that is havin continuous diarrhea or 3 loose stools 24 hour period has MD notification for proper interventions. Review all new orders to ensure that the order was properly transcribed into the Electroni Charting System and that the Resider received the treatment promptly. The Nurse responsible for receiving the laid diff culture order will enter it into the E	gional wing: ent d to rried d to g in a	7/17/14
	the last dose of Flag 6/21/14 at 10:00 pm used to treat a bacte A review of the nurs	yl was administered on . Flagyl is an antibiotic that is rial infection. es' notes revealed the			lab tracking. The 2nd shift Supervisor ensure all labs/C-diff cultures obtained received, distributed to the appropriation responsible nurse, the MD is notified a new orders are transcribed and	d are e	
	following blood pres - 6/21/14 (128/70 - 6/21/14 (126/68	o) at 10:53 pm b) at 10:54 pm			implemented. The Morning Nurses Q review all these completed labs/C-diff cultures the following morning to ensuring the 2nd shift Supervisor completed the continued tracks. The Lab Company of the continued tracks.	ire e	
	part read "Recheck secondary to persist				assigned tasks. The Lab Company al Critical Labs will be called to the DON designee. The DONB/designee will e that the MD is notified and ensure tha	/ nsure	
	6/26/14, did not refle stool specimen, faci manage loose stools	es' notes on 6/23, 6/24, 6/25, ect an attempt to collect a lity care interventions to s/diarrhea or the physician or as consulted for guidance.			new orders are carried out timely. 4. During the morning nurses QA mee all areas listed in #2 will be completed the Nurse Management Team. This r QA meeting was started on 7/17/14 a	l by new	

Facility ID: 923077

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMPI	
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		345434	B. WING			07/	17/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704		21 EAST CARVER STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	revealed the following 6/26/14 "three land A review of the nurse 6/29/14 did not reflect specimen, facility card loose stools/diarrhea practitioner was cons A review of the bowel revealed the following 6/29/14 "two med 6/30/14 "two larg A review of the nurse 7/3/14 did not reflect specimen, facility card loose stools/diarrhea practitioner was cons A review of the nurse following blood press 7/3/14 (108/64) a A review of the MAR received Lisinopril 5 r am on 7/1, 7/2, 7/3, 7 order was indicated a Lisinopril sign a medicat such as high blood pr failure. An action of L decrease certain cher	elimination pattern record g: rge loose stools" s' notes on 6/27, 6/28, t an attempt to collect a stool e interventions to manage or the physician or nurse ulted for guidance. elimination pattern record g: dium loose stools" e loose stools" s notes on 6/30, 7/1, 7/2, an attempt to collect a stool e intervention to manage or the physician or nurse ulted for guidance. s's note revealed the ure:	F	309	continued was monitored by the RVP. During thes meetings any discrepancies identified of documented, investigated, and correcte required. From any discrepancies identifier education or disciplinary action of occur with staff members responsible. are noted this QA process will be revised the QA Committee. These new QA prowill be a permanent practise of the facility QA process will be followed by the QA of for compliance and revisions if needed. are identified through these QA audits frequeational and training will be provided. The facility will contact and set up in serion medication errors and transcriptions. Pharmacist. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance an A member of the Home Office staff will site weekly for the next 30 days to offer support, and training and monitoring of All findings will be presented to the mon committee meeting. 5. Compliance is 7/17/14.	vill be d as d as d as d as d as d as d by grams d as trend arther d. This with the d support of a support guidance this plan	ds t.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345434	B. WING				C 17/2014
	ROVIDER OR SUPPLIER			ST#	REET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET IRHAM, NC 27704	1	1772017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	A review of the bowe revealed the following. 7/5/14 "one med. 7/6/14 "two med loose stool" A review of the nurse 7/7/14 did not reflect specimen, facility car loose stools/diarrhea practitioner was cons. A review of the bowe revealed the following. 7/7/14 "one large following blood press. 7/7/14 (109/65): A review of the nurse following blood press. 7/7/14 (111/57): A review of the bowe revealed the following. 7/8/14 "one small a review of a critical nursing facility by the 6:16 am to Nurse #7 potassium 2.3." Physical review of 2.3	delimination pattern record g: ium loose stool" ium loose stools, one large 's notes on 7/4, 7/5, 7/6 an attempt to collect a stool e intervention to manage or the physician or nurse sulted for guidance. I elimination pattern record g: e loose stool" 's note revealed the sure: at 4:42 am es' note revealed the sure: at 5:51 pm I elimination pattern record g: Il loose stool" lab result, reported to the lab provider on 7/8/14 at in part read "Critical sician #1 was indicated as order received on 7/8/14 at	F	309			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345434	B. WING				C /17/2014
	ROVIDER OR SUPPLIER	1		3	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET DURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	35	F:	309			
	7/8/14 received by No "potassium 20 millied The MAR did not reflex was administered on nursing facility was not level of 2.3 on 7/8/14 provider. A review of the nurse following blood press 7/8/14 (98/58) at A review of the nurse did not reflect an attes specimen, facility cardiose stools/diarrhea practitioner was consonal A review of the nurse following blood press 7/9/14 (98/58) at A review of the MAR med by mouth (15 min 7/9/14 at 9:00 am. A review of the nurse following blood press 7/9/14 (95/54) at 7/9/14 (95/54) at 7/9/14 (100/54)	uivalent (meq) every day." ect that potassium 20 (meq) 7/8/14 as ordered when the offied of a critical potassium at 6:16 am by the lab 's note revealed the ure: 7:02 pm s' notes on 7/8, and 7/9/14 mpt to collect a stool e interventions to manage or the physician or nurse ulted for guidance. s's note revealed the ure: 6:10 am revealed that potassium 20 lilliters) was administered on s' notes revealed the ures: 5:12 pm					
		ample was obtained for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345434	B. WING_			C 07/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	revealed the following revealed the following revealed the following revealed the lab respectively. The lab respective to the critical results called with unit manager # Due to the critical late 7/10/14 at 8:20 am to positive C-Diff, the po	el elimination pattern recordig: ge loose stools, two medium eport received by the nursing om the lab provider at in particile toxin result positive. I to, read back and verified if at 8:20 am." o reported to UM #1 on by the lab provider related to hysician ordered Vancomycin our times a day for C-Diff for in is an antibiotic used to treat and potassium chloride 20 by potassium. ician order dated 7/10/14; fied, in part read "increase o 20 meq by mouth twice ected the resident only 20 meq once on 7/10/14 at eport received by the nursing provider on 7/11/14 in particritical level." The MAR	F				
	facility on 7/14/14 at	eport received by the nursing 2:56 pm from the lab Nurse #6 in part read					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345434	B. WNG _		0	C 7/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 309	at 3:00 pm read "gi then increase potas mouth twice daily for reflected on 7/14/14 administered "pm" meq (2 tablets) was 5:00 pm. A review of the lab facility from the lab read "potassium 2.7/16/14 potassium administered at 9:00 In an interview on 7 and unit manager (results of the stool rechecked by the p stated per review of the electronic record stool sample had be date. UM #1 indical should have been a physician, however stool specimen had lin an interview on 7 medical director state sample ordered on obtained as ordere continued C-Diff, directly medical treatment.	sician order dated 7/14/14 pm ve potassium 40 meq now, saium chloride to 40 meq by or low potassium." The MAR 4 that potassium 40 meq was and on 7/15/14, potassium 20 administered at 9:00 am and report received by the nursing provider on 7/16/14 in part 4." The MAR reflected that on 20 meq (2 tablets) was 10 am and 4:00 pm. 7/9/14 at 11:42 am, Nurse #2 UM) #1 were asked about the sample ordered to be hysician on 6/23/14. Nurse #2 if Resident #263's chart and red she did not see another een attempted or collected to ted a stool sample recheck completed as ordered by the rishe could not find where the dibeen completed or obtain. 7/9/14 at 12:40 pm, the ated he expected the stool 6/23/14 to have been did revealuate the resident for ue to persistent diarrhea, so could have been initiated.	F3				
		acknowledged they reviewed imination pattern on a daily	V.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION MUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFEANO	CONNECTION	IDENTIFICATION OF THE PROPERTY	A. BUILD	NG		, ا	
		345434	B. WING			1	17/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	acknowledged they had completed previous completed previous after completed fo/21/14. They both if the physician via tele continued loose storesecond stool sample had no permanent he throughout the facilit. In an interview on 7/ acknowledged she side fo/23/14, which direct C-Diff "secondary to #4 indicated she waneeded but she did her shift because the She further stated siregarding the order stool specimen had. In an interview on 7/ stated she expected obtained as ordered clinical record to refit was unable to be obtained as ordered clinical record to refit was unable to be obtained as ordered clinical record to refit was unable to be obtained as ordered clinical record to refit was unable to be obtained she was una	r daily routine. Both nurses were aware Resident #263 lous antibiotics (ABT) for ent continued to have loose on of the ABT (Flagyl) on indicated they did not contact ephone regarding the ols, nor had they obtained a e. Both nurses stated they all assignment and worked by. 10/14 at 2:05 pm, Nurse #4 signed the physician order on ted to recheck the stool for opersistent diarrhea." Nurse is aware a stool sample was not obtain a stool sample on ere was no bowel movement. The did not follow back up because she assumed the been obtained.	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245424	8. WING				3
NAME OF B	ROVIDER OR SUPPLIER	345434	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 071</u>	17/2014
	LIVING CENTER			321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	In an interview on 7/stated on 7/8/14 Resstool described as "w mucous and slimy." Sindings to Nurse #3 part of her normal rown of the rownish of the rownish, and smeller notified Nurse #6 on 6/30/14 of her finding. In an interview on 7/stacknowledged on 7/8 received a critical postelephone; however and thought should not recall a concluded she did not related to the foul od potassium 20 meg to the interview on 7/stacknowledged on 7/8 received a critical postelephone; however and thought should not recall a concluded she did not related to the foul od potassium 20 meg to the interview on 7/stacknowledged on 7/8 received a critical postelephone; however and thought should not recall a concluded she did not related to the foul od potassium 20 meg to the interview on 7/stacknowledged on 7/8 who was the primary 7 am-7 pm indicated selimination pattern discomputer system by was aware Resident loose stools. She state (no date specified) the because she (Nurse	ve running stool to me." 16/14 at 11:26 am, NA #8 ident #263 had a loose small ratery, greenish color, with She stated she reported her before she documented as utine. 16/14 at 12:15 pm, NA #10 14 and 6/30/14 stated she 263 's stools "loose, ad bad." She stated she 6/26/14 and Nurse #4 on is. 16/14 at 12:54 pm, Nurse #7 3/14 from 7pm-7am she tassium lab result via she was not the primary he conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab her was not the primary her conveyed the critical lab	F	309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/01/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICALD SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B. WING 345434 07/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET **CARVER LIVING CENTER** DURHAM, NC 27704 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 F 309 Continued From page 40 Nurse #3 concluded she did not administer potassium 20 meg during her shift because she was not made aware there was an order to administer potassium on 7/8/14. In an interview on 7/16/14 at 1:53 pm, the medical director stated he became aware of the critical potassium level on 7/8/14 "early morning" and ordered for potassium 20 meg to be administered due to the critical lab. He stated he expected the medication to have been administered to the resident on 7/8/14 as ordered, considering the facility staff was aware of the resident critical lab result. He indicated he expected the potassium to have been administered on 7/8/14, because the resident's potassium level was at a critical level and the resident could have had cardiac problems such as an abnormal heart rhythm, while awaiting the potassium to be administered on 7/9/14. He stated on 7/14/14 the resident required more aggressive treatment in which potassium 40 mg was ordered to be given "now" and then to 40 mg twice daily (total of 80 mg daily) because the potassium level continued to drop. As the medical director, he stated factors which contributed to the low potassium were "fluid loss as a result of continued loose stools/diarrhea." The medical director concluded he was not made aware by the facility staff the resident was having persistent diarrhea, however he was aware the resident had a history of loose stools and had completed a course of antibiotics for 10 days (Flagyl). In an interview on 7/16/14 at 2:23 pm, the DON stated any abnormal stool presentation such as persistent diarrhea, color change or foul odor; she expected the clinical record to reflect such and the physician or NP to be notified.

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34543 4	B. WING			07/	7/2014	
	<u> </u>		321	EAST CARVER STREET			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD &	BE	(X5) COMPLETION DATE	
In an interview on 7/1 practitioner stated sh once (6/23/14) the rediarrhea, however discontacted her. The Norder for the resident "stool sample" for Cinformed unit manager responshe stated if she was related to Resident # stools/diarrhea, followshe would have orde intervention to help with stools/diarrhea. In an interview on 7/1 stated per her review MAR did not reflect padministered as orded the MAR reflected pot administered until 7/5 added potassium 20 administered on 7/10 daily and the MAR resided potassium 20 administered once estated the order to in transcribed into the eproperly, so the order to ensure transcribed properly In an interview on 7/1 medical director stated the order to the the orders to ensure transcribed properly	e recalled being informed sident was having continued of not specifically know who P stated she entered an 's stool to be re-checked Diff. She added she also er #1 of the order and the ded she would follow up. Is made aware by the facility 263 continued to have loose wing the order on 6/23/14, and an antibiotic, as an with the persistent loose with the persistent loose of the physician orders, the otassium 20 meq was ared on 7/8/14. She indicated stassium 20 meq was not 20/14 at 9:00 am. The DON meq was also ordered to be 1, 7/11, 7/12, 7/13/14 twice offected the medication was and day at 9:00 am. She crease potassium was not electronic computer system of the physician orders were and carried out.	F	309				
daily was discontinue resident's low blood	ed on 7/6/14 due to the pressures. He stated						
	Continued From page In an interview on 7/1 practitioner stated sh once (6/23/14) the re diarrhea, however die contacted her. The N order for the resident "stool sample" for C-informed unit manage unit manager respond She stated if she was related to Resident # stools/diarrhea, follow she would have orde intervention to help w stools/diarrhea. In an interview on 7/1 stated per her review MAR did not reflect p administered as orde the MAR reflected po administered until 7/3 added potassium 20 administered on 7/10 daily and the MAR re administered once es stated the order to in transcribed into the e properly, so the orde DON concluded her of manager to have che the orders to ensure transcribed properly In an interview on 7/1 medical director state daily was discontinued	ASSISTANCE OF SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. She stated if she was made aware by the facility related to Resident #263 continued to have loose stools/diarrhea, following the order on 6/23/14, she would have ordered an antibiotic, as an intervention to help with the persistent loose	ROVIDER OR SUPPLIER LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. She stated if she was made aware by the facility related to Resident #263 continued to have loose stools/diarrhea, following the order on 6/23/14, she would have ordered an antibiotic, as an intervention to help with the persistent loose stools/diarrhea. In an interview on 7/16/14 at 4:02 pm, the DON stated per her review of the physician orders, the MAR did not reflect potassium 20 meq was administered as ordered on 7/8/14. She indicated the MAR reflected potassium 20 meq was not administered until 7/9/14 at 9:00 am. The DON added potassium 20 meq was also ordered to be administered on 7/10, 7/11, 7/12, 7/13/14 twice daily and the MAR reflected the medication was administered once each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out. In an interview on 7/16/14 at 6:17 pm, the medical director stated Lisinopril 5 mg by mouth daily was discontinued on 7/6/14 due to the	ROMDER OR SUPPLIER LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. 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In an interview on 7/16/14 at 6:17 pm, the medical director stated Lisinopril 5 mg by mouth daily was discontinued on 7/6/14 due to the	ROMDER OR SUPPLIER 345434 ROMOER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 In an interview on 7/16/14 3:40 pm, the nurse practitioner stated she recalled being informed once (6/22/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked "stool sample" for C-Diff. She added she also informed unit manager #1 of the order and the unit manager #1 of the order and an interview on 7/16/14 at 4:02 pm, the DON stated pre her review of the physician orders, the MAR did not reflect potassium 20 meq was an intervention to help with the persistent loose stools/diarrhea. In an interview on 7/16/14 at 4:02 pm, the DON stated per her review of the physician orders, the MAR reflected potassium 20 meq was not administered until 7/9/14 at 9:00 am. The DON added potassium 20 meq was also ordered to be administered one each day at 9:00 am. She stated the MAR reflected potassium 20 meq was not administered one each day at 9:00 am. She stated the MAR reflected the medication was administered one each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed properly and carried out. In an interview on 7/16/14 at 6:17 pm, the medical director stated Lisinopril 5 mg by mouth daily was discontinued on 7/6/14 due to the	A BUILDING 345434 B. WING STREET ADDRESS, CITY, STATE, JIP CODE 321 EAST CARVES TISTED BUNAMAY STATEMENT OF DEFICIENCIES GRAD DEFICIENCY MUST 6E PRECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 In an interview on 7/16/14 3-40 pm, the nurse practitioner stated she recalled being informed once (6/23/14) the resident was having continued diarrhea, however did not specifically know who contacted her. The NP stated she entered an order for the resident's stool to be re-checked 'stool sample' for C-Diff. She added she also informed unit manager #1 of the order and the unit manager responded she would follow up. She stated off is how as made aware by the facility related to Resident #263 continued to have loose stools/diarrhea. In an interview on 7/16/14 at 4:02 pm, the DON stated part her review of the physician orders, the MAR (id not nelled polassium 20 meq was administered as ordered on 7/19/14, 15% indicated the MAR reflected polassium 20 meq was administered once each day at 9:00 am. She stated the order to increase potassium was not administered once each day at 9:00 am. She stated the order to increase potassium was not transcribed into the electronic computer system properly, so the order was not carried out. The DON concluded her expectation was for the unit manager to have checked the carbon copies of the orders to ensure the physician orders were transcribed into the electronic computer system properly, so the order was not carried out. In an interview on 7/16/14 at 6:17 pm, the medical director stated Lisinopril 5 mg by mouth daily was discontinued on 7/16/14 due to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345434	B. WING			1	C 17/2014
	ROVIDER OR SUPPLIER	010104		S1 32	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET URHAM, NC 27704	1 011	1772014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	In an interview on 7 administrator stated order, the receiving ensuring the order transcribed into the correctly. She adderesponsible for follot to ensure all new or transcribed and me ordered. In an interview on 7 who worked from 7 critical lab result da 1) was notified by the 6:16 am as indicated the medical direction 7/8/14 at 6:18 at the medical direction administer potassi stated she was sup into the electronic of potassium 20 meg however she mistal administered on 7/8/14 as ordered. who worked on 7/8/14 as ordered. who worked on 7/8/14 as ordered. Who worked on 7/8/14 as ordered. The administrator worked on 7/8/14 as ordered.	cools/diarrhea was causing the rop." 7/17/14 at 12:32 pm, the when a physician gives an nurse is responsible for its read back for clarity and electronic computer system and the unit managers were owing up on new orders daily, reders had been properly dication administered as 7/17/14 at 6:55 pm, Nurse #7 pm-7am when presented the sted 7/8/14 acknowledged she had be provider on 7/8/14 at and on the lab report pm, and received an order from from from from from from from fro	F	309			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		DENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345434	B. WING			07/	7 17/2014	
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	allegation on July 17, as follows: "RESIDENT IDENTIFAT the time this IJ was had a C-diff reconsurvey. MD was aware of during the survey. The Potassium of 7/14/14 with correct of errors on 7/16/14 at the current treatment. The MD is aware monitoring closely. IDENTIFYING OTHE 1. A 100% Bowel Moompleted from 7/10 residents that are exidiarrhea/loose stools. CNA bowel movemer Electronic charting. The Nurse Managers. From this audit Fas having a long hister facility notified the MI 7/16/14 and orders for obtained as a safety 2. A 100% lab audit 30 days to ensure all orders that were receated and instered as order out all lab orders from system to validate this	ided an acceptable credible 2014 at 8:25 pm for F 309 FIED s announced R 263- culture on 7/9/10 During the of the loose stools 7/9/10 errors have been resolved as orders. The MD was notified and had gave no changes in plan. The facility printed out is constructed in the facility printed out the facility printed out the first audit was completed at This task was completed by R1, R2 and R3 were identified out of these loose stools on or C-diff cultures were	LL.	309				
		no further medication errors			5.1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345434	B. WING _			C 07/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704	1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	in relationship to lat facility did note that orders in the last 30 these errors and net 3. A 100% in house completed to ascert 's were identified be aware. This audit w 7/16/14 by the Nurse completed on 7/16/14 by the Nurse completed on 7/16/14 by the notification. The ME on 7/16/14 by the notification the MD interventions for the 4. A 100% MD on 7/10/14-7/16/14 to were entered into the as ordered. This proby the nurse managers. To 7/17/14 @ 3:35 pm. From this audit These error for R4-be held on 7/16/14 notified and no new tabs ordered and 1 changed to 2 tabs), Fosamax weekly as stated to start Fosa order of Dry gauze a week and it was to stated to change to these residents suffitness errors.	o results were observed. The 13 labs were not drawn per I days. The MD was notified of w orders were obtained. Se resident audit was sain if all changes of Condition by nursing and the MD was was completed from 7/14/14- we Managers. This was 14 @ 10:37 PM. I there were 19 changes of ciclity could not find MD D was notified of all changes were managers. Upon had no new orders or were residents. I der audit was completed from ensure that all new orders we Electronic Charting System becass was started on 7/16/14 gers. This process will we completed on	F 3	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
			A. BOILD	.10			.
		345434	B. WING				17/2014
	ROVIDER OR SUPPLIER			321	REET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	•	
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	FURTHER OCCUR 1. In-servicing for assistants was start Managers. At this progression of the nurse will be able to work serviced. The facility's Comparishments of includes; residents persistent loose store potassium levels are the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility's Moreon of the facility of t	RRENCES If the nursing staff and nursing sted on 7/16/14 by the Nurse soint 84 nursing staff and out of 138 are in-serviced. No sing staff or nursing assistants the floor until they are in thange of Condition Policy and f MD notification which that are experiencing sols and have critical and other critical/abnormal labs. Itedication transcription policy the proper transcription of 7/16/14 AND ONGOING AT magers were in-serviced by the ident on 7/17/14 on the	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
		345434	B. WING			07/	C 17/2014
	ROVIDER OR SUPPLIER	Allower Allower		32	FREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET URHAM, NC 27704	<i>-</i>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI. .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	that all C-diff cultures The Nurse responsib will enter into it into the o The 2nd shift Su labs/ C-diff cultures of distributed to the app the MD is notified and and implemented. o The Morning Nur completed labs/C-diff morning to ensure the completed the assign o The Lab Compar called to the DON/de will ensure that the M any new orders are co	ew. o tracking sheet to ensure were obtained as ordered. le for receiving the lab order he ECS lab tracking. pervisor will ensure that all btained are received, ropriate responsible nurse, d new orders are transcribed reses QA will review all these fultures the following e 2nd shift Supervisor hed task. hy and all Critical Labs will be signee. The DON/designee lD is notified and ensure that arried out. high the facility staff to ensure	£	309			
F 318 SS=D	was validated. Staff in urses and nursing a had implemented the actions one should take or reported with person diarrhea, 2) chang physician orders recespecimen to be obtain policy, 5) physician in hour condition report or transcribing new ocharting system for in	spm, the credible allegation interviews with licensed ssistants revealed the facility following as it related to: 1) take if a resident is observed istent, continued loose stools es in stools pattern, 3) sived for stool sample or ned, 4) change in condition otification, 6) twenty-four and 7) process for entering refers in the electronic nedications and labs. ASE/PREVENT DECREASE	F.	318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION 3	(X3) DATE COMP		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 318	resident, the facility n with a limited range o	chensive assessment of a nust ensure that a resident of motion receives t and services to increase or to prevent further	F 31	The facility does ensure that a limited range of motion receive treatment and services to incremotion and/or prevent further drange of motion. 1. Resident#160 was assessed contractures needs and ROM pimplemented on 7/22/14. Resident was updated on 8/11/14	s appropriate ease range of ecrease in by therapy for the by the	8/20/14
	by: Based on observation interviews and record provide range of motive resident's with contral resident #93) reviews Findings included:	f review, the facility failed to ion (ROM) services for 2 of 4 ictures (resident #160 and ed for range of motion.		was assessed by therapy for co and ROM program was implen Resident #93 plan of care was 8/11/14 to reflect the program. 2. Identifying other residents at residents were assessed by Th their contracture needs. Resid with Restorative/therapy needs and a formal program was impl	nented on 7/9/14 updated on risk, all other erapy to determ ents identified were identified emented on).
	4/27/12 with cumulati hemiplegia, vascular quarterly Minimum D indicated resident #1 impairment and was range of motion on o restorative or therapy. The updated care plate.	is admitted to the facility on live diagnoses of left sided dementia and seizures. The lata Set (MDS) dated 6/7/14 60 had severe cognitive coded for impairment in line side. There were now services noted on the MDS. In dated 6/14/14 did not las an identified problem with		8/8/14. To prevent further occu Nursing Management was in se Corporate Clinical/Ops on 7/31 following; The restorative nurse that each resident in this facility by Therapy upon admission, ch condition, and at least quarterly Restorative Nurse will utilize The form to communicate screens for condition, new admissions, and contractures. Any Resident ne	erviced by the /14 on the will ensure / is, screened hange of / for contracture herapy referral or changes of I quarterly for	S.
	#160 was lying in bed the elbow lying acros was in a fist position. A review of restorativ receiving ROM and s	7/7/14 at 10:58 AM, resident d with his left arm flexed at as his chest. The left hand be nursing list for residents aplinting, resident #160 did to 0.7/9/14 at 12:12 PM, the		identified are documented, a for put into place, and directed by Therapist, staff is communicated a care plan is derived. 3. Monitoring will be as follower Nurse will complete the Contrator for each new admission and or quarterly MDS schedule to ens	the Licensed and the plan and d; the Restorative cture QA Tool a each resident's	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345434	B. WING_				C 17/2014	
NAME OF P	ROVIDER OR SUPPLIER	7.2.27	1	Si	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	17/2014	
				32	21 EAST CARVER STREET			
CARVER	IVING CENTER			D	URHAM, NC 27704			
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F 318	director of nursing state over the restorative presponsible for ROM. In an interview on 7/9 #160's wife stated he left hand prior to his a stated she kept a rolle when she had him at admission to the facilithe left hand contracted she was concerned at fixed that his fingerna palm. The wife attempts left hand but the rest in a group interview of three restorative aides #160 was not receiving ROM or splinting. In an interview on 7/9 rehabilitation director screened on admission He stated he did not for the did however recombeneded due to He did however recombeneded was solved to the man observation on a resident #160 was obswash cloth in his left he stated she washed refacted anything about Roll the nurse told her too told anything about Roll.	rogram which was and splinting. /14 at 2:30 PM, resident had the contracture to his dmission at the facility. She ed up wash cloth in his hand home and that since his ty, nobody had discussed ure with her. The wife stated bout his hand getting so ils would start to cut into his bited to open resident #160 'ident voiced discomfort. In 7/9/14 at 3:05 PM the is confirmed that resident g any passive ROM, active /14 at 3:22 PM, the stated resident #160 was an and again in April 2014. eel splinting services was the risk of skin breakdown. Inmend ROM services but lete a referral form for the stated he assumed the form ROM.	F3	318	continued has been screened by Therapy, needs documented, and a formalized plan is implemented as recommended. The QA tools will be reviewed at the mo QA meeting for completeness. If further discrepancies continue to be identified will be revised by the IDT. The Restora Nurse will be responsible for compliance all findings will be presented at monthly Committee Meetings. 5. Compliance date is 8/20/14	orning the plan ative e and	8/20/14	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704		
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F 318	In a telephone intervithe MDS nurse stated program worked was resident to her progra and assessment and for the restorative aid stated she did not reclaim an interview on 7/1 medical director states some sort of ROM se	ew on 7/10/14 at 11:09 AM, if the way the restorative that therapy would refer a sim based on their evaluation write out a treatment plan es to follow. The MDS nurse revive a referral from therapying done in April 2014. 0/14 at 12:40 PM, the sid he would have expected revices or something to be 0's hand to prevent further	F	318			
	07/18/2006 with right lower extremity contrivascular accident. A dated 6/21/14, the recognitively intact and limitations on one sid and lower extremities. The most recent Reh provided as per docu 09/26/13 and was conferapy (PT) Rehab stated. "History of the range of motion and motion with upper eximaintenance program						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMP	Survey Leted
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	ROVIDER OR SUPPLIER	·		321 E	ET ADDRESS, CITY, STATE, ZIP CODE AST CARVER STREET HAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	encourage use of pre equipment and mainted to the care plan dated (potential for further de with the goal as descerange of motion." No specified on the care 's contractures. The care guide correscare plan dated 06/25 staff to provide any so splinting services. The resident was observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed to be contracted at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the right without any sort of spin observed at the righ	up with restorative aides to viously established enance program. " 26/25/14 identified the ecline due to contractures ribed as " Maintain current to specific approaches were plan to address the resident sponding to the resident 's si/14 did not instruct nursing out of range of motion or erved to be sitting in a 14 at 11:00 AM. He was to elbow and right hand, lint in place. He was also acted at the right knee, lint in place. With the resident on 07/07/14 do that he received range of "a few months in 2009" the services were stopped. In a service were stopped at used to have leg and arm now where they are at the not used them in years. He go brace became at one point and he was eive a new brace but he sident #93 also stated that a evaluated him "about 8 as told that he was supposed facility 's restorative actures but did not know	F	8			

STATEMENT OF DEI AND PLAN OF CORI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3)) DATE SURVEY COMPLETED
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NAME OF PROVID				321 E	ET ADDRESS, CITY, STATE, ZIP CODE AST CARVER STREET HAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Nur 11:3 did or a ser con she con let a pro The 07// was he v con abla refe the The 07// did resi 09// Ref The inte con to h 09// exp	30 AM. She start and have orders any range of movices, restorative eventional nursing was aware that anyone touch his vided routine day and a second anyone touch his vided routine day and a second anyone touch his vided routine day and a second anyone touch his vided routine day anyone touch his vided routine day anyone touch his vided routine day anyone touch his vided routine day anyone touch anyone touch anyone anyo	interviewed on 07/07/14 at ted that Resident #93 currently to receive splinting services tion services by rehable nursing services, or ag services. She stated that at the resident had multiple at the resident typically did not as contractures when staff ally care. Interviewed on M. He stated that the resident by him on 09/26/13 and that the sident #93's multiple PT Rehab Director was not a documentation regarding a storative care as specified on abilitation Screening. Interviewed on M. He confirmed that rehable and alternative splints or e care for this resident since and on the resident's	F	318			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345434	B. WING		07/17/2014	
NAME OF P	ROVIDER OR SUPPLIER	1.00	s	TREET ADDRESS, CITY, STATE, ZIP CODE		١
			3	21 EAST CARVER STREET		
CARVER I	_IVING CENTER			OURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ИC
F 318	Continued From pa	age 52	F 318			
	documented discus	ssions/referrals took place			***************************************	
	between rehab and	restorative care departments.		 Resident #263 had a C-Diff re-cultured	on 7/17/1	,
	She also stated that	at her expectations were that				4
	all residents receiv	ed the care that they needed.		7/9/14 during the survey. MD was made	aware	į
F 333	483.25(m)(2) RESI	DENTS FREE OF	F 333	of loose stools on 7/9/14 during survey.	ine	
SS=J				Potassium errors have been resolved a		
				7/14/14 with correct orders. The MD w		
	The facility must er	nsure that residents are free of		notified of errors on 7/16/14 and had ga		
	any significant med	dication errors.		changes in the current treatment plan. I		
				is aware of resident #263 condition and	is	
				monitoring closely.		
	\$	NT is not met as evidenced		2. A 100% bowel movement audit was		
	by:			completed from 7/10-7/16/14 to identify	any	
		eview, staff, physician and		residents that are exhibiting persistent of	iarrhea/	
		ant interviews, the facility		loose stools. The facility printed out the	CNA	
		r potassium as ordered by the ident with a critical potassium	animove e	bowel movement charting from the elec-	tronic	
		3 reference range) for 1 of 1		charting system. This audit was comple	ted at	
		reviewed (Resident #263).		9:03 pm on 7/16/14. This task was comby Nurse Managers. From this audit 3	1	
	The immediate ien	pardy began on 7/8/14 when		were identified as having a long history		
		equivalent (meq) was not		stools. The facility notified MD on 7/16		
		esident #263 who had a critical		orders for C-diff cultures were obtained	as a	
	potassium level. T	he immediate jeopardy was		precautionary measure. A 100% lab au	dit was	
		4 at 8:47 pm when the facility		completed for the last 30 days to ensure		
	provided an accep	table credible allegation of		were obtained and any orders that were		
		acility will remain out of		received were transcribed and administ		
		ope and severity of D (no		ordered. The Managers printed out all	L.	
		ne potential for more than		orders from the Electronic Charting Sys		
		is not immediate jeopardy to	v r r r r r r r r r r r r r r r r r r r	validate the orders. This was complete		
		systems put in place are		7/16/14 at 9:10 pm. From this audit no		
	effective. Findings	included:		medication errors in relationship to lab r		
	Desident #000	- admitted into the facility on		were found. The facility did note that 13		
		s admitted into the facility on		were not drawn per orders in the last 30		
		s included clostridium difficile		The MD was notified of these errors an		
		nfectious diarrhea), diarrhea, potassium), hypertension and		orders were obtained. A 100% in house		
		reakness). The admission		audit was completed to ascertain if all C		
	deniità (huàsicai w	reannessy. The admission	**************************************	in Condition were identified by pursing	-	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPL	
		345434	B. WING_			07/	7/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		ļ
O A DIVIED I	NINO CENTED			32	1 EAST CARVER STREET		
CARVER	IVING CENTER			D	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					the MD was made aware. This audit w	as	
F 333	Continued From pa	ae 53	F3	333	completed from 7/14-7/16/14 by the Nu	rse	7/17/14
	· ·	completed on 5/9/14 indicated			Managers this was completed on 7/16	6/14 at	
		short and long term memory		- 1	10:37 pm. From this audit there were	19	
		making was listed as			changes in condition that the facility co	uld not	
	moderately impaire				find the MD notification. The MD was	notified	
					of all changes on 7/16/14 by the Nurse		
		ric Dosage Handbook, 17th		ļ	Managers. Upon notification the MD h	ad no	
		s "potassium is the major			new orders or interventions for these R	esidents	
		ositive charge) of intracellular			A 100% MD order audit was completed	f from	
		ithin the cell) fluid and is		İ	7/10-7/16/14 to ensure that all orders	were	
		ction of nerve impulses in			entered into the Electronic System as	ordered.	
	cardiac, skeletal an	eletal muscle; contraction of			This audit was completed on 7/17/14 a	t 3:35 pm	,
		mal renal (kidney) function,			From this audit 4 medication errors we	re noted	
		carbohydrate metabolism,			These errors were for, Metformin was t	o be held	
	and gastric (stomac				on 7/16/14 and was administered. MD	notified	
	and galante (otterner	,			and no new order given. Multi tab orde	ered for	
	A review of the Apri	il 2014 admission monthly			1 tab and 2 were given. MD changed	order	
		vealed Resident #263 was not		Ì	to 2 tabs. Facility failed to give Fosam	ax	
	prescribed potassiu	ım on admission into the			weekly as ordered for 2 weeks. MD ch	anged	
	facility. Medications	that related to heart/blood			order to start Fosamax weekly. Treatn	nent	
	pressure included:				order for Dry Gauze and TAO was order	ered	
]		3 times a week and it was transcribed	as daily.	
		lligram (mg) by mouth daily			MD changed order to 3 times weekly.	None of	
	Lisinoprii 5 mg	by mouth daily			the Residents suffered any ill effects r	elated	
	A ravious of the lab	report received by the nursing			to these errors.	Ţ	
		provider on 5/13/14 revealed			3. In-servicing for the nursing staff and	nursing	
	a potassium level o				assistants was started on 7/16/14 by N	urse	
	a potacolam io ioi o				Managers. In services included, Facili	ty's	
	A review of the med	dication administration record			Change in Condition Policy and the		
	(MAR) reflected Re	esident #263 received Lisinopril			requirements of MD notification which	includes;	
	5 mg by mouth dail	y at 9:00 am on 7/1, 7/2, 7/3,			Resident's that are experiencing persis	tent loose	>
		. The order was indicated as			stools and have critical potassium leve	ls and	
		6/14. Lisinopril is a medication			other critical/abnormal labs. The facilit	y's	
		lions such as high blood			Medication transcription policy was rev	iewed	
		estive heart failure. An action			with nurses to include proper transcrip		
		functions to decrease certain			potassium and other medications. The		
	1 -	ten the blood vessels, thus					

Facility ID: 923077

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345434	8. WING			1	C 17/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	177201-4
TO UTIL OT T	NOVIDEN ON GOLVERN				21 EAST CARVER STREET		
CARVER	LIVING CENTER						
				···	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	A(review) of a critica nursing (facility) by th 6:16 am to Nurse # potassium 2.3." Ph notified with a new	al lab result, reported to the ne lab provider on 7/8/14 at 17 in part read "Critical ysician #1 was indicated as order received on 7/8/14 at	F:	333	continued Managers were in serviced by the Revice President on 7/17/14 on the foll the facility's new morning nurses QA meeting to include: review of 24 hou condition report to ensure that all Residents that have exhibited persis loose stools have been communicated.	owing:	
	7/8/14 received by "potassium 20 med	cian telephone order dated Nurse #7 in part read every day."			the MD and new orders have been on the MD and new orders have been out. Review the 24 hour Bowel Recensure that any Resident that is have continuous diarrhea or 3 loose stook 24 hour period has MD notification for	and new orders have been carried eview the 24 hour Bowel Record to that any Resident that is having ous diarrhea or 3 loose stools in a	
	was administered on nursing facility was	effect that potassium 20 meq on 7/8/14 as ordered when the notified of a critical potassium 14 at 6:16 am by the lab			proper interventions. Review all new orders to ensure that the order was properly transcribed into the Electror Charting System and that the Reside received the treatment promptly. The Nurse responsible for receiving the least the second se	iic ent	
	by mouth (15 millili 7/9/14 at 9:00 am.	R revealed potassium 20 meq iers) was administered on R revealed potassium 20 meq			diff culture order will enter it into the lab tracking. The 2nd shift Supervisor ensure all labs/C-diff cultures obtained received, distributed to the appropriate	ECS or will ed are	
	tablet was administ 9:00 am.	ered by mouth on 7/10/14 at			responsible nurse, the MD is notified new orders are transcribed and implemented. The Morning Nurses (and QA will	
	order time not spec potassium chloride daily." The MAR re received potassium 9:00 am. A review of the lab facility from the lab	sician order dated 7/10/14; ified, in part read "increase to 20 meq by mouth twice flected the resident only 20 meq once on 7/10/14 at report received by the nursing provider on 7/11/14 in part			review all these completed labs/C-di- cultures the following morning to ensithe 2nd shift Supervisor completed the assigned tasks. The Lab Company of Critical Labs will be called to the DOI designee. The DONB/designee will that the MD is notified and ensure the new orders are carried out timely.	ure ne and all V/ ensure at any	
	reflected potassium	2 critical level." The MAR 120 meq was administered 17/11, 7/12 and 7/13/14.			4. During the morning nurses QA me all areas listed in #2 will be complete the Nurse Management Team. This QA meeting was started on 7/17/14 a	d by new	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1200	(
		345434	B. WING_			07/	17/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				32	21 EAST CARVER STREET		
CARVER	LIVING CENTER			Þ	URHAM, NC 27704		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	A review of the lab re facility on 7/14/14 at 2 provider reported to N "potassium 2.2 critical A review of the physical 3:00 pm read "give then increase potassis mouth twice daily for reflected on 7/14/14 administered "pm" and meq (2 tablets) was a 5:00 pm. A review of the lab refacility from the lab pread "potassium 2.4." 7/16/14 potassium port received by the nursing 2:56 pm from the lab durse #6 in part read at level." cian order dated 7/14/14 pm potassium 40 meq now, ium chloride to 40 meq by low potassium." The MAR potassium 40 meq was id on 7/15/14, potassium 20 administered at 9:00 am and port received by the nursing rovider on 7/16/14 in part 17 The MAR reflected on 18 meq (2 tablets) was am and 4:00 pm. 0/14 at 5:07 pm, the DON all orders to have been by the physician and the loct such, if the stool sample asined. 6/14 at 12:54 pm, Nurse #7 murse and thought she lab (potassium) to Nurse #3. did not administer potassium int on 7/8/14. 6/14 at 1:28 pm, Nurse #3 nurse on 7/8/14 from	L.		Was monitored by the RVP. During this any discrepancies identified will be docu investigated, and corrected as required. From any discrepancies identified further education or disciplinary action woccur with staff members responsible. I are noted this QA process will be revise the QA Committee. These new QA prowill be a permanent practise of the facility QA process will be followed by the QA of for compliance and revisions if needed. are identified through these QA audits freeducational and training will be provided the facility will contact and set up in ser on medication errors and transcription of the Pharmacist. The facility will continue to involve the Medical Director in the facility processes in order to seek guidance and A member of the Home Office staff will the site weekly for the next 30 days to offer support, and training and monitoring of the All findings will be presented to the monicommittee meeting. 5. Compliance is 7/17/14.	vill If trends d by grams ty. This committee As trend urther d. vicing with the y d support be on guidance this plan.	S	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345434	B, WING				C 17/2014
NAME OF P	ROVIDER OR SUPPLIER	010101			STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	1112014
				3	21 EAST CARVER STREET		
CARVER	LIVING CENTER			[DURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	was not made aware administer potassium. In an interview on 7/1 medical director state critical potassium level and ordered for potas administered due to the expected the medicat administered to the reordered, considering of the resident critical expected the potassiu administered on 7/8/1 potassium level was a resident could have has an abnormal heart potassium to be administered on 7/14/14 the aggressive treatment was ordered to be given twice daily (total of 80 potassium level continuity of continued loose stock of the low potassium of continued loose stock of the MAR reflected potadministered as order the MAR reflected potadministered until 7/9 added potassium 20 radministered on 7/10,	there was an order to on 7/8/14. 6/14 at 1:53 pm, the d he became aware of the el on 7/8/14 "early morning" sium 20 meq to be he critical lab. He stated he ion to have been esident on 7/8/14 as the facility staff was aware lab result. He indicated he ion to have been 4, because the resident's at a critical level and the ad cardiac problems such rhythm, while awaiting the nistered on 7/9/14. He resident required more in which potassium 40 mg en "now" and then to 40 mg en "now" and then to 40 mg en "now" and then to 40 mg en "fluid loss as a result cols/diarrhea." 6/14 at 4:02 pm, the DON of the physician orders, the at potassium 20 meq was red on 7/8/14. She indicated cassium 20 meq was not /14 at 9:00 am. The DON meq was also ordered to be 7/11, 7/12, 7/13/14 twice	L.	3333			
	administered once ea stated the order to inc	lected the medication was ch day at 9:00 am. She rease potassium was not ectronic computer system					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
	IDENTIFICATION NUMBER:	A. BUILDII	1G					
		345434	B. WING_			07/	17/2014	
	ROVIDER OR SUPPLIER			321 EA	TADDRESS, CITY, STATE, ZIP CODE ST CARVER STREET AM, NC 27704			
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 333	properly, so the order DON concluded her manager to have che the orders to ensure transcribed properly In an interview on 7/ administrator indicate ensuring physician of correctly as ordered gives an order, the reformer ensuring the order ensuring the order ensuring the order ensuring the order ensuring the order ensuring the order ensuring the order ensuring the order ensure all new ordered. In an interview on 7 facility's consultant	er was not carried out. The expectation was for the unit ecked the carbon copies of the physician orders were and carried out. 17/14 at 12:32 pm, the ed the facility process for orders were transcribed revealed when a physician receiving nurse is responsible er is read back for clarity and electronic computer system do the unit managers were wing up on new orders daily, ders had been properly dications administered as	F	333				
	expected all orders administered as ord the resident's critical In an interview on 7 who worked 7pm-7 lab result dated 7/8 notified by the lab pas indicated on the medical director as 7/8/14 at 6:18 am, medical director on "administer potassistated that she was order into the elect potassium 20 med however she mistal	for potassium to have been lered by the physician due to						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE S	
			B, WING			07/4	
NAME OF S	DOMES OF SHORTER	345434	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	<u> 1 07/1</u> 7	7/2014
	PROVIDER OR SUPPLIER			32	1 EAST CARVER STREET URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	did not administer to #263 on 7/8/14 as of Nurse #3 who work took over the care of Nurse #7 indicated her (Nurse #3) awa level/order received. The administrator of jeopardy on 7/17/14 provided the following 17, 2014 at 8:25 pm. "RESIDENT IDENT At the time this IJ work as aware during the survey. MD was aware during the survey. The Potassium 7/14/14 with correct of errors on 7/16/14 the current treatme. The MD is aware monitoring closely. IDENTIFYING OTH. A 100% Bowel completed from 7/17 residents that are ediarrhea/loose stock CNA bowel movem Electronic charting 9:03 pm on 7/16/14 the Nurse Manager. From this audit as having a long his facility notified the	the potassium to Resident ordered. Nurse #7 concluded ed on 7/8/14 from 7am-7pm of Resident #263 after her. she was not sure if she made re of the critical potassium f. It was notified of the immediate 4 at 10:10 am. The facility ing credible allegation on July in for F 333 as follows: IFIED was announced R 263-culture on 7/9/10 During the effect of the loose stools 7/9/10 in errors have been resolved as at orders. The MD was notified and had given no changes in int plan. The facility and its effect of R 263 condition and is exhibiting persistent ols. The facility printed out the lent charting from the intrins audit was completed at 4. This task was completed by	F	333			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		STRUCTION		TE SURVEY MPLETED C
		345434	B. WING				7/17/2014
	ROVIDER OR SUPPLIER			321 E	ET ADDRESS, CITY, STATE, ZIP CODE AST CARVER STREET HAM, NC 27704		
(X4) ID PREFIX TAG	FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	obtained as a safety 2. A 100% lab aud 30 days to ensure al orders that were rece administered as order out all lab orders froi system to validate the the nurse managers From this audit in relationship to lab facility did note that orders in the last 30 these errors and nev 3. A 100% in hous completed to ascert 's were identified by aware. This audit to 7/16/14 by the Nurs completed on 7/16/ From this audit condition that the fa notification. The MD on 7/16/14 by the no notification the MD in interventions for the 4. A 100% MD or 7/10/14-7/16/14 to e were entered into the as ordered. This pro by the nurse manage continue and will be nurse managers. Ti 7/17/14 @ 3:35 pm From this audit These error for R4- be held on 7/16/14 notified and no new tabs ordered and 1	measure. It was completed for the last I labs were obtained and any eived were transcribed and ered. The Managers printed in the Electronic Charting is. This was completed by on 7/16/14 at 9:10 pm. The first was completed by on 7/16/14 at 9:10 pm. The first were observed. The 13 labs were not drawn per days. The MD was notified of worders were obtained. The resident audit was an if all changes of Condition of an interest was completed from 7/14/14- The Managers. This was 14 @ 10:37 PM. There were 19 changes of cility could not find MD was notified of all changes were managers. Upon that no new orders or the residents. The electronic Charting System process was started on 7/16/14 pers. This process will ecompleted on 7/16/14 by the his audit was completed on	F	333			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILD			, ا	
		345434	B. WING			1	17/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				32	1 EAST CARVER STREET		
CARVER	LIVING CENTER			DL	JRHAM, NC 27704		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 333	Continued From page	a 60	F	333			
1 333	1	ordered for 2 weeks (MD	·				
		ax weekly), R7 treatment					
		nd TAO was ordered 3 times					
		nscribed as daily (MD					
		times weekly). None of		ĺ			
		red any III effects related to		1			
	these errors.	•		1			
						ļ	
		MENTED TO PREVENT					
	FURTHER OCCURR						
		ne nursing staff and nursing					
		d on 7/16/14 by the Nurse					
		int 84 nursing staff and					
		t of 138 are in-serviced. No		1		İ	
		ig staff or nursing assistants		1		!	
	serviced.	ne floor until they are in		i		i	
	i .	ange of Condition Policy and		i		i	
	the requirements of N						
	includes; residents th		-				
	persistent loose stool						
		other critical/abnormal labs.					1
		dication transcription policy					
	which would include	the proper transcription of					
	potassium.						
	a. STARTED ON 7	/16/14 AND ONGOING AT		ļ			
	THIS TIME.			Ì			
		agers were in-serviced by the		i			
		ent on 7/17/14 on the					
	following:	ou Morning Nurses OA	***				
	Meeting which will in	w Morning Nurses QA		1			
		hour condition report to					1
		nts that have exhibited					
		Is have been communicated					
		I new orders have been					
	carried out.						
		hour Bowel Record to					
		lent that is having continuous					ļ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCAMINATION AND ADDRESS.			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345434	8. WING	B. WING		C 07/17/2014		
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET DURHAM, NC 27704	1 017			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 333	diarrhea or 3 loose st MD notification for pr o Review of all new order was properly to Charting System and the treatment prompt for receiving the lab/(into it into the ECS la Managers will ensure their morning QA rev o Review of the la that all C-diff cultures. The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsib will enter into it into the The Nurse responsible will enter into it into the The Nurse responsible will enter into it into the The Nurse and implemented. On The Lab Compacion of the Lab Compacion of Properly manage proper resident care. The Completion date. On 7/17/2014 at 8:26 was validated. Staff nurses and nursing a had implemented the actions one should the physician order for properly into the physician order for properly into the the complete the the complete the complete the complete the the complete the complete the same resident care.	tools in a 24 hour period has oper interventions. w orders to ensure that the anscribed into the Electronic I that the resident received by. The Nurse responsible C-diff culture order will enter to tracking. The Nurse et this is completed during few. b tracking sheet to ensure sewere obtained as ordered. The ECS lab tracking the lab order the ECS lab tracking. The pervisor will ensure that all obtained are received, propriate responsible nurse, denew orders are transcribed tracks. The pervisor had all critical Labs will be esignee. The DON/designee MD is notified and ensure that carried out. Ing the facility staff to ensure is provided.		333				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345434 B. WING			C 07/17/2014	
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	persistent, continued changes in stool patt received for stool sar obtained, 5) change in physician notification condition report and transcribing new ordersystem for medicatio 483.65 INFECTION (SPREAD, LINENS) The facility must estal Infection Control Prosafe, sanitary and control Prosafe, sanitary and control prevent the drof disease and infection Control The facility must estal Program under which (1) Investigates, control in the facility; (2) Decides what prosahould be applied to (3) Maintains a reconsactions related to infection the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will trait (3) The facility must in the f	loose stools or diarrhea, 3) ern, 4) physician orders inple or specimen to be in condition policy, 6) in, 7) twenty-four hour is process for entering or ers in the electronic charting ins and labs. CONTROL, PREVENT In this process for entering or ers in the electronic charting ins and labs. CONTROL, PREVENT In this process for entering or ers in the electronic charting ins and labs. CONTROL, PREVENT In this process for entering or ers in the electronic charting ins and labs. CONTROL, PREVENT In this provide a man designed to pro	F		ned to infortable ie of disease ture # 263 had 4. The vital sanitized on sk during the iff or ther in serviced 4 and 8/11/14 plation the facilities / on glove partment desident care Each Managobservations ger will . Each quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.07404		A. BUILDING		C	
	345434 B. WING				07/	17/2014	
	ROVIDER OR SUPPLIER			32	TREET ADDRESS, CITY, STATE, ZIP CODE 21 EAST CARVER STREET URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	transport linens so as infection. This REQUIREMENT by: Based on record revinterviews, the facility isolation notice or sig staff and visitors to entering the room; 2) leaving the room; 3) facare of resident's room; 3) facare of residents; 4) vital sign equipment (Clostridium difficile (Coreviewed for infection #158). Findings include the facility policy in page 158). Findings include the facility policy in page 250 include watery diarrh precautions while haconsiderations: wash do not use an alcohologottact isolation indication.	dile, store, process and store, process and store, process and store, process and store, observations and staff (1) failed to post contact anage to alert the residents, ake precautions prior to failed to wash hands after before going to the next ailed to wash hands between and failed to disinfect the for a resident with C-Diff) for 2 of 8 residents in control (Resident #263, ded: Deart read "C-Diff is a found that causes diarrhea estinal conditions such as symptoms of C-Diff disease ea. Precautions: contact wing diarrhea. Special hands with soap and water; if handrub" The type of cated for C-Diff included acility specifications for	F	441	4. Monitoring will be with QA tools be reviewed daily at the Morning Meeting discrepancies noted will be identified a further interventions will be implement The QA process will continue until subcompliance is obtained from NCDHHS At that time the QA committee will rever this QA process will continue weekly to the Infection Control in-servicing will at least quarterly. The DON and Admit will be responsible for compliance and findings to the monthly QA Committee 5. Facility will be in compliance 8/20/19	a. Any and ed. ostantial o	
		with a resident who has an he same organism but with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I INCLUSION FROM THE PROPERTY OF THE PROPERTY		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		0111112014	
CARVER LIVING CENTER				321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 441	gloves; Gloves worn whe while providing care if After glove remo should not touch pote surfaces or items; Gowns should be entering the room or removed before leaving the resident of the resident of the resident of the resident with the lab refacility on 6/12/14 from read "clostridium diffication administrative last dose of Flagy!	horting); completed prior to donning en entering the room and for the resident; val and hand hygiene, hands entially contaminated end donned (put on) prior to resident's cubicle and ing the resident's room; ent care equipment should be esident, or if use of common is unavoidable, the items or cleaned and/or disinfected en resident." Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. Inditted into the facility on included C-Diff and diarrhea. In the lab provider in part included C-Diff and diarrhea. In the lab provider in part included C-Diff and diarrhea. In the lab provider in part included C-Diff and diarrhea. In the lab provider in part in t	F	141			
:	revealed Resident #2 6/29, 6/30, 7/5, 7/6, 7						
	facility on 7/10/14 from	port received by the nursing m the lab provider in part cile toxin result positive.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULI A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
	345434 B. WING		0	C 7/17/2014		
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP 321 EAST CARVER STREET DURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	with unit manager #1 Due to the critical lab 7/10/14 at 8:20 am by positive C-Diff, the ph 125 mg by mouth fou 14 days (Vancomycin bacterial infections). During an observation 2:55 pm, and 4:03 pn isolation signage pos Located on the door vand masks on a cadd different divisions who During an observation (nursing assistant) #6 room without any per (PPE) on and obtaine At 9:50 am, NA #6 ex without washing her h Resident #158's room the resident. At 9:55 a resident's room, sanit proceeded with the vi hallway, without clear 200 hall and left the v pressure cuff and the hallway for other staff During a follow-up ob am, no contact isolati posted on Resident # In an interview on 7/9 and unit manager (United to the contact isolati posted on Resident # In an interview on 7/9 and unit manager (United to the contact isolati posted on Resident #	to, read back and verified at 8:20 am." reported to UM #1 on by the lab provider related to hysician ordered Vancomycin or times a day for C-Diff for a is an antibiotic used to treat the non 7/7/14 at 11:47 am, and there was no contact ted on Resident #263's door. Were isolation gowns, gloves by (a storage container with the are item are stored). In on 7/8/14 at 9:45 am, NA is contered Resident #263's sonal protected equipment and vital signs on the resident. The dited the resident's room the nands, proceeded into the nand obtained vital signs on the ited her hands and then ited sign equipment down the nand or disinfecting to the resident on the hall to use. Servation on 7/9/14 at 9:51 on signage was observed 263's door.	F.	441		
	and unit manager (UI					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345434	B. WING			C 07/17/2014		
	ROVIDER OR SUPPLIER			321	EET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	1 011	11112014	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 441 F 497 SS=D	posted on Resident in an interview on 7/ acknowledged that is nurse. She stated she #263 was supposed. In an interview on 7/ stated she was awar contact isolation, how was suppose to 1) usequipment when taking resident, 2) wash he room, 3) disinfect the using it on other resident, 2 wash he room, 3) disinfect the using it on other resident, and interview on 7/ of nursing stated she signage to be posted with the isolation equipment when contact its policy whe	#263's door. 9/14 at 12:05 pm Nurse #5 the was the infection control the was not sure if Resident to be on contact isolation. 9/14 at 12:10 pm, NA #6 the Resident #263 was on the was not sure if Resident to be on contact isolation. 9/14 at 12:10 pm, NA #6 the Resident #263 was on the resident #263 was on the resident protective the vital signs on the resident prior to the dents. 9/14 at 12:14 pm, the director of the expected contact isolation of the residents' doors along the suital sign equipment prior to the expected contact isolation of the PPE to be used per per per per per per per per per per		441				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345434 B. WING			C 07/17/2014	
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		D BE COMPLETION		
F 497	aides providing servicognitive impairment the cognitive impairment the cognitively impair This REQUIREMENT by: Based on record reviacility failed to ensur (NA) acquired 12 hoc annually (NA#9). Find NA#9 was hired on 6 employee list revealed 12 hours of in-services 7/17/14. In an interview on 7/1 administrator stated 1 NAs have acquired 1 training." The administrator that the training to have be completed for each N (DON). The administrator in administrator of the received any and in an interview on 7/1 (former ADON) stated role of the ADON, he which included: staff nurse and the unit mad 12 hour annual required and she could not produce the staff of the staff	ces to individuals with s, also address the care of red. F is not met as evidenced liew and staff interviews, the re 1 of 1 nursing assistants are of in-service training dings included: 6/20/13. A review of a NA d NA #9 had not completed raining from 6/21/13 to	F 49	The facility must complete a perform of every nurse aide at least once ever months, and must provide regular in education based on the outcome of reviews. The in-service training must sufficient to ensure the continuing conurse aides, but must be no less that per year; address areas of weaknest determined in nurse aides' performation and may address the special needs as determined by the facility staff; and aides providing services to individual cognitive impairments, also address the cognitively impaired. EMPLOYEE(S) IDENTIFIED 1All CNA's are identified as potential at risk for this citation. PROCESSES IMPLEMENTED TO PREVENT FURTHER OCCURRENT I.In-Service held 8/6/14 for Human II.In-Service held 8/6/14 for Human III.In-Service held 8/6/14 for Human	ery 12 -service these t be competence of in 12 hours is as ince reviews of residents and for nurse its with is the care of the met for essing the it as the on at least cation cognitively as deemed ity for the
F 516 SS=D	otherwise. 483.75(I)(3), 483.20(f SAFEGUARD CLINIC)(5) RELEASE RES INFO, CAL RECORDS	F 51	Nursing Aides which will include doc of time spent and Topics presented: A.The facility will generate a calenda In-services to be presented on a reg B.The calendar shall be posted in the	r of ular basis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345434	B. WING_	B. WING			C 17/2014
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	077	1772014
					21 EAST CARVER STREET		
CARVER LIVING CENTER							
					DURHAM, NC 27704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 516	Continued From page	68	F {	516	continued 497.		
		ase information that is	, ,		breakroom and also be available in the	staff	
	resident-identifiable to				scheduler's office.		
	Toolaalii iaaliiinaaja (a	110 54510.			C. The calendar shall include in-service		
	The facility may releas	se information that is			education for care of the cognitively imp	aired	
	resident-identifiable to				D. The calendar shall include a variety		
		ntract under which the agent			the in services shall be conducted so it		•
		isclose the information			reasonable for all cna's to receive the re		
	except to the extent th	ne facility itself is permitted			hours.	.quiiou	ļ
	to do so.	•			E. Individual learning resources may als	o ho	
,		ļ			created that would contribute to the edu	i	
	The facility must safeg				hours /needs of the cna's.	Çalıbılal	
	information against los	ss, destruction, or			· ·	_	
	unauthorized use.				F. The DON or designee will generate a		
					Master list of all cna's and monitor progr	ess and	
	THE DECLERATION				attendance of the cna's.		
		is not met as evidenced			3. the HR department will ensure CNA	evaluatic	ins
	by:				are completed annually;		
		n, record review and staff failed to safeguard 1 of 38			A. HR will create and/or ad to the emplo	•	-
		fical records reviewed to			a line listing for the date of the employer	evalu-	
		located inside the facility			ation is due.		
	(Resident #167). Findi			-	B. Prior to the date due the appropriate		.
	(1.00.00.00.00.00.). 1 11101	nigo moraco.			will be notified of the need of the evalua	lions	ļ
1	The facility policy for s	igning out of medical			to be conducted.		Ī
1		ted in part read "medical		İ	C. HR will generate a master list of all ci	na's	1
		the filing area are to be			regularly to ensure the evaluations are		
		y policy for retention of			completed timely.	1	
1	medical record in part	read "1) medical records		-	D. The completed evaluations will be rev		J
	shall be retained by th	e facility in accordance with		ļ	with DON and if a plan of action is neces	ssary	I
ŀ	• •	s, 2) medical records of			for specific educational needs it will be a	ddresse	d
		ill be retained for a period of		İ	at that time.		
	five years."	ł			Monitoring:	İ	
	Resident #167 was ad	mitted into the facility on			1. this process shall be monitored through	h the	
	1/21/2011 and was a d	-			facilities QAPI process.		}
	and mas a c	anone roomone.			2. The Administrator/designee will meet		·
***************************************	During an observation	on 7/10/14 at 9:30 am,			personnel and the DON/Staff developme	ent	
		was unable to be located		- 1	designee weekly for 4 weeks to assess	1	
Ī		password locked door on			progress made.		
PRM CMS-2567(02-99) Previous Versions Obsolete Event ID: W3RR11				Fac	-3. Upon completion of the 4 weekly QA aity ID: 923077 If continue		Page 69 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	(X3) DATE COME	SURVEY PLETED	
					С	
	345434 B. WING		07/	17/2014		
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER		[STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	BE .	(X5) COMPLETION DATE
F 516	the 300 hallway.		F 5	continued 497 will be reviewed at the regular mont	ily QAPI.	
	She was asked to loc responded that she w going into the chart or Resident #167 reside she did not see where out. She added that s for the chart. At 10:50 the chart was not local in an interview on 7/1 medical record coordi search had begun thromedical record (hard record was not locate where the record was was still inside of the land copy medical record medical record was to locate where the record was was still inside of the land copy medical record medical record was not locate where the record was was still inside of the land copy medical record medical record was not locate where the record was was still inside of the land copy medical record medical record was not locate where the record was was still inside of the land copy medical record was not located the hall formation with the presence of the confirmed the original inside the building. The following information with the progress notes, psychorders and labs." She did not know how long had been missing. The should have been local locked door on the hall	0/14 at 11:00 am, the nator (MRC) stated a coughout the facility for the copy chart), however the d and they were not sure located, or if the record coulding. A newly developed cord was provided by the he following resident: face sheet with ion, allergies, diagnoses, sysician orders, labs, and an ament. In, the MRC was interviewed administrator. The MRC medical record was not e MRC indicated the was contained in the record,	F516	1.Resident #167 the medical record of not found. It was recreated by Medical 2. All Residents were at risk. A 100% audit was performed for the entire fact 7/10/14 and no other charts were miss not easily accessed. 3. Managers were in-serviced on 8/6/2 Corporate Risk Manager and Staff inton 8/11/14 regarding Facility must sat clinical record information against lost destruction, and or unauthorized use, policy and procedure-Physical Securi Manual/Paper records; maintaining a sign out system. HIM-Record Sign of 4. Medical Records Coordinator and will review daily the sign out log to enterprocedure is maintained to ensure sat guarding of paper/electronic resident Medical records Coordinator will report QA Committee x 4 weeks and then must Findings will be presented monthly to QA Committee. 5. Substantial compliance will be 8/26	al Records chart ility on sing or 4 by serviced eguard c, The HIM y of Record ut Log, Ward Cleri sure prope e- records, t to Daily onthly, the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345434	B. WING				C 7/17/2014
NAME OF P	ROVIDER OR SUPPLIER	2000		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	111112014
CARVER	L DUNG ARVITA				EAST CARVER STREET		
CARVER	LIVING CENTER			į .	RHAM, NC 27704		
(X4) ID	TO VOLUME IN	ATEMENT OF DEFICIENCIES	·	1 50			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 516	0			1			
F 5 10	Continued From page		F	516			
	tracking resident char	ts was the staff signed the					
	chart out; however, sh	ne did not see where the					
	chart had been signed	d out.					·
	In an intendeur au 700	044 + 400 "	-				
	In an interview on 7/10	0/14 at 4:06 pm the	-				
	record to have been n	he expected the medical naintained by the facility and		Ì			
	knowledge of where the	naintained by the facility and ne chart was located in the		-			1
	facility.	to chart was located in the		l			
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