OCT 1 6 2014

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			CX3) DATE SURVEY COMPLETED	
		345434	B. W.NG		•	09/11/	2014
NAME OF PROVI	IDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
					1 EAST CARVER STREET		
CARVER LIVI	NG CENTER			Dί	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=J (III	consult with the resignown, notify the resignown, notify the resign an interested farm coident involving the partier and has the partier and has the partier and has the partier and has a significant, or leterioration in heal attus in either life the dimical complication in legislication form of treat aconsequences, or to reatment; or a decrease.	diately inform the resident; dent's physician; and if sident's legal representative ly member when there is an are resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial threatening conditions or is); a need to alter treatment the discontinue an area of commence a new form of dision to transfer or discharge e facility as specified in	E	157	The following Plan of Corresubmitted by the facility in accordance with the pertinand provisions of 42 CFR Seand/or related state regulations is intended to serve as a creallegation of our intent to othe practices identified as of the Plan of Correction sho construed or interpreted admission that the deficientalleged did, in fact, exist; refacility is filing this docume order to comply with its obas a provider participating Medicare/Medicald programmed.	ent terms ction 488 tions, and edible correct leficient. uld not be s an icles ether, the int in oligations in the	
	The facility must also and, if known, the representative specified in §483.1 resident rights under this section. The facility must reflect the address and placed representative this section. This REQUIREME by: Based on record reservices (EMS) resident rights and record reservices (EMS) resident.	so promptly notify the resident esident's legal representative member when there is a roommate assignment as (5(e)(2); or a change in prederal or State law or officed in paragraph (b)(1) of ecord and periodically update none number of the resident's e or interested family member. NT is not met as evidenced review, emergency medical port, and staff and physician lility failed to immediately notify			Corrective action for residency: Resident #186 no longer rethis facility. Corrective action for residency be affected by this deficiency and again on by the nurse manage (director of nursing (I assistant director of recount (ADON), 2 unit manage wound nurse) a. The audit corrective action for residency action for (ADON), 2 unit manage wound nurse) a. The audit corrective action for residency action for action for (ADON), 2 unit manage wound nurse) a. The audit corrective action for residency action for actio	esides at lents that eficiency: npleted on 9/11/14 ment team DON), sursing gers, nsisted of	

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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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NDNH11

Facility ID: 923077

If continuation sheet Page 1 of 40

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E .	(X2) MULTIPLE CONSTRUCTION A. BUILDING			EURVEY ETEO
		345434	B. WNG	8. WNG			1/2014
	NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			321	REET ADDRESS, CITY, STATE, ZIP CODE I 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 157	the resident's physiciand continuous seizuresidents reviewed for (Resident 186). The Immediate Jeop at 5:30 AM for Residents reviewed for the seizures and month of the seizure seizures and month of the seizure seizures as a proble have airway open.	an of respiratory distress ares, for 1 of 3 sampled or notification of change ardy (IJ) began on 08/18/14 tent #186 when the resident arguments are	F	157	on a anti app phy. noti ii. 2 re had app phy noti iii. 1 ho resi exp app phy not iv. No con	any ndition nursing nd , as ysician or further indicated n of EMS if sidents e started in biotic with ropriate sician fication sidents a fall with ropriate sician	

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,	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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345434	B, WING		09/11/2014	
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER	32	REEY ADDRESS, CITY, STATE, ZIP CODE 1 EAST CARVER STREET URHAM, NC 27704		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
side effects and effectiveness, neurological assessment as needed, notify MD as needed, maintain airway, and report seizures. On 09/10/14 at 5:45 PM, an interview was conducted with Nurse Aide (NA #1) who took care of the resident on 8/18/14 (third shift 11PM to 7AM). She stated the resident was fine during the night. "I went into the room on rounds about 5:30 AM and she was breathing hard." NA #1 indicated when she discovered the resident, she was having trouble breathing and Jerking movements. NA #1 stated she went to get Nurse #1. In an Interview with Nurse #1 on 09/10/14 at 11:51 AM, she stated she knew Resident #186 and had taken care of her prior to 08/18/14. She stated when she entered the room around 5:30 AM she observed the resident in respiratory distress and having seizures. The resident was in a supine (flat on her back) position. The nurse stated she took the resident's vital signs and her pulse oxygen saturation was low at 87 percent. She moved the resident to a 45 degree angle, and applied oxygen at 2 [liters per minute. Nurse #1 stated "I gave her a breathing treatment with a Nebulizer." Nurse #1 stated the resident was unresponsive and actively having a continuous seizure. She stated the resident normally had some movements in her extremities but this was non-stop movements. Nurse #1 stated it sounded like she had a blockage in her throat. She stated there were no secretions coming from her mouth. She stated she did not attempt to suction the resident. Nurse #1 stated when a repeat oxygen saturation was done the oxygen was up to 89 or 90 percent and she increased the oxygen flow to 4 liters per minute. Nurse #1	F 157	 On 9/10/14 and 9/11/14, facility nurse manager hat assigned to each unit obself all facility residents which on those units for any condition in the facility staff will not if the facility staff will not if the contacted through the one contacted through the one contacted through the contacted in the medical recommendately in non-life threatening emergencies further guidance and aft is activated in life threatening emergencies. Measures that will be put in to ensure that this deficience not recur; In-servicing for the nurse started on 9/10/14 by the Clinical Resource Nurse and poly 11/14 40 nurse poly 11/14 40	s been serving in reside in reside in cerns on. cerns ed in sito an ation. nurse cility lie in fy them of in the in-call cation is nursing ecord. s for er EMS ening to place y does es was are and	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED C	
		345434	B. WING		i -	/2014	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE			
CARVER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE	
F 157	stated she did not careport the seizure or increased at that time called Emergency M stated probably some #1 stated she did not time. She stated she responsible party aft facility with EMS at 8 In nursing notes for (#1 documented, "BI AM, pulse (rate) 64, rate 25 (breaths per saturation) 87% on r Comments: Resident gurgling, very lethant has seizures. Nebul (oxygen) started at 4 Seizure was non-stoimprove. The Night helped in assessing called and resident hospitally via stretche physician of notified; r resident's transfer". Review of Resident Medical Service (EM County services "w 08/18/14 reporting a mbulance in route traveled one mile ar 6:59 AM, emergency Chief Complaint, Se seizure duration great type- Grand Mal [for Dictionary, 19th edital called the complaint, se seizure duration great type- Grand Mal [for Dictionary, 19th edital called the called t	Il the resident's physician to see if oxygen should be e. Nurse #1 stated she edical Service (EMS) and etime after 6:00 AM. Nurse t call the physician at that e called the physician and er the resident had left the 6:14 AM. 28/18/14 at 8:14 AM Nurse ood pressure 92/58 at 5:30 temperature 98.2, respiratory minute), O2 (oxygen	F 15	of 52 have been in-se nurse will be able to will be able to will be able to will be able to will be in-service address following: a. 24 Hour Rep b. Alert Charting. c. Infection Red d. Change of Commentation of the commentatio	vork the serviced. sed the ort g Process ports podition which vsician ion which vsician s, follow up ions Procedures lagement sident in situations ded but not hitial (objective live head lerations, ractures, ling, f breath, syncope,		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			72 20,25,				C	;
		345434	B. WING				l	1/2014
NAME OF D	ROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	<u></u>	
I INTONIC OF T	TO FIDER ON OUT LIE!			321 EAST CAR	VER STREET	•		
CARVER	IVING CENTER			DURHAM, NO	27704			}
47410	SUMMARY ST	ATEMENT OF DEFICIENCIES	GI		PROVIDER'S I	PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(E) CRO	88-REFEREN	TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	E ATE	COMPLETION DATE
				_		coma/ketoacido	sis,	
F 157	• •		F 15	2/		insulin shock/ins	ulin	
		dremities). The report				reaction, acute		
Ì	continued, "lung sou	inds Left Wheeze/Rhonchi,				psychotic behav	iors.	
	and lung sounds righ	it wheezes/ Rhonchi."				ingestion of toxi		
	[Rhonchi are describ	ed by Taber's as "A				physician notific		
	wheezing, snoring, o	r squeaking sound heard		1.	j.	Emergency Proc		
	during auscultation (listening to chest with rson with partial airway			1.	which included	cuures-	
	stetrioscope) or a pe	or other secretion in the				physician notific	ation	İ
	oinuau branchial hu	peractivity that occlude			,	, ,		
1	respiratory passages				j.	On 9/30/14 it w		
	Toophatory passage	,		-		determined tha	1	
	In an interview with I	Nurse #2 on 09/10/14 at				the 52 nurses h		
		d that on 08/18/14 between				received the in-		
	6:00 AM to 7:00 AM	Nurse #1 came out in the			k.	As of 10/1/14 n		
	hall to request help v	vith Resident #186. She				nurses have bee	en hired	
	stated it must have t	een between 6 and 7 AM;				in the facility.		:
	she did not recall the	e exact time. Nurse #2 stated			l.	Any new nurses	hired	
		ent #186's room with Nurse		1		will receive edu	cation	
	#1 and observed the	resident lying on the bed;				on physician		
		d having difficulty breathing.		1		notification dur	ing the	
		blood pressure cuff on her				orientation pro-		
	ngni ann, and was g	etting oxygen via nasal responsive. Nurse #2 stated		2.	Two nu	rses were identifi		
		ing a sternal rub. She opened		-		iciency.		
		poke. Her eyes were hazy			a.		n-	
	and she was coughi	ng." Nurse #2 stated she			4.	serviced on 9/1:	-	
		rub. She stated the				(see builet poin		
	resident's body cont	inued to shake during sternal		1		above).		
	rubs. Nurse #2 state	ad that she told Nurse #1 that			b.		hac	
1	they needed to call I	EMS. Nurse #2 stated Nurse			U.			
1	#1 left the room to c	all EMS and prepare the				been suspended		
		k and she stayed in the room				time pending ar		
		he stated "I opened the				allegation of ne		
	closet and picked of	ut an outfit for the resident.	1			she was suspen		
		up and dressed her. I had to				9/11/14. The n		
		her shirt and pants on." resident was seizing and				employment w		
		being bathed and dressed.				terminated on		
		was aware the resident was				and the allegati	ion of	

signed a manufacture of the active improved to the control of the control of the state and active and active and active and active and active and active active and active
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CENTER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(IPLE	CONSTRUCTION	COMPLETED	- 1
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A BUILDI				ļ
ration country						C	İ
		345434	B, WING			09/11/2014	
	OWNER OR STORE ISO			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PE	NOVIDER OR SUPPLIER			32	21 EAST CARVER STREET		
CARVER L	IVING CENTER		!	D	URHAM, NC 27704		
			ID.	L	PROVIDER'S PLAN OF CORRECTION	ų (X5))
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	PREF	ΙX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLE	
PREFIX TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	•	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	inic	
1710							
					neglect was		
F 157	Continued From p	age 5	F	157	substantiated.		
	having continued :	seizures throughout the bath			3. The Nurse Managers w	ere in-	
	and dressing, how	rever she continued on with the			serviced by the Clinical	Resource	
ļ	tasks because she	e wanted the resident to look			Nurse on 9/10/14 on th		
1	nice to go to the h	ospital.			following:		
					a. 24 Hour Repor	t- and	
	Summary stateme	ent from EMS read:			how to use the		
	"Dispatched by 9"	11 to a seizure. Arrived to find a			b. Alert Charting		
	51 year old femal	e actively seizing. Patient					
	assessed as char	ted. Patient found in care of d facility with active seizure			1		
<u> </u>	staff at local skille	aff stated patient with hx					
1	activity noted. St	secondary to cardiac arrest and			Guidelines- W		
1	coorie brain injur	y. Patient began selzing at			included phys	Ician	
	annioy (annioxim	nately) 5:30 this morning. IV			notification	ļ	
	(Intravenous) acc	ess established x 1 attempt as			e. Documentation		
1	charted and IV V	ersed administered per			Guidelines- w	1	
	protocol " (Verse	d is a benzodiazepine used for			included phys	ician	
Ì	status epilepticus	s, a continuous seizure activity			notification	1	
	without a pause.]	"Seizure activity reduced			f. Appropriate		
	however some re	esidual focal activity remained.			assessment,	1	
Ì	Patient continued	d on O2 at 10 liters per minute.			interventions	, follow up	
1	During transport,	second dose of IV Versed to continued seizure activity.			to intervention		
	administered du	never fully ceased during EMS			g. Emergency P	rocedures-	
ļ	care and/or trans	anort "			Seizure Mana	igement	
1	Care and/or train	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			h. Care of a Res	ident in	
	Review of Resid	ent #186's hospital records on			Emergency S	ituations-	
1	08/18/14 in part	read. "The patient presented in			which include		
1	status epilepticu	s. She required intubation for			limited to- in	1	
1	airway protection	n and admission to the ICU	Į		assessment (
	(intensive care t	init). She was placed on a			and subjective		
	Versed git (drip)	, her Keppra was increased and			symptoms),		
	she was Dilantir	(another anticonvulsant) loaded.			injuries, lace		
	Her EEG (electr	oencephalogram, to view brain	1		suspected fr		
	waves) indicate	d an underlying seizure disorder.					
	She was felt to	be having breakthrough seizures (aspiration pneumonia)". Patient			burns, choki		
1	due to intection	ng from septic shock due to			shortness of		
	was also sullen	ion pneumonia.			chest pain, s	yncope,	
I	hossing ashirar	TOTA PROGRAMME				it it land Dag	0 5

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NORDER.	A. BUILDI	NG		C	
		345434	B. WING			09/11/20	14
NAME OF PE	ROVIDER OR SUPPLIER		 	i	ET ADDRESS, CITY, STATE, ZIP CODE		
				t	AST CARVER STREET		
CARVER	IVING CENTER			DUR	HAM, NC 27704 PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(CACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TO BE COM	PLETION DATE
F 157	Interview with the D 09/10/14 at 2:13 PM expectation was if n resident selzing that to an upright position toward the left side. EMS if the selzure if The DON stated Rea medical emergent resident flat on her the resident was in revealed the event the morning meeting two hour time fram was not concerned EMS time to stabilithought the 'gurgli In an interview with 09/10/14 at 12:52 called by the nurse left for the hospital expected to have resident, with a his that fasted more the should be initiated. The Administrator Jeopardy on 9/11/1/ provided the follow compliance: RESIDENT IDEN 1. Resident #15 facility.	irector of Nursing (DON) on M, revealed that her nursing staff observed a the resident should be raised in to protect airway, rolled, and the nurse should call lasted more than 15 minutes. It is assident #186 was experiencing cy on 08/18/14 and laying the back for bathing and dressing appropriate. The DON was discussed on 08/19/14 at ing. She stated she saw the e on the nurses' notes but it because sometimes it takes are resident. She stated she ing' was due to seizure activity. In the Medical Director on PM, he acknowledged he was some on 08/18/14 after the resident in the stated he would have been called by staff if	F	157	seizures, dizi diabetic coma/ketoa insulin shock reaction, act psychotic be ingestion of physician not. Emergency which include physician not. The nurse managers continue with the AN Meeting Monday — Fi. On an nu wi fact date ii. Physician not. On continue with the continue with th	cidosis, c/insulin ute chaviors, toxins and otification. Procedures- ded otification will of Clinical oriday a Saturday d Sunday a rse manager ll be in the cility each	

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	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILOII	NG _		C		
		345434	B. WING			09/1	1/2014	
MANE OF FR	OVIDER OR SUPPLIER			l .	TREET ADDRESS, CITY, STATE, ZIP CODE			
			-		21 EAST CARVER STREET			
CARVER L	IVING CENTER			D	URHAM, NC 27704	NI T	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	IBE	COMPLETION DATE	
F 157	again on 9/11/14 by (director of nursing, 2 unit managers, wo a. The audit consinursing notes in the residents experienchave had an appropinterventions, as indefor further guidance of EMS immediately 1. 2 residents were appropriate physicia. 2 resident had physician notification. 3. 1 hospice resident physician notification. 4. No other concerns who of the facility those units for any condition. 1. No concerns who notification. 3. The MD and/other facility then the facility then the on-call service. No under the nursing 4. The MD is not threatening emergafter EMS is actival the facility then the on-call service. PROCESSES IMI FURTHER OCCL.	the nurse management team assistant director of nursing, and nurse) sted of reviewing 100% of the past 24 hours to ensure all ling any change of condition oriate nursing assessment and licated; physician notification, as indicated and activation or if indicated. The started on an antibiotic with an notification a fall with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated with appropriate or if indicated in regards to MD or his nurse practitioner are in or if indicated in the facility or there. When they are not in indicated in the medical record. It is indicated in the medical record. It is indicated in the indicated and in the threatening in the medical record.	F	157	physinotif furth guide addi nurs will a any whice had iden chai	cation for er er er ence. In cion, the emanager ound on residents h have an tifled log and I change of municated ance has lented in the nurse surance tus form will se audit formed to, the audit y the nurse day weeks, s will use) e	

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1	-	COMPLETED	
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		345434	B. WING		09/11/2014	
NAME OF PE	ROVIDER OR SUPPLIER		, i	REET ADDRESS, CITY, STATE, ZIP CODE		
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CARVER	IVING CENTER		D	JRHAM, NC 27704	ECTION (X5)	
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OOLD BE COMPLETION	
PREFIX TAG	(EACH DEFICIENT REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	
IAG						
				Measures that will be imple	mented to	
F 157		e 8	F 157	monitor the continued effe	ctiveness of	
	At this point 40 nurs	es out of 52 have been		the corrective action taken	to ensure	
	in-serviced. No nuts	se will be able to work the	,	that this deficiency has bee	n corrected	
	floor until they are in	-serviced. The in-service	1	and will not recur:		
	addressed the follow			1. During the AM Clin		
	b. Alert Charting F			all areas listed in #	3	
İ	c. Infection Repor	ts		completed by the I		
	d. Change of Condition Guidelines- which			Management Tean		
	included physician r	notification		a. The Nurse		
1		Guidelines- which included		Managem		
	physician notificatio	sessment, interventions, follow			f the DON, Unit Managers	
	f. Appropriate as up to interventions		į	and 2 MD	1	
	g. Emergency Pro	ocedures- Seizure		Coordina	i i	
	Management			b. The AM C	ł .	
	h. Care of a Resi	dent in Emergency Situations-	1	Meeting i	1	
1	which included but	not limited to- initial live and subjective symptoms),			Friday at 8:45	
	head injuries lacer	ations, suspected fractures,		AM.	111007 00 01.0	
1	burns, choking, sho	ortness of breath, chest pain,		c. On Satur	dav and	
	evocone seizures.	dizziness, diabetic		Sunday a		
	coma/ketoacidosis	insulin shock/insulin reaction,			will be in the	
	acute psychotic be	haviors, Ingestion of toxins and		1	ach day to	
	physician notification	on. ocedures- which included	1	complete	the areas	
l	nhysician notificati	on		listed in a	#4.	
1	2. Two nurses w	rere identified in this deficiency.		2. During the AM Cli	nical Meeting	
	a. One nurse wa	s in-serviced on 9/11/14.		any discrepancies	identified will	
	b. The other nur	se has been suspended at this	1	be documented, l		
]	time pending an al	ouse allegation of neglect-she		and corrected im	1	
1	was suspended or	nagers were in-serviced by the		the Nurse Manag		
	Clinical Resource	Nurse on 9/10/14 on the		3. From any discrep	ancies	
	following:			identified further		
1	a. 24 Hour Repo	ort- and how to use them		and/or disciplinar	y action will	
	b. Alert Charting	Process		occur with the sta	aff member	
1	c. Infection Rep	orts andition Guidelines- which		responsible.	1	
1	d. Change of Co included physiciar	notification		4. The Clinical Resor	urce nurse will	

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and some with the transfer of the first of the property of the second section of the section of the second section of the section of the second section of the sect

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
345434		B. WING			- 1	; 11/2014
ROVIDER OR SUPPLIER		\	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
101101111111111111111111111111111111111			321 l	EAST CARVER STREET		j
IVING CENTER			DUF	RHAM, NC 27704		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
(INJURY/DECLINE/F A facility must immed consult with the resid known, notify the residence or an interested family accident involving the injury and has the pointervention; a significant on the alterioration in health status in either life the clinical complications significantly (i.e., and existing form of treat consequences, or to treatment); or a deci	diately inform the resident; lent's physician; and if lident's legal representative ly member when there is an e resident which results in otential for requiring physician loant change in the resident's psychosocial status (i.e., a ch, mental, or psychosocial areatening conditions or s); a need to alter treatment leed to discontinue an iment due to adverse commence a new form of sion to transfer or discharge	F	157	submitted by the facilia accordance with the pand provisions of 42 Cand/or related state reis intended to serve as allegation of our intenthe practices identified. The Plan of Correction construed or interpresadmission that the dealleged did, in fact, extending this doorder to comply with as a provider participal.	ity in sertinent terms sertinent terms sertinent terms segulations, and se a credible at to correct de as deficient. In should not be ted as an ficiencies sist; rather, the cument in its obligations ating in the	
and, if known, the recording the rested family in change in room or respecified in §483.18 resident rights under regulations as specific this section. The facility must record the address and pholegal representative. This REQUIREMENT by: Based on record recording the recording terms and recording terms.	resident's legal representative member when there is a commate assignment as 5(e)(2); or a change in rederal or State law or filed in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member.			found to have been a deficiency: Resident #186 no long this facility. Corrective action for may be affected by the surface of his part of the nurse mare director of nursing assistant director.	residents that his deficiency: s completed on in on 9/11/14 nagement teaming (DON), or of nursing nanagers,	
	CORRECTION COVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR 483.10(b)(11) NOTIF (INJURY/DECLINE/F A facility must immed consult with the resid known, notify the resid known, notify the resid consult with the resid known, notify the resid known, notify the resid consult with the resid known, a significant involving the injury and has the po- intervention; a significant involving the clinical complications significantly (i.e., a resident involving to treat consequences, or to treatment); or a decid the resident from the §483.12(a). The facility must als and, if known, the re- or interested family in change in room or re- specified in §483.14 resident rights under regulations as specified	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	CORRECTION IDENTIFICATION NUMBER: A BUILDI 345434 B. WING. ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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WING COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.40(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status from the facility as a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	CONDER ON SUPPLIER 345434 STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704 BYING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an Interested family member when there is an accident involving the resident which results in intervention; a significant change in the resident's physicial, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatoning conditions or cilinical complications); a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility as specified in \$483.15(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member whon there is a change in room or roommate assignment as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, emergency medical services (EMS) content and staff and physician medical provincing and physician medical provincing and physician medical provincing and physician medical provincing and physician medical provincing and physician medical physician medical and physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physician medical physicia	CORRECTION CONTRICTION CONTRICTION NUMBER: A BUILDING CONTRICTION CONTRICTI

Any deficiency statement ending with an asterisk (*) dendtes 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.

Event ID: NONH11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345434	B. WING		09/11/2014
	ROVIDER OR SUPPLIER	1	321	EET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLE
F 157	the resident's physic and continuous seiz residents reviewed if (Resident 188). The Immediate Jeorat 5:30 AM for Resident sey found with contrespiratory distress. notified on 09/11/14 removed on 09/11/14 demonstrated it had allegation. The facility of the facility of the services and more implemented and in Assurance Program. Findings included: Resident #186 was 01/27/12 with diagrand seizure disorder Review of the residence September 2014 review of the residence September 2014 review of the residence and Klonopin is a mediproperties. A 07/10/14 quarter indicated the residence as a problem and seizures as a problem airway open.	cian of respiratory distress ures, for 1 of 3 sampled for notification of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of change of the control of the con	F 157	all residents experiencin change of c have had al appropriate assessment interventio indicated; notification guidance, a and activat immediate indicated. i. 2 w or ar ap pl ne ii. 2 ha ap pl ne iii. 1 re e a p no iv. N	ers to ensure s g any ondition en enursing and ens, as ohysician is indicated lon of EMS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/25/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES			(X2) MULTIPLE CO	(X3) DATE SURVEY	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION CONTRACT	A. BUILDING		c
		0.5404	B. WING		09/11/2014
		345434		REET ADDRESS, CITY, STATE, ZIP CODE	1 03/1/12014
NAME OF P	ROVIDER OR SUPPLIER				
6 1 BV ED 1	NUMO AENTED			EAST CARVER STREET	
CARVER	IVING CENTER		UU	RHAM, NC 27704	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DESICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION
F 157	side effects and effer assessment as need maintain airway, and On 09/10/14 at 5:45 conducted with Nurs of the resident on 8/7AM). She stated the night. "I went in 5:30 AM and she was indicated when she was having trouble to movements. NA #1 #1. In an interview with 11:51 AM, she state and had taken care stated when she en AM she observed the distress and having in a supine (flat on I stated she took the pulse oxygen sature She moved the resident and applied oxygen #1 stated "I gave he a Nebulizer." Nur unresponsive and a selzure. She stated some movements in non-stop movement sounded like she he She stated there we her mouth. She stated there we her mouth. She stated repeat oxygen sature was up to 89 or 90	ctiveness, neurological ed, notify MD as needed,	F 157	2. On 9/10/14 and 9/11/14 facility nurse manager hassigned to each unit oball facility residents which on those units for any coand or change in condition. No convere lidentification in the physician and/or his practitioner are in the facility staff will not there. When they are refacility then they will be contacted through the service. Physician not documented under the charting in the medical. 4. The physician is notified immediately in non-life threatening emergencies immediately in fife threatening emergencies. Measures that will be put if to ensure that this deficier not recur: 1. In-servicing for the nurstarted on 9/10/14 by Clinical Resource Nurse DON. On 9/11/14 40 resource process.	as been serving th reside oncerns on. oncerns fied in les to dian sation. Is nurse acility while in ify them not in the electrication is nursing record. It is for fiter EMS tening on the place cy does sees was the electrication is and place and in the electric in the el

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A, BUILDING							
AND PLAN OF	OURREUTION	Services Control of the Control of t	A, poiluit				;
		345434	B. WING_		The state of the s	}	1/2014
MAME OF DE	ROVIDER OR SUPPLIER		-1 1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FR	COMPER ON ODE FEIGH			321	I EAST CARVER STREET		
CARVER L	IVING CENTER			DU	IRHAM, NC 27704		_,,
WALE	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(XS) COMPLETION
(X4) ID PREFIX	(EACH DEEICH	ENCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	1,70		DEFICIENCY)		
					of 52 have been in-serv	iced. No	
F 157	Continued From p	age 3	F	157	nurse will be able to we	- 1	
	etated she did not	call the resident's physician to			floor until they are in-s		
	renort the seizure	or see if oxygen should be		- 1	The in-service addresse		
	increased at that I	time. Nurse #1 stated she		1	****	a uie	
	calted Emergency	Medical Service (EMS) and			following:		
İ	stated probably so	ometime after 6:00 AM. Nurse		1	a. 24 Hour Repo		
	#1 stated she did	not call the physician at that		1	b. Alert Charting		
	time. She stated	she called the physician and		1	c. Infection Repo		
	responsible party	after the resident had left the		- 1	d. Change of Cor		
1	facility with EMS	at 8:14 AM.			Guidelines- w	hich	
					included phys	ician 🔧	
	In nursing notes f	or 08/18/14 at 8:14 AM Nurse			notification		
	#1 documented,	"Blood pressure 92/58 at 5:30			e. Documentatio	on	
	AM, pulse (rate) (34, temperature 98.2, respiratory			Guidelines- w	hich	
	rate 25 (breaths p	per minute), O2 (oxygen			included phys		
	saturation) 87% (on room air at 5:30 AM.			notification	101011	
	Comments: Resid	dent was wheezing, obvious					
	gurgling, very let	nargic/sleepy; difficult to arouse, abulizer treatment given, O2			f. Appropriate		
1	has seizures. Ne	at 4L/minute (Liters per minute).	1		assessment,	C_11	
	(oxygen) staned	-stop and resident status did not			interventions		
	Seizure was non	ght Nurse in the front hall also			to intervention		1
	halprove. The ini	ing the resident. EMS was			g. Emergency P		
	called and reside	ent was transported to [local			Seizure Mana	gement	
1	hospitall via stret	icher at 7:30 AM. Dr. [attending			h. Care of a Res	dent in	
	physicianl notifie	d; resident's daughter notified of			Emergency Si		
	resident's transfe	er".			which include		1
			į		limited to-in		
	Review of Resid	ent #186's 08/18/14, Emergency			assessment (
	Medical Service	(EMS) report Dispatch for the			and subjective		
	County services	"was called at 6:53 AM on			symptoms), i		
	08/18/14 reporting	ng a resident with seizures,					
	ambulance in ro	ute at 6:54 AM, the ambulance			injuries, lace		
	traveled one mile	e and arrived at the facility on			suspected fra		
	6:59 AM, emerg	ency crew at bedside 7:05 AM.			burns, choki		
	Chief Complaint	, Seizures/Convulsion, Actively.			shortness of	-	
1	Selzure duration	greater than 5 minutes, seizure			chest pain, s	yncope,	
1	type- Grand Mal	[for] 1 hour." (Taber's Medical			selzures, dizz	iness,	
	Dictionary, 19th	edition, describes Grand Mal as			diabetic		
1	epilepsy, loss of	consciousness with violent					

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	S POIN IMEDIOAINE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LIPLE (CONSTRUCTION	ļo	(3) DATE S	
	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					COMPLE	:150
		İ				1	C	
		345434	B. WING				09/1	1/2014
1141F OF 51	ROVIDER OR SUPPLIER	1	_1	ST	REET ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF PI	KONDER ON SUPPLIER			32	1 EAST CARVER STREET			
CARVER	IVING CENTER			1	URHAM, NC 27704			
			1		PROVIDER'S PLAN C	E CORRECTION		(X5)
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	x l	(EACH CORRECTIVE A	TTON SHOULD BE	_	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO DEFICIE		E	UAIL
,,,,,					DEI TOICE	.01)		
					com	a/ketoacidos	is.	
F 157	Continued From pag	e 4	F	157		ilin shock/inst		
, ,,,,		dremities). The report				ction, acute		
	continued "lung sol	unds Left Wheeze/Rhonchi,				chotic behavio	are	
	and tung sounds rigi	nt wheezes/ Rhonchi."				estion of toxin		
	IRhonchi are descrit	oed by Taber's as "A	1					
	wheezing, snoring, o	or squeaking sound heard	ļ			sician notifica		
ļ	during auscultation (listening to chest with				ergency Proce	dures	
1	stethoscope) of a pe	rson with partial airway			l · · · ·	ch included	.	
]	obstruction. Mucus	or other secretion in the				rsician notifica		
	airway, bronchial hy	peractivity that occlude			J. On	9/30/14 it wa	is	
	respiratory passage	s."}			det	ermined that	52 of	
					the	52 nurses ha	ve	
	In an interview with	Nurse #2 on 09/10/14 at			rec	elved the in-s	ervice.	
	12:21 PM, she state	d that on 08/18/14 between			k. As	of 10/1/14 no	new	
	6;00 AM to 7:00 AM	Nurse #1 came out in the				ses have bee		
	hall to request help	with Resident #186. She			1	he facility.		
	stated it must have	been between 6 and 7 AM; e exact time. Nurse #2 stated			•	y new nurses	hirad	
	she did not recall th	ent #186's room with Nurse				y new narses I receive educ		
	she went into Resid	e resident lying on the bed;			,		สมอเร	
	#1 and observed in	d having difficulty breathing.			•	physician		
	The recident had a	blood pressure cuff on her				tification duri		
	with arm and was	getting oxygen via nasal				entation proc		
	cannula and was U	responsive. Nurse #2 stated	i		E .	were identifie	ed in	
	"We woke her up us	sing a sternal rub. She opened			this deficier			
	her eves but never	spoke. Her eyes were hazy			1	e nurse was it		
	and she was cough	ing." Nurse #2 stated she			sei	viced on 9/11	./14	
	repeated the sterna	ll rub. She stated the			(se	e bullet point	ts a-i	
	resident's body con	tinued to shake during sternal			,	ove).		
	rubs. Nurse #2 sta	ted that she told Nurse #1 that			1	e other nurse	has	
	they needed to call	EMS. Nurse #2 stated Nurse				en suspended		
	#1 left the room to	call EMS and prepare the				ne pending an		
	discharge paperwo	rk and she stayed in the room				egation of neg		
	with the resident.	She stated "I opened the						
	closet and picked of	out an outfit for the resident.	1			e was suspend		
	Then I washed her	up and dressed her. I had to				11/14. The m		
	lay her down to get	ther shirt and pants on."				nployment w		
	Nurse #2 stated the	e resident was seizing and	-			rminated on 9		
	unresponsive while	e being bathed and dressed. He was aware the resident was			ar	ıd the allegati	on of	
1	I Nurse #2 stated sh	B was aware the resident was	i i		1			

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C 345434 B. WNG 09/11/2014 NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER CARVER LIVING CENTER DURHAM, NC 27704 PROVIDER'S PLAN OF CORRECTION (%5)	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i		ONSTRUCTION	(X3) DATE (
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STATE AST CARVER STREET DVRHAM, NC 27704	AND PLAN OF	CORRECTION	IDENTIFICATION NONIOCIA.	A. BUILOI	NG		,	,
ARVER LIVING CENTER SUMMARY STATEMENT OF DEPICIENCY: REGULATORY ON LSD DENTIFYING INFORMATION) F157 Continued From page 5 having continued seizures throughout the bath and dressing, however she wanted the resident to look nice to go to the hospital. Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 5f year old female actively seizing. Patient assessed as charted. Patient found in care of staff at looal skilled facility with active seizure activity noted. Staff stated patient with bx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) E.30 like morning. IV (intravenous) access established X 1 attempt as charted and IV Versed administered per protocol." (Versed is a benzodiazepine used for status epilepticus, a continued seizure activity reduced however some residual footal activity remined. Patient continued on Q2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient continued and Q2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity reduced however some residual footal activity remined. Patient presented in status epilepticus. Since per minute in the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the p			345434	B. WNG				•
CARVER LIVING CENTER DURHAM, NC. 27704	NAME OF PE	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCES PROVIDERS PLAN OF CORRECTION CRACH DEFICIENCY NUST SET PRECEDED BY FULL TAG	A + DV/ED 1	NAME OF STATE			ł			
PREFIX TAG REGULATORY OR LSC IDENTIFYING BYFORMATION) F 157 Continued From page 5 having continued seizures throughout the bath and dressing, however she continued on with the tasks because she wanted the resident to look nice to go to the hospital. Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 51 year old female actively seizure activity noted. Staff stated patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 lifs morning. IV (intravenous) access established x1 attempt as charted and IV Versed and ministered per protocol." (Versed is a benzodiazepine used for status epilepticus, a continuous seizure activity without a pause.) "Seizure activity reduced however some residual focal activity remained. Patient continued on O2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never fully ceased during EMS care and/or transport." Review of Resident #186's hospital records on 08/18/14 in part read, "The patient presented in status epilepticus. She required intubation for airway protection and admission to the ICU (intensive care unit)). She was piaced on a Versed and subjective	CARVERI	IVING CENTER			υū			
F 157 Confinued From page 5 having continued seizures throughout the bath and dressing, however she continued on with the tasks because she wanted the resident to look nice to go to the hospital. Summary statement from EMS read: "Dispatched by 911 to a seizure. Arrived to find a 5 f year old female actively seizing. Patient assessed as charted. Patient found in care of staff at local skilled facility with active seizure activity noted. Staff stated patient with hx (history) of same secondary to cardiac arrest and anoxic brain injury. Patient began seizing at approx (approximately) 5:30 this morning. IV (intravenous) access established x 1 attempt as charted and IV Versed administered per protocol." (Versed Is a benzodiazepine used for status epilepticus, a continuous seizure activity without a pause.] "Seizure activity remained. Patient continued on O2 at 10 liters per minute. During transport, second dose of IV Versed administered due to continued seizure activity. Seizure activity never fully ceased during EMS care and/or transport." Review of Resident #186's hospital records on 08/18/14 in part read, "The patient presented in status epilepticus. She required intubation for airway protection and admission to the ICU (Intensive care unit). She was placed on a Versed att (drip), her Keppra was increased and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	. 1	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Her EEG (electroencephalogram, to view brain waves) indicated an underlying selzure disorder. She was felt to be having breakthrough selzures due to infection (aspiration pneumonia)". Patient was also suffering from septic shock due to chest pain, syncope,	F 157	having continued sei and dressing, howev tasks because she wanice to go to the host summary statement "Dispatched by 911 to 51 year old female a assessed as charted staff at local skilled factivity noted. Staff (history) of same sed anoxic brain injury. approx (approximate (intravenous) access charted and IV Verse protocol." [Versed is status epilepticus, a without a pause.] "Showever some resid Patient continued or During transport, se administered due to Seizure activity never care and/or transport. Review of Resident 08/18/14 in part reastatus epilepticus. Sairway protection ar (intensive care unit) Versed gtt (drip), he she was Dilantin (ar Her EEG (electroen waves) indicated ar She was felt to be houe to infection (as)	zures throughout the bath er she continued on with the ranted the resident to look pital. from EMS read: to a seizure. Arrived to find a ctively seizing. Patient the Patient found in care of acility with active seizure stated patient with hx condary to cardiac arrest and Patient began seizing at sely) 5:30 this morning. IV is established x 1 attempt as sed administered per as a benzodiazepine used for continuous seizure activity remained. In O2 at 10 liters per minute. Cond dose of IV Versed continued seizure activity. Fully ceased during EMS of admission to the ICU. #186's hospital records on the required intubation for a damission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the admission to the ICU. She was placed on a frequired intubation for the ICU. The patient presented in the ICU. She was placed on a frequired intubation for the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU. The patient presented in the ICU.	F	157	substantiated 3. The Nurse Managers we serviced by the Clinical Nurse on 9/10/14 on the following: a. 24 Hour Report how to use the behavior of the control	ere in- Resource ie 't- and em Process orts idition nich ician follow up ns ocedures- gement dent in tuations- d but not tial objective e ead ations, ctures, g, oreath,	

about the state of the additional and the control of the control o

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	COMPLETED
		345434	B. WING		09/11/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 157	o9/10/14 at 2:13 P expectation was if resident seizing th to an upright positi toward the left side EMS if the seizure The DON stated R a medical emerger resident flat on he the resident was in revealed the even the morning meeti two hour time frant was not concerned EMS time to stabil thought the 'gurgi In an interview wit 09/10/14 at 12:52 called by the nurs left for the hospital expected to have resident, with a hi that lasted more to should be initiated. The Administrator Jeopardy on 9/11 provided the follor compliance: RESIDENT IDEN 1. Resident #1 facility. IDENTIFYING OT	Director of Nursing (DON) on M, revealed that her nursing staff observed a at the resident should be raised fon to protect airway, rolled a, and the nurse should call lasted more than 15 minutes. Resident #186 was experiencing ancy on 08/18/14 and laying the reback for bathing and dressing mappropriate. The DON towas discussed on 08/19/14 at ing. She stated she saw the me on the nurses' notes but debecause sometimes it takes lize a resident. She stated she ling' was due to seizure activity. With the Medical Director on PM, he acknowledged he was een 08/18/14 after the resident al. He stated he would have been called by staff if the story of seizures, had a seizure than 5-10 minutes and EMS dimmediately.	F1	diabetic coma/ketos insulin shoot reaction, act psychotic be ingestion of physician in the first physician in the	acidosis, ck/insulin cute ehaviors, f toxins and otification. Procedures- ded otification c will M Clinical Friday n Saturday ad Sunday a urse manager ill be in the cility each

were sooned indicated and the contraction of the co

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTR G	истом	COMPL	ETED .
		345434	B. WING _	·		1	11/2014
	ROVIDER OR SUPPLIER			321 EAST	DDRESS, CITY, STATE, ZIP CODE CARVER STREET I, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	again on 9/11/14 by (director of nursing, 2 unit managers, wo a. The audit consinursing notes in the residents experienchave had an approprinterventions, as indefer further guidance of EMS immediately 1. 2 residents were appropriate physicia 2. 2 resident had physician notificatio 3. 1 hospice reside physician notificatio 4. No other conce 2. On 9/10/14 and manager has been observing all facility those units for any condition. 1. No concerns who condition. 3. The MD and/of the facility Monday staff will notify them the facility then the on-call service. Munder the nursing of 4. The MD is notification generge after EMS is activate emergencies. PROCESSES IMP FURTHER OCCUF 1. In-servicing for	the nurse management team assistant director of nursing, and nurse) sted of reviewing 100% of the past 24 hours to ensure all ing any change of condition triate nursing assessment and licated; physician notification, as indicated and activation, if indicated. To started on an antibiotic with an notification a fall with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in texpired with appropriate in the session of the concerns and or change in the residents which reside on concerns and or change in the facility in the nurse practitioner are in Friday and while in the facility in there. When they are not in the provided in the medical record, iffied immediately in non-life encies for further guidance and ted in life threatening	F1	5.	phys notif furth guida addit nurse will revie hour report, alert charting nursing notes to ensure all conditions have been comto the physician, that guidabeen provided and docum the medical record under to charting tab.	ication for er er ence. In cition, the emanager ound on residents h have an tiffied ge of litton. We the 24 log and change of municated ance has ented in he nurse curance cus form will emudit form it to, he audit the nurse ay reeks, will use	

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	1			NSTRUCTION	COMPLI	ETED
	345434 B.1	WING_			09/1	1/2014
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			321 E	EET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704		
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRETAGE REGULATORY OR LSG IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
At this point 40 nurses out of 52 h in-serviced. No nurse will be able floor until they are in-serviced. The addressed the following: a. 24 Hour Report b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelinic included physician notification e. Documentation Guidelines- will physician notification f. Appropriate assessment, into up to interventions g. Emergency Procedures- Seit Management h. Care of a Resident in Emerg which included but not limited to-assessment (objective and subjee head injuries, lacerations, suspect burns, choking, shortness of breast syncope, seizures, dizziness, diacoma/ketoacidosis, insulin shock acute psychotic behaviors, ingest physician notification. i. Emergency Procedures- which physician notification 2. Two nurses were identified a. One nurse was in-serviced of b. The other nurse has been stime pending an abuse allegation was suspended on 9/11/14. 3. The Nurse Managers were in Clinical Resource Nurse on 9/10 following: a. 24 Hour Report- and how to b. Alert Charting Process c. Infection Reports d. Change of Condition Guidelincluded physician notification	to work the se in-service nes- which which included erventions, follow zure ency Situations-initial ctive symptoms), sted fractures, ath, chest pain, betic //nsulin reaction, tion of toxins and lich included in this deficiency. In 9/11/14. Suspended at this in of neglect- she in-serviced by the in-serviced by the included in the included in this deficiency. In 9/11/14. The included in this deficiency is not neglect in the included in this deficiency is not neglect. The included in this deficiency is not neglect in the included in this deficiency is not neglect. The included in this deficiency is not neglect in the included in the included in this deficiency is not neglect. The included in this deficiency is not neglect in the included in this deficiency is not neglect. The included in this deficiency is not neglect in the included in the included in the included in this deficiency. The included in this deficiency is not neglect in the included in the include	F 1	157	Measures that will be implemented monitor the continued effective the corrective action taken to that this deficiency has been considered by the Nurse all areas listed in #4 we completed by the Nurse Management Team. a. The Nurse Management Consists of the ADON, 2 Unit and 2 MDS Coordinators by The AM Clinic Meeting is he Monday-Frich AM. c. On Saturday Sunday a nursular manager will facility each complete the listed in #4. 2. During the AM Clinical any discrepancies ided be documented, invested in the Nurse Managemented and/or disciplinary and course with the staff of the clinical Resource with the staff of the Clinical Resource 4. The Clinical Resource and will be the control of the clinical Resource the Nurse Managemented for the Staff of the Clinical Resource 4.	veness of ensure orrected I Meeting ill be se t Team ne DON, t Managers cal eld lay at 8:45 and rse I be in the day to e areas al Meeting entified will estigated diately by ent Team. lies ucation ction will member	

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA LIDENTIFICATION NUMBER:			CONSTRUCTION	COMPLE	
		345434	B. WING			09/1	1/2014
	NOVIDER OR SUPPLIER	1		32	REET ADDRESS, CITY, STATE, ZIP CODE 14 EAST GARVER STREET URHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH 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)	3E	(X5) COMPLETION DATE
F 157	e. Documentation of physician notification of. Appropriate assupt to interventions g. Emergency Prod Management h. Care of a Residuhich included but no assessment (objective head injuries, laceral burns, choking, shore syncope, seizures, docoma/ketoacidosis, is acute psychotic behaphysician notification i. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Emergency Prophysician notification ii. Physical round unit, every AM, prior nurse manager will in nurses regarding an conditions and physician and physician and physician ii. In additional ii. A nurse manager eport, alert charting ensure all change of communicated to the been provided and record under the nurse MONITORING	Guidelines- which included essment, Interventions, follow cedures- Seizure ent in Emergency Situations- ot Ilmited to- initial ye and subjective symptoms), tions, suspected fractures, tness of breath, chest pain, lizzlness, diabetic nsulin shock/insulin reaction, aviors, ingestion of toxins and a cedures- which included a lagers will continue with the Monday - Friday and Sunday a nurse manager each day. It is a speaking to the floor by resident change of ician notification for further on, the nurse manager will into which have had an condition. It is a speaking to the floor by resident change of ician notification for further on, the nurse manager will into which have had an condition. It is a speaking to the floor by resident change of ician notification for further on, the nurse manager will into which have had an condition. It is a speaking notes to for conditions have been a more manager will review the 24 hour and grant nursing notes to for conditions have been a more manager will will review the 24 hour and grant nursing notes to for conditions have been a more manager will review the 24 hour and grant nursing notes to for conditions have been and countered in the medical	E.	157	review the daily audits (I nursing notes, BM list, telephone orders) comp the Nurse Management weekly times 4 weeks, to there is appropriate phy notification and guidance been provided for any condition. 5. If trends or discrepancies noted this Quality Assur (QA) process will be revited the QA committee. 6. As discrepancies and treation training will be provided through these audits further education training will be provided. 7. The facility will continue involve the Medical Direating the facility processes in seek guidance and supplements. 8. A member of the Home staff will be on-site week least the next 30 days to guidance, support, training of this plant. 9. On 8/25/14, Apex Heal Solutions, the managin company for Carver Live Center, hired a new Clin Resource Nurse, who we continue to provide guisupport, training and me to the DON and Nurse Management Team.	leted by Team, o ensure sician he has hange of sare ance ised by ends are e QA h and d. e to ector in order to oort. Office kly for at o offer hing and thCare ig ing hical ill dance,	
	listed in #2 will be o	ompleted by the Nurse	ļ				<u> </u>

was removed and about individue will remove an every continuous of the continuous of the continuous of an international

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	COMPL	ETED
		345434	B. WING_				1/2014
	ROVIDER OR SUPPLIER			32	REET 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	38	(X5) COMPLETION DATE
F 157	Management Team. a. The Nurse Mana DON, ADON, 2 Unit Coordinators. b. The AM Clinical Monday-Friday at 8: c. On Saturday an will be in the facility areas listed in #2. 2. During the AM C discrepancies identif investigated and cor Nurse Management 3. From any discreducation or disciplinated from the condition of the composition of the composition of the composition of the composition of the condition. f. If trends or discreducation or disciplinated has been condition. f. If trends or discreducation or disciplinated has been condition. f. If trends or discreducation or discreducation or discreducation. f. If trends or discreduced has been condition. f. If trends or discreduced has been condition. f. The facility will be provided. As discrepancial through these QA at training will be provided. As discrepancial through these QA at training will be provided. As member of the on-site weekly for a offer guidance, supplied the plan. f. On 8/25/14, Ap. Resource Nurse, will be provided the plan.	Agement Team consists of the Managers and 2 MDS Meeting is held as AM. If SAM. If Sunday a nurse manager each day to complete the collinical Meeting any ited will be documented, rected immediately by the Team. If Spancies identified further hary action will occur with the asible. If Source Nurse will review the arring notes, BM list, ampleted by the Nurse weekly times 4 weeks, to opriate MD notification and provided for any change of the provided for any change of the provided for any change of the provided trends are identified and ded. If If Samura is a support, the Home Office staff will be the facility processes in order and support. If If I will be the mext 30 days to cort, training and monitoring of the writed a new Clinical the will continue to provide training and monitoring to the staffing and monitoring and monitoring to the staffing and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitoring and monitor	F	157	10. The Quality Assurance Committee will review for progress monthly on the identified concerns. 11. Facility alleges complianthis deficiency on 10/15	e ice with	

months and anti-children was to the second contraction and the contraction and the second contraction and administration and administration and

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	COMPLETED
		345434	B, WNG		09/11/2014
	OVIDER OR SUPPLIER		32	REET ADDRESS, CITY, STATE, ZIP CODE 1 EAST CARVER STREET JRHAM, NC 27704 PROVIDER'S PLAN OF CORRECT	TON (X5)
(X4) ID PREFIX TAG	(CACU DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIC DATE
F 157	The facility allege discrepancies have discrepancies have on 09/11/14 at 6: was validated. So nurses revealed to corrective measu licensed nurses reprocedure and prosedures and prosedures are procedure and proseduring a seizure, LOC or any eme 483.13(c) PROHMISTREATMENT The facility must policies and proomistreatment, not and misapproprise and misapproprise Based on reconsinterviews, the fit treatment for gridistress, including the services of the construction o	s the immediacy of these re been abated on 9/11/14. 45 PM, the credible allegation taff interviews with licensed the facility had implemented res which included in-services of egarding proper facility otocol for residents experiencing ory distress, changes in levels of OC), emergency situations, activation of emergency and appropriate resident care respiratory distress, change in regency situation. IBIT TINEGLECT/MISAPPROPRIATIN develop and implement written redures that prohibit reglect, and abuse of residents ation of resident property. MENT is not met as evidenced of review, staff and physician acility failed to provide emergency and mal seizures and respiratory and immediate initiation of	F 157	all nursing notes in thours to ensure ther identified concerns of with residents experchange of condition. a. 0 out of a 1 had no identified concerns respect. b. No other concerns dentified change in concerns and change in concerns and change in concerns assigned to each unit concerns assigned to each unit concerns assigned to each unit concerns assigned to each unit concerns the concerns assigned to each unit concerns assigned to each unit concerns the concerns assigned to each unit concerns the concerns assigned to each unit concerns the con	es at this sthat lency: mpleted on n 9/11/14 ement team assistant 2 unit urse) of reviewing he past 24 re were no of neglect riencing a81 residents ntified egarding oncerns ified ADL cares or condition1/14, a ger has been nit observing
	by: Based on recordinterviews, the force treatment for gradientess, including emergency medification of the	d review, staff and physician acility failed to provide emergency and mal seizures and respiratory		neglect. b. No other co were ident regarding A change in c 3. On 9/10/14 and 9/1 facility nurse manag	oncerns lified ADL cares or condition. 11/14, a ger has been nit observing which reside ligns and

a social and commencement and a commence of the confidence of the confidence of the commence o

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	SURVEY .ET&D
	CORRECTION	IDENTIFICATION NUMBER:	A BUILD	NG			
		345434	B. WING			091	; 11/2014
		340404			REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER				1 EAST CARVER STREET		
CARVER	LIVING CENTER	-		1	JRHAM, NC 27704		
V/3/11 HI\ =	·			L 50	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 224	Continued From page The Immediate Jeop 5:30 am for Resident found by the staff in respiratory distress. removed on 9/11/14 provided and impler allegation of compliance a (no actual harm with minimal harm) that it ensure monitoring seffective and included Assurance Program A review of the facility "If a resident is in b resident's head and maintain airway pape possible, to facilitate decrease possibility. Resident #186 was 1/27/12. Diagnoses Brain injury (anoxia not receive oxygen in loss of brain function for some pattern we extensive assistant mobility and transficare plan dated 2/ problem. A stated airway open. Appras ordered, obsen effectiveness, neuropersistensive assistant and page 1.	te 12 ardy (IJ) began on 8/18/14 at at #186 when the resident was continuous seizures and The immediate jeopardy was at 6:45 pm when the facility mented an acceptable credible ance. The facility will remain a scope and severity of [D] in the potential for more than a not immediate jeopardy to yestems put in place are ed in the facility's Quality in Findings included: ity's procedure policy dated in Nursing Management of: - Licensed Nurse" in part read ed, remove pillow from under it gently hyperextend head to tency. Position on side, if a drainage of mucus and a of aspiration of secretions." Is admitted into the facility on a sincluded Seizures, Anoxic is a cocurs when the brain does for a period of time resulting cition). The Minimum Data Set 1/14 indicated the resident's as severely impaired. Ce was required with bed ers. Seizure was indicated. The 1/14 indicated seizures as a goal read: resident will have oaches read: administer meds are for side effects and ro (neurological) assessment	F	224	a. No concerns identified in neglect relat activities of (ADL) cares. 4. On 9/11/14 the adm completed 100% faci to ensure there were concerns with neglect ADL cares. a. No concerns identified in neglect rela cares. Measures that will be put intensure that this deficiency do recur: 1. In-servicing for the nestarted on 9/10/14 k Clinical Resource Nu DON. On 9/11/14, 4 out of 52 have been No nurse will be able the floor until they a serviced. The in-serviced. The in-serviced. The in-serviced activity and the following activity activity and the following activity activity and the following activity activity activity and the following activity activity activity and the following activity	regards to red to dally living inistrator lity rounds no areas of trelated to swere regards to ted to ADL oplace to place to oplace to oplace to oplace to oplace to work are inserviced to work are inserviced operations. Condition	
	as needed, notify airway, and report	ohysician as needed, maintain			assessmen		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED							
	CORRECTION	IDENTIFICATION NUMBER:	I			COMP	LETEU
			1				
		345434	B. WING			09/	11/2014
NAME OF ST	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAME OF PI	(OVIDER OR SOLIT CICK			32	1 EAST CARVER STREET		
CARVER I	IVING CENTER			D)	URHAM, NC 27704		
	010000000000000000000000000000000000000	TATEMENT OF DEFICIENCIES	ID	' 	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX	(FACH DEFICIENC	LY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU	LD BE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	1	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FRIAIE	
			_				
F 224	Continued From pag	e 13	F	224	to interventi	ons	
					g. Emergency F	rocedures-	
	A review of the nurse	es' notes dated 8/14 and			Seizure Man	agement	
	1	seizures or respiratory or			h. Care of a Re	-	
	lung concerns.				Emergency S	ituations-	
	A	iolog ardare for August 2014			which include		
	A review of the phys	ician orders for August 2014 led (prn) seizure medications			limited to- in		
	ordered. Scheduled	saizure medications			assessment		
	included:	36/20/0 11/64/04/04/0			and subjecti		
	moraucu.				symptoms),		
	Clonazepam 1 i	miiligram (mg) every eight			injuries, lace		
	hours at 6:00 am, 2:	00 pm and 10:00 pm.			suspected fr		
	· Lacosamide 20	0 mg every 12 hours at 6:00			•		
	ат алd 6:00 рт.				burns, chok		
ļ	· Keppra 1000 m	g twice daily at 8:00 am and			shortness of		
	8:00 pm.				chest pain, s	•	
					seizures, diz	ziness,	1
	On 9/10/14 at 11:51	AM, in an interview, Nurse #1			diabetic		
	acknowledged she v	was resident #186's primary			coma/ketoa		
	nurse from / pm - /	am. She stated when she ound 5:30 am she observed	l		insulin shoc		
		ratory distress, having			reaction, ac	ute	
	rite teometit in tesh	ipine (flat on her back)			psychotic b		
	position. The nurse	stated she assessed the			ingestion of	toxins and	
	resident's vital signs	s and her pulse oxygen			physician ne	tification.	
	saturation was low	at 87 percent (%). She			I. Emergency	Procedures	- [
	indicated she position	oned the resident to a 45			which inclu		
	degree upright angl	e, applied oxygen at 2 liters			physician n	tification	
1	per minute and gav	e her a breathing treatment			and residen		1
	with a Nebulizer. No	urse #1 stated the resident			and preven	•	1
1	was unresponsive a	and actively having a seizure.			in an emerg	- •	
	She stated the resid	dent normally has some			situation (R		
	movements in her e	extremities but this was			Protection		
	non-stop and sound	ded like she (Resident #186)	İ		·		
	nad a blockage in n	er throat. Nurse #1 stated etions observed coming from			j. On 9/30/14		
	the resident's most	h, nor did she have to suction.			determined		
	Muree #1 eleted ret	peated oxygen saturation	- 1		the 52 nurs		
	rayaalad the avvine	n increased to 89 or 90 % and			received th		· [
i i	LIGACOICH HIG AVIA	11 21/2/ 40000 12 02 21 40 12 2116	1			TATION HOW	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1, ,		CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	√G		c	
		345434	B. WNG			1	1/2014
		340434	1	ęr	REET ADDRESS, CITY, STATE, ZIP CODE	1 0071	,, 80 17
NAME OF P	ROVIDER OR SUPPLIER				HEAST CARVER STREET		
CAPMEDI	LIVING CENTER						
OMINATIVE				וע	URHAM, NC 27704	T	
(X4) ID PREFIX TAG	IFACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 224	Continued From pag	19 14	F	224	nurses have b	een hired	
, , , , , , ,		d the oxygen flow to 4 liters			In the facility.		
	per minute. Nurse #	1 Indicated she initiated EMS					
	- she stated she pro	bably initiated EMS after 6:00			1		
	am. She stated she	did not notify the physician			will receive e		
	concerning the resid	ient's current status. Nurse #1			regarding the		
1	stated she called the	e physician after the resident			"Resident Pro		
1	left the facility by an	nbulance to the local hospital			System (Prev		
ļ	with EMS. Nurse #1	did not elaborate why she did			Abuse and Ne		
	not immediately cal	l 911.			Two nurses were ident	ifled in	
					this deficiency.		
	A review of the nurs	e's noted dated 8/18/14			a. One nurse wa	is in-	
	revealed at 5:30 an	n, Resident #186 was			serviced on 9	/11/14	
	assessed by Nurse	#1 with an oxygen saturation			(see bullet po		
1	of 87% (normal 95-	100%) on room air, blood			above).		
	pressure 92/58, res	piratory rate of 25 breaths per			b. The other nu	rse has	
]	minute, wheezing,	obvious gurgling, very ficult to arouse and seizures.			been suspend		
1	A nabulizar traatme	ent (a common treatment for			time pending		
	respiratory problem	s; for example asthma) was					
	administered oxyd	en was started at 4 liters per			allegation of		
	minute seizure ind	icated as nonstop and resident			she was susp		
	status did not impro	ove. Nurse #1 further noted the			9/11/14. The		}
	night nurse (Nurse	#2) in the front hall helped her			employment		
	in assessing the re	sident. Emergency Medical			terminated o		
	Services was docu	mented as called and the			and the alleg	ation of	1
	resident was transp	ported to the local hospital via			neglect was		
	stretcher at 7:30 at	n. The physician and			substantiate	d.	
	responsible party v	vere indicated as notified of the			a. The other nurse h	nas been	
	resident's transfer	to the hospital by Nurse #1.			suspended at this		
					pending an abuse		
	On 9/10/14 at 12:2	1 pm, in an interview, Nurse #2	1		of neglect- she w		
	stated Nurse #1 ca	ime out in the hall and			suspended on 9/		
	requested her help	. She stated it must have been			nurse's employs		
	petween 6:00 am a	and 7:00 am because she was			• •		
1	making rounds and	d did not recall the exact time.			terminated on 9		1
	Nurse #2 indicated	I she went into Resident #186's 1 and observed the resident			the allegation of		
	room with nurse #	ne resident was shaking and			was substantiate		
1	lying on the beo; to	eathing and coughing a lot. She			3. The allegation of neg	lect was	
L	I Daving dillicuity of	earning and oversiming a feet one			. Land to the source	CPS Plantas	

The first form of production and advantagement and a standard considers and a second consideration and a second considers and a second considers and a second considers and a second considers and a second considers and a second considers and a second considers and a second considers and a second considers and a second considers and a second consideration and a secon

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	S FOIL MEDIOVICE &		(X3) PH II.	nel 호	CONSTRUCTION	(X3) DATE S	BURVEY
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			COMPL	
WAND LEVEN OF	CONTECTION	Delin Commission	A ROILD	NG		1 0	
		045494	B, WING			1	1/2014
		345434	S. 1111G		REET ADDRESS, CITY, STATE, ZIP CODE	1 001	HEVIT
NAME OF PR	ROVIDER OR SUPPLIER			}	1 EAST CARVER STREET		}
CARVER	IVING CENTER			i			j
CARVER	-11112 ALI11PI			DI	URHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
				204			
F 224			F	224	state agencles on 9/11/3	14. The 5	
	stated the resident h	ad a blood pressure cuff on			day investigation was	į	
	her right arm, receivi	ng oxygen by nasal cannula		1	completed, substantiate	ed and	
	and unresponsive. N	lurse #2 indicated they (she			filed with the North Car		
	and Nurse #1) woke	the resident up using a	1		Department of Health a		
	sternal rub (briskly ru	abbing knuckles over			Human Services on 9/1		
	sternum) performed	2 or 3 times and her body hroughout the sternal rubs.	Ì		4. The resident is protecte		
	Continued to strake t	resident opened her eyes but		-	no longer reside in the f		
	DIR GIADOLATER THE I	ere hazy and she was					
	coughing Nurse #2	sald she informed Nurse #1					
	they needed to activ	ate (call) EMS. Nurse #2			follow the abuse protoc		
	indicated Nurse #1 t	hen left the room and she			complete the investigat		
	(Nurse #2) opened t	he closet, picked out an outfit			outlined in the policy ar		
	for the resident, low-	ered the resident to a flat			procedures and per fed	eral	
	position on her back	, bathed the resident in the			regulations.		
	flat position on her b	eack and then dressed the	l		6. The Nurse Managers w		
	resident while in the	same position, until she			serviced by the Clinical	Resource	
	completed the bath	and put the resident's shirt	-		Nurse on 9/10/14 on th		1
	and pants on. She f	urther indicated the resident			following:		
	continued with seizu	ires and coughing throughout			a. 24 Hour Repor	t- and	
	being bathed and di	ressed by her. Nurse #2			how to use the		
	concluded she was	aware the resident was			b. Alert Charting		
	having continued se	sizures and coughing while					
	she bathed and dre	ssed the resident, however			1		
	sne continued with	the tasks because the			_		
	resident had oxyger	n on and she wanted the			Guidelines- wi		1
	testaeur to took pice	to go to the hospital.			included phys	cian	
	A review of the EMA	3 dispatch report for the	- 1		notification		
	Construency	services in part read "Was			e. Documentation		
	called at 6:53 am of	n 8/18/14 reporting a resident			Guldelines- w		
	with seizures, ambu	lance in route at 6:54 am, the			included phys	ician	
	ambulance traveled	one mile and arrived at the			notification		
	facility at 6:59 am,	emergency crew at bedside			f. Appropriate		
	7:05 am. Chief com	plaint: seizures/convulsion -			assessment,		
	actively. Seizure du	ration greater than 5 minutes,			interventions,	follow ur	, l
	seizure type - Gran	d Mal [for] 1 hour." The EMS	1		to Interventio		
	report further read '	"Vital signs on scene on					.]
	8/18/14 at 7:09 am	temperature 97.4, pulse 84,			g. Emergency Pr		[

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STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE	
ANO PLAN OF	CORRECTION	TOTALL IOUION HOUSE	A. BUILDI	NG			,
		345434	B. WING			1 -	11/2014
NAME OF P	ROVIDER OR SUPPLIER	 		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
		•		321	EAST CARVER STREET		
CARVER	LIVING CENTER			DŪ	RHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE
F 224	respirations 20, lung (abnormal lung soun wheezes/ rhonchi. Ri Taber's as "A wheezi sound heard during a chest with stethoscor airway obstruction. In the airway, bronchial respiratory passages. A review of the summar report read "Dispatci Arrived to find Resid Patient assessed as care of staff at local seizure activity noted (history) of same sea anoxic brain injury. Find approx (approximate (intravenous) access EMS) as charted an protocol. Versed is a status epilepticus, a without a pause. Sei however some resid Patient continued or minute. During trans Versed administered activity. Seizure activity.	sounds left wheeze/rhonchi ds), lung sounds right honchl is described by ing, snoring, or squeaking auscultation (listening to pe) of a person with partial flucus or other secretion in it hyperactivity that occlude s." mary statement from the EMS ned by 911 to a seizure, ent #186 actively seizing, charted. Patient found in skilled facility with active d. Staff state patient with hx condary to cardiac arrest and Patient began seizing at ely) 5:30 this morning. IV is established x 1 attempt (by d IV Versed administered per a Benzodiazepine used for continuous seizure activity izure activity reduced ual focal activity remained. In oxygen at 10 liters per eport, second dose of IV if due to continued seizure vity never full ceased during	E.	224	h. Care of a Resi Emergency Si which include limited to- ini assessment (c and subjectiv symptoms), h injuries, lacer suspected fra burns, chokir shortness of chest pain, sy seizures, dizz diabetic coma/ketoac insulin shock, reaction, acu psychotic bel ingestion of t physician not i. Emergency P which include physician not and resident and preventi in an emerge situation (Re Protection Sy 7. The nurse managers w continue with the AM Meeting Monday — Fr a. On Saturday	tuations- id but not tial objective e ead ations, ctures, g, oreath, incope, iness, idosis, /insulin te naviors, oxins and ification. rocedures- ed ification protection ng neglect ncy sident system). vill Clinical iday and	
	protection and aspir admitted into to the	ation pneumonia and was ICU (intensive care unit). She rsed gtt (drip), her Keppra			Sunday a nu manager will facility each	be in the	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE (CONSTRUCTION	(X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	A BUILDI	NG_		COMPL	LEIEU
							;
		345434	B. WNG_			09/	11/2014
NAME OF P	ROVIDER OR SUPPLIER	1	1	\$7	REET ADDRESS, CITY, STATE, ZIP CODE		
MARCOTTI				32	1 EAST CARVER STREET		
CARVER	IVING CENTER			Dŧ	JRHAM, NC 27704		
	STAVANIA	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COR		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
F 224	Continued From pag	ne 17	F	224		.	
1 227		medication) was increased	,			ed on each	
	(seizure prevention	n (anticonvulsant medication)				ry AM, prior to	
	looded Her FFG (e	lectroencephalogram, to view		- 1		cal Meeting. A	
	brain waves) indicat	ed an underlying seizure				anager will be	
	disorder. She was fe	elt to be having breakthrough				to the floor	
	seizures due to infe	ction and thought to have	}	1		egarding any	
	septic shock due to	aspiration pneumonia, which	1		resident	change of	
	required volume res	uscitation with intravenous		ļ	conditio	ns, ADL cares,	
	fluids." Resident #1	86 was discharged from the			neglect a	and	
'	hospital on 8/30/14	to another skilled nursing			physicia	n notification	
	facility.				· ·	er guidance.	
					ŧ .	on, the nurse	
	On 9/10/14 at 2:13	om, in an interview, the				r will round on	
	Director of Nursing	stated if a resident was seizure she expected the			1	dents which	
	observed having a	tion the resident in an upright			•	d an identified	:
	nortion to protect the	ne airway with the resident				of condition to	
	rolled toward the lef	t side and call EMS			_	here are no	
	immediately if the s	eizure lasted more than 15			i		
	minutes. The DON	stated Resident #186 was				s with ADL	
	experiencing a med	lical emergency and laying the			cares.	***	
	resident flat on her	back and bathing her was				manager will	
	inappropriate consi	dering the resident's physical			1	he 24 hour	
	condition.				1	alert charting	
						nursing notes	1
	On 9/10/14 at 12:52	2 pm, in an interview, the	ļ		1	re all change of	
	physician (medical	director) stated if a resident			condition	ins have been	
ļ	was having a seizu	re that lasted longer than	- [commu	nicated to the	
		expected the resident to be			physicia	n, that	
1		nospital immediately by EMS mmediately afterwards. The			guldano	e has been	
	nhysician indicated	if a resident was having an			provide		
	active seizure he d	id not expect the resident to be			•	ented in the	
	positioned in a flat	supine (positioned on back)			T .	record under	
	position because th	ne resident would be at risk for			*	se charting tab.	
	respiratory aspiration	on. He concluded he recalled			1	_	1
	being made aware	by the facility the resident was	}		8. On 9/30/14 a "C Assurance Work		+
	transported to the I	nospital; however he did not					1
i	know the event tim		1		Status Change"	audit form was	1

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NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER OP/11/2014 PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER CARVER LIVING CENTER PROVIDE STANDARY STREMENT OF DEFICIENCES SEAD-OF CORRECTION SEAD-OF CORRE	WAR LIVIN OL	POUVEDHOM		A BOILDING		. c	
ARVER LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES FORTH REGULATORY OR I.SC IDENTIFYING INFORMATION) F 224 Continued From page 18 The Administrator and the Director of Nursing were notified of the immediate jeopardy was removed on 9/11/14 at 16.45 pm when the facility provided an acceptable credible allegation that in part read: "Credible Allegation of Compliance: RESIDENT AT RISK 1. Resident #168 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing, 2 unit managers, wound nurse) 2. The audit consisted of reviewing all nursing notes in the past 24 hours to ensure there were no identified concerns regarding neglect. b. No other concerns were identified. concerns regarding neglect. b. No other concerns were identified to cach unit observing all facility residents which reside on those for signs and symptoms of neglect related to ADL cares. a. No concerns were identified in reparts to neglect related to ADL cares. a. No concerns were identified in reparts to nerves or or or or or or or or or or or or or			345434	B. WING		09/1	1/2014
PREFIX TAG F 224 Continued From page 18 The Administrator and the Director of Nursing were notified of the immediate jeopardy was removed on 9/11/14 at 0.45 am. The immediate jeopardy was removed on 9/11/14 at 0.45 pm when the facility provided an acceptable credible allegation that in part read: "Credible Allegation of Compliance: RESIDENT AT RISK 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team (director of nursing, assistant director of nursing). 2 unit managers, wound nurse) 2. The audit consisted of roviewing all nursing notes in the past 24 hours to ensure there were no identified concerns or neglect with residents experiencing a change of condition. a. 0 out of a 181 residents had no identified concerns were identified. b. No other concerns were identified to ADL (activities of Dally Living) cares. a. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. 4. On 9/1/1/14 the administrator completed 100% facility routh regions are so concerns with neglect related to ADL (activities of Dally Living) cares. a. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. On person were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to activities of dally living (ADL) cares. A. No concerns were identified in regards to neglect related to ADL cares. A. No concerns were					321 EAST CARVER STREET		
The Administrator and the Director of Nursing were notified of the immediate jeopardy on 9/11/14 at 10:45 am. The immediate jeopardy was removed on 9/11/14 at 6:45 pm when the facility provided an acceptable credible allegation that in part read: "Credible Allegation of Compliance: "Credible Allegation of Compliance: RESIDENT AT RISK 1. Resident #186 no longer resides at this facility. IDENTIFYING OTHER RESIDENTS AT RISK 1. A 100% audit was completed on 9/10/14 and again on 9/11/14 by the nurse management team Monday through Friday times 12 weeks, then the nurse managers will use the audit form of 5 random charts weekly times 4 weeks. 9. On 9/17/14 and 9/18/14 inserved for all facility staff (which included but not limited to nurses, nurse aldes and certified nursing assistants) was started on the following: a. Out of a 18 residents had no identified concerns regarding neglect. b. No other concerns were identified. 3. On 9/10/14 and 9/11/14, a facility nurse manager has been assigned to each unit observing all facility residents which reside on those for signs and symptoms of neglect related to ADL (Activities of Daily Living) cares. a. No concerns were identified in regards to neglect related to activities of daily living (ADL) cares. a. No concerns were identified in regards to neglect related to activities of ADL cares. a. No concerns were identified in regards to neglect related to a ADL cares. a. No concerns were identified in regards to neglect related to a ADL cares. a. No concerns were identified in regards to neglect related to a ADL cares. a. No concerns were identified on a reas of concerns were identified in regards to a reas of concerns were identified on the service of the provided through the restated to ADL cares. a. No concerns were identified in regards to the provided to the subtract of the audit to, ensure them were no areas of concerns were identified on the following: a. Resident Protection System - Preventing Abuse and Neglect b. Observation of Resident and Report c.	PREFIX	(EACH DEFICE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
	F 224	The Administrator were notified of the 9/11/14 at 10:45 at was removed on facility provided at that in part read: "Credible Allegate RESIDENT AT R 1. Resident #14 facility. IDENTIFYING O' 1. A 100% aud again on 9/11/14 (director of nursite 2 unit managers, 2. The audit concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard b. No other concerns regard those for signs at the ADL (Activities a. No concernneglect related to cares. 4. On 9/11/14 100% facility rou areas of concern cares.	r and the Director of Nursing the Immediate jeopardy on the immediate jeopardy 9/11/14 at 6:45 pm when the the acceptable credible allegation Silon of Compliance: ISK 86 no longer resides at this THER RESIDENTS AT RISK It was completed on 9/10/14 and by the nurse management team and, assistant director of nursing, wound nurse) to insisted of reviewing all nursing 24 hours to ensure there were cerns of neglect with residents thange of condition. The residents had no identified ing neglect. Incerns were identified, and 9/11/14, a facility nurse then assigned to each unit illity residents which reside on and symptoms of neglect related to activities of daily living (ADL) The administrator completed ands to ensure there were no the with neglect related to ADL	F 22-	management ter form includes, b to, ensuring that change was not performance an possible neglect through the "Re Protection Syste form will be use nurse managem Monday throug 12 weeks, then managers will u form on 5 rando weekly times 4 9. On 9/17/14 and servicing for all (which included to nurses, nurse certified nursing started on the f a. Reside System Abuse b. Observ Reside Report inform Their C or Beh c. What i Report d. When	am. The audit ut is not limited to the status related to staff dif it was, has been reported sident am". The audit did daily by the sent team he friday times the nurse se the audit om charts weeks. 9/18/14 infacility staff but not limited a aldes and gassistants) was following: nt Protection appropriate and Neglect vation of and sing important ation About care, Condition avior to Observe and to Report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	j		DNSTRUCTION	(X3) DATE S COMPL	
	345434	B. WING			O 09/1	1/2014
	343434	10.11.10	070	EET ADDRESS, CITY, STATE, ZIP GODE	1 00/1	
NAME OF PROVIDER OR SUPPLIER						1
AL THE LANGING OFFITED			-	EAST CARVER STREET		
CARVER LIVING CENTER			DUI	RHAM, NC 27704		
BREEN (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224 Continued From page neglect related to AD PROCESSES IMPLE FURTHER OCCURR 1. In-servicing for the 9/10/14 by the Clinical At this point 40 nurse in-serviced. No nurse floor until they are inaddressed the follow a. 24 Hour Report b. Alert Charling P. c. Change of Cond. Documentation e. Appropriate assup to interventions f. Emergency Proc. Management g. Care of a Resid which included but in assessment (objective head injuries, lacera burns, choking, shor syncope, seizures, coma/ketoacidosis, acute psychotic behing physician notification h. Emergency Proc. Two nurses we a. One nurse was bullet points a-h about the pending an abut was suspended on it. The allegation of appropriate state agili. The resident is reside in the facility.	EMENTED TO PREVENT RENCE the nurses was started on al Resource Nurse and DON. The se out of 52 have been the will be able to work the eserviced. The in-service oring: Trocess Stition Guidelines Guid	F	2224	that all employees exceed have received this in-servicing is compared to return to we the in-servicing is compared to receive education regares and will preceive education regares and will be implemented the corrective action taken to extend this deficiency has been consisted in #4 with completed by the Nurse Management Team. a. The Nurse Management Consists of the ADON, 2 Unit and 2 MDS Coordinators. b. The AM Clinical AM. c. On Saturday and Sunday and an anager will facility each of complete the	ervice. be ork until oleted. red will rding the ystem Neglect) year. nted to eness of ensure orrected Meeting li be e Team e DON, Managers al id ay at 8:45 and se be in the day to	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	1			ONSTRUCTION		(X3) DATE S COMPL	
									:
		345434		B. WING					1/2014
	ROVIDER OR SUPPLIER	Accessors to the State of Stat			321	EETADDRESS, EAST CARVE RHAM, NC 2			-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION	LL DN)	IO PREFIX TAG		(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 224	protocol and complet outlined in the policy federal regulations. 3. The Nurse Man Clinical Resource Nut following: a. 24 Hour Report- b. Alert Charting P. c. Infection Report- d. Change of Condincluded physician netification f. Appropriate assup to interventions g. Emergency Prof. Management h. Care of a Residwhich included but n assessment (objection head injuries, lacera burns, choking, shor syncope, seizures, doma/ketoacidosis, i acute psychotic behaphysician notification I. Emergency Prophysician notification I. Em	e the investigation as and procedures and person agers were in-serviced tree on 9/10/14 on the and how to use them rocess in the services of t	by the ded follow tions- toms), es, eain, ction, ns and d the nager each . A	F:	224	3. 4. 7.	During the AM Clinical Many discrepancies identified documented, investig and corrected immediate the Nurse Management. From any discrepancies identified further educat disciplinary action will or with the staff member responsible. The Clinical Resource Nureview the daily audits (Inursing notes, BM list, telephone orders) comp the Nurse Management weekly times 4 weeks, to there is appropriate phy notification and guidance been provided for any cloudition. If trends or discrepancies noted this QA process we revised by the QA command As discrepancies and tresidentified through these audits further education training will be provided. The facility will continue involve the Medical Direct the facility processes in seek guidance and supp A member of the Home staff will be on-site weel least the next 30 days to guidance, support, train	ied will ated ely by Team. ion or ccur rse will abs, leted by Team, o ensure sician e has hange of sare ell be alttee. Inds are ell be and l. eto ort. Office kly for at o offer	
FORM CMS-2	round on any reside 567(02-99) Previous Versions O		Event ID: NDNH11		Fa	cility ID: 923077	monitoring of this plan.	nuation shee	1 1 Page 21 of 40

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (PLE CONSTRUCTION (X3) DATE SUF		
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILD	NG			
+		345434	B. WING			09/1	; [1/2014
	OVIDER OR SUPPLIER			ST 32	REET ADDRESS, CITY, STATE, ZIP CODE 11 EAST CARVER STREET URHAM, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 224 F 309 SS≂J	no concerns with AD c. A nurse manager report, afert charting ensure all change of communicated to the been provided and direcord under the nur. The facility alleges the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have to the discrepancies have the corrective measures ilicensed nurses regarded the corrective measures ilicensed nurses regarded the corrective measures in levels of emergency situation activation of emergency situation activation of emergency situation 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessary or maintain the high mental, and psychological accordance with the and plan of care.	condition to ensure there are L cares. er will review the 24 hour log and nursing notes to conditions have been a MD, that guidance has ocumented in the medical se charting tab. The immediacy of these been abated on 9/11/14." In the credible allegation interviews with licensed facility had implemented which included in-services of arding proper facility lest respiratory distress, consciousness (LOC), as, physician notification, ancy medical services and a care during a seizure, change in LOC or any and the facility must ary care and services to attain lest practicable physical, social well-being, in a comprehensive assessment		224	9. On 8/25/14, Apex Health Solutions, the managin company for Carver Liv Center, hired a new Clir Resource Nurse, who we continue to provide guisupport, training and me to the DON and Nurse Management Team. 10. The Quality Assurance Committee will review progress monthly on the identified concerns. 11. Facility alleges compilate this deficiency on 10/1	g ing nical ill dance, conitoring facility ne	
	This REQUIREMEN	NT is not met as evidenced					

extravarious bank representations continued with the continued and an extra continued and an extra continued as

come a dense a territori della considerational accessorial.

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			S HAVE		С
		345434	B. WNG _		09/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
OADVEDI	NUMO CENTED			321 EAST CARVER STREET	
CARVER	IVING CENTER			DURHAM, NC 27704	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IÐ PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
	Continued From pag by: Based on record rev services (EMS) report interviews, the facility freatment for seizure including immediate medical services and 1 of 3 residents review #186). The Immediate Jeop at 5:30 AM for Resid found by staff in confrespiratory distress. notified of the Immediate	iew, emergency medical rt, and staff and physician r failed to provide emergency s and respiratory distress, initiation of emergency I notification of physician, for ewed for wellbeing (Resident ardy (IJ) began on 08/18/14 ent #186 when resident was diate Jeopardy on 9/11/14 at ediate Jeopardy was t at 6:45 PM when the facility implemented a credible thy was left out of compliance th potential for more than not immediate jeopardy [D] n complete all staff itoring systems could be cluded in the Quality admitted to the facility on ative diagnoses of seizure	F 3	Corrective action for resident have been affected by this defected by this defected by this defected by this defected by this deficience. 1. A 100% audit was considered by the nurse manager (director of nursing, director of nursing not past 24 hot all resident experiencing change of of have had a appropriate assessment interventlo indicated; processed as the second director of nursing not past 24 hot all resident experiencing change of of have had a appropriate assessment interventlo indicated; processed director of nursing not past 24 hot all resident experiencing change of of have had a appropriate assessment interventlo indicated; processed director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director of nursing not past 24 hot all resident experiencing changes director di	ts found to eficiency: les at this ts that may impleted on n 9/11/14 ement team assistant 2 unit urse) consisted of 00% of the es in the irs to ensure s ig any condition n e nursing and ns, as chysician if or further is indicated
- Andrews	September 2014 rev Vimpat, and Klonopi anticonvulsant, Vim	realed orders for Keppra,		W	residents ere started
	proportios.			Į.	an Hiblotic with

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) ĐAT	E SURVEY PLETED
		048404	T WILLO				С
NAME OF D	DOMBER OF CURRENCO	345434	B. WING		T. (1)	90	/11/2014
INAMIC OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CARVER	LIVING CENTER		ļ		21 EAST CARVER STREET		
			- 	_ D	PURHAM, NC 27704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF BEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD F		₿Ë	(X5) COMPLETION DATE	
F 309	F 309 Continued From page 23		F 3	09	appro		
		rly Minimum Data Set			assess	•	
		Indicated the resident was		ĺ	interv		
	severely cognitively in	npaired.			•	ysician	
	Care plan dated 00/1/	U44 indicated activities		1	notific		
	nrohlem Gnal resider	l/14 indicated seizures as nt will have airway open.		1	ii. 2 resid		
	Approaches: administ	er meds as ordered		ļ	i e e e e e e e e e e e e e e e e e e e	all with	
		s and effectiveness, neuro			appro		
	(neurological) assessr	nent as needed, notify MD		I	assess	•	
	as needed, maintain a	irway, and report seizures.			interv		
	A 884844				and pi notific	ysician	i
	On 09/10/14 at 5:45 P	M, an interview was		- 1	***************************************		
	of the resident on 9/19	Aide (NA #1) who took care W14 (third shift 11PM to			III. 1 hosp		
	7AM) She stated the	resident was fine during			reside	-	
		the room on rounds about			expire		
		breathing hard." NA#1		- [аррго		
	indicated when she dis	scovered the resident, she				nents,	
	was having trouble bre				interv		. 1
		ated she went to get Nurse				ysician	1
	#1.			Ì	notific		1
	In an Internal				iv. No oti		
	In an interview with Nu	rse #1 on 09/10/14 at she knew Resident #186				ns were	
	and had taken care of	her prior to 08/18/14. She			identi		<u> </u>
	stated when she enter	ed the room around 5:30			regard		
1	AM she observed the				shortn		
	distress and having se	izures. The resident was			breath		1
	in a supine (flat on her	back) position. The nurse	ļ		seizur		
{		ident's vital signs and her	1			in level	
	pulse oxygen saturatio	n was low at 87 percent.			of		
	one moved the resider	nt to a 45 degree angle,]			ousness.	
	and applied bxygen at	2 liters per minute. Nurse a breathing treatment with			2. On 9/10/14 and 9/11/14		
1	a Nahulizar" Muree	#1 stated the resident was			facility nurse manager h		
	unresponsive and activ	ely having a continuous		{	assigned to each unit ob		
-	seizure. She stated th	e resident normally had			all facility residents which		
	some movements in he	er extremities but this was			on those units for any co		
	поп-stop movements.				and/or change in condit	on.	

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STATEMENT	OF DEFICIENCIES	VAL BROWN COUNTY (TO A LA LA LA LA LA LA LA LA LA LA LA LA L				OMB N	IO, 0938-0391
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		E SURVEY MPLETED
		345434	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER					0:	9/11/2014
					TREET ADDRESS, CITY, STATE, ZIP CODE		
CARVER	LIVING CENTER			1 .	21 EAST CARVER STREET		
(X4) ID	CHAINADVOY	ATTIMENT		Γ_0	URHAM, NC 27704		
PREFIX TAG] (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BF	(X6) COMPLETION DATE
F 309	Continued From page	. ታለ			a. No conce	PDC 11/070	
	1		F	309			
	She stated there were	a blockage in her throat.				in regards to	
	her mouth Sho state	no secretions coming from		1		notification	
	suction the resident	Sursing did not attempt to Nurse #1 stated when a				to identify a	}
	repeat oxygen saturat	ion was done, the oxygen	į.			change of	
	was up to 89 or 90 ne	rcent and she increased the		1	condition		
	oxygen flow to 4 liters	Derminute Nurse#1		1		of breath,	
	stated she did not call	the resident's physician to		- 1		nd change in	
	report the seizure or s	ee if oxygen should be				nsciousness.	
	increased at that time.	Nurse #1 stated she			b. The physic	ian and/or	
	called Emergency Med	dical Service (EMS) and		1		oractitioner	
	stated probably somet	ime after 6 AM. Nurse #1			are in the	facility	
	stated she did not call	the physician at that time.				Friday and	1 1
	She stated she called	the physician and		1	while in th	e facility staff	1
	facility with EMS at 8:1	the resident had left the		-]		them there.	
	would will Ello at o. i	4 AIVI.				y are not in	[
	In nursing notes for 08	/18/14 at 8:14 AM Nurse			the facility		
	#1 documented, "Bloo	d pressure 92/58 at 5:30		-	will be cor		
	AM, pulse (rate) 64, ter	mperature 98.2, respiratory		Ì	through th		
	rate 25 (breaths per mi	nute), O2 (oxygen			service. P		
1	saturation) 87% on roo	m air at 5:30 AM.			notification		İ
	Comments: Resident v	as wheezing, obvious		ĺ		ed under the	
	gurgling, very lethargic	/sleepy; difficult to arouse,				arting in the	
	has selzures. Nebulize	er treatment given, O2			medical re		
İ	Seizuro was non atau	minute (Liters per minute).		1	c. If the MD o		
	improve The Might No	and resident status did not			site they w		
	helped in assessing the	rse in the front hall also					ļ
1.	called and resident was	transported to floor			immediate		1
	hospital) via stretcher a	t 7:30 AM. Dr. [attending	1		to the resig	ient's room	
	physician] notified; resid	dent's daughter notified of			ir a change	of condition	
	resident's transfer".					hortness of	1
					breath, sei:		
	In an interview with Nur	se #2 on 09/10/14 at			change in l		ļ
1	12:21 PM, she stated th	at on 08/18/14 between			consciousn	ess is noted.	
1.	6:00 AM to 7:00 AM Nu	rse #1 came out in the			The physician is noti		
	hall to request help with	Resident #186. She			immediately in non-		
	stated it must have bee	п between 6 and 7 AM;	1	-	threatening emerge	ncles for	1

and on all explicative action of about mandellines and decreasing accountages a particular of the first explication of a section of the control of the contr

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIT	TIPLE C	ONSTRUCTION		(X3) DATE S	
	of Deficiencies Correction	IDENTIFICATION NUMBER:	1				COMPL	ETED
, ., . ,			1				c	
		345434	B. WNG				09/1	1/2014
NAME OF DE	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STAT	E, ZIP CODE		———
HANGE OF FE	14 - 15 Eli Air Air Air 1 mair			321	EAST CARVER STREET			
CARVER	IVING CENTER			บต	RHAM, NC 27704			
444 155	SHWWARY ST	ATEMENT OF DEFICIENCIES	10	Ţ	PROVIDER'S P	LAN OF CORRECTION		(X5) COMPLETION
(X4) ID PREFIX	/FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF			IVE ACTION SHOULD B ED TO THE APPROPRE		DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			FICIENCY)		
			1		£	uidanas and sh	OF ENAC	
F 309	Continued From pag	e 25	F	309		guidance and afte		
1. 208	and did not rough the	exact time. Nurse #2 stated	1			ted in life threat	crinig	
	she went into Reside	ent #186's room with Nurse		1	emerger	icies.		
	#1 and observed the	resident lying on the bed;		-		ا - معملا عبير ميا ال	nea to	
	she was shaking and	I having difficulty breathing.			Measures that w			
İ	The resident had a b	lood pressure cuff on her			ensure that this	aeticiency abes	HOL	
	right arm, and was g	etting oxygen via nasal			recur:	.) Es u éla a usunar		
	cannula and was uni	responsive. Nurse #2 stated				cing for the nurse		
	"We woke her up us	ing a sternal rub. She I never spoke. Her eyes were				on 9/10/14 by th		
	opened her eyes but	oughing." Nurse #2 stated				Resource Nurse		
	the reneated the ete	ernal rub. She stated the	Į.			n 9/11/14, 40 nt		
ĺ	resident's body conti	inued to shake during sternal	1		0 0	2 have been in-s		
1	rubs. Nurse #2 state	ed that she told Nurse #1 that		1	**	e will be able to		
	they needed to call t	EMS. Nurse #2 stated Nurse		1		r until they are i		
	#1 left the room to c	all EMS and prepare the		1	*	i. The in-service		
	discharge paperwork	k and she stayed in the room				ed the following		
1	with the resident. S	he stated "I opened the				24 Hour Report		
	closet and picked or	at an outfit for the resident.		1	b.	Alert Charting I		
	Then I washed her t	up and dressed her. I had to her shirt and pants on."			¢.	Infection Report		1
	hurse #2 stated the	resident was seizing and		Ì	ď.			
	unresponsive while	being bathed and dressed.	ļ			Guidellnes- wh		
	Nurse #2 stated she	was aware the resident was				included physic	cian	
	having continued se	izures throughout the bath				notification		
	and dressing, howe	ver she continued on with the			e.	Documentation		
	tasks because she	wanted the resident to look				Guidelines-wh		
	nice to go to the hos	spital.				included physi	cian	
]	MADON DOMOMA Paragrament				notification		
	Review of Resident	#186's 08/18/14 Emergency			f.	Appropriate		
	Medical Service (El	MS) report revealed Dispatch ices "was called at 6:53 AM				assessment,		
	on 08/18/14 reporting	ng a resident with seizures,				interventions,	follow up)
	ambulance in route	at 6:54 AM, the ambulance				to intervention	าร	
	traveled one mile a	nd arrived at the facility on			g.	Emergency Pro	ocedures-	.
	6:59 AM, emergeno	cy crew at bedside 7:05 AM.				Selzure Manag		
	Chief Complaint, St	eizures/Convulsion, Actively.	1		h.			
	Seizure duration gr	eater than 5 minutes, seizure			,	Emergency Sit		
1	type- Grand Mal [fo	r] 1 hour." (Taber's Medical				which include		
1	Dictionary 19th edi	ition, describes Grand Mal as	l		1			i

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COMPLE	
		345434	B. WING		49	09/1	1/2014
NAME OF PR	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	21 EAST CARVER STREET		
CARVER	IVING CENTER			0	OURHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 309	epilepsy, loss of con movements of the excontinued, "lung sould and lung sounds right [Rhonchi are described wheezing, snoring, of during auscultation of stethoscope) of a peopstruction. Mucus airway, bronchial hy respiratory passage Summary statement "Dispatched by 911 51 year old female a assessed as charter staff at local skilled activity noted. Staff (history) of same see anoxic brain injury, approx (approximat (intravenous) access charted and IV Verse "IVersed is a benzo epilepticus, a continued on O2 at transport, second of due to continued so never fully ceased transport." Review of Residen 08/18/14 in part reastatus epilepticus, airway protection a fintensive care unit	sciousness with violent ktremities). The report unds Left Wheeze/Rhonchi, not wheezes/ Rhonchi." bed by Taber's as "A por squeaking sound heard (listening to chest with earson with partial alrway or other secretion in the peractivity that occlude s."]	F	309	and subjective symptoms), injuries, lace suspected from burns, choking shortness of chest pain, so seizures, dized diabetic coma/ketoa insulin shock reaction, act psychotic be ingestion of physician noting. Emergency which include physician noting. In the facility on the facility on emergency services and notification orientation.	nead rations, actures, ng, breath, yncope, ziness, cidosis, c/insulin ate chaviors, toxins and otification. Procedures- ded otification it was it that 52 of es have e in-service. 14 no new e been hired ty, arses hired education ncy initiation of medical d physician a during the process.	
	יין ללמויט) זון				this deficiency.	continuation she	et Page 27 of 4

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, , ,		CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBERS	A. BUILD	NG		0	
		345434	B, WING			i .	, 1/2014
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				32	1 EAST GARVER STREET		
CARVER	IVING CENTER			DI	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Her EEG (electroence waves) indicated an She was felt to be he due to infection (aspinas also suffering from possible aspiration pure interview with the Di 09/10/14 at 2:13 PM expectation was if not resident selzing that to an upright position toward the left side, EMS if the selzure is the DON stated Resamedical emergency resident flat on her between the morning meeting two hour time frame was not concerned in EMS time to stabilize thought the 'gurgling. In an interview with 09/10/14 at 12:52 Physical called by the nurse left for the hospital, expected to have be resident, with a hister that lasted more that should be initiated in The Administrator was popardy on 9/11/14.	other anticonvulsant) loaded. ephalogram, to view brain underlying seizure disorder. eving breakthrough seizures ration pneumonia)". Patient om septic shock due to neumonia. rector of Nursing (DON) on revealed that her ursing staff observed a the resident should be raised and the nurse should call asted more than 15 minutes. sident #186 was experiencing y on 08/18/14 and laying the wack for bathing and dressing ppropriate. The DON vas discussed on 08/19/14 at y. She stated she saw the on the nurses' notes but because sometimes it takes a resident. She stated she if was due to seizure activity. the Medical Director on M, he acknowledged he was on 08/18/14 after the resident He stated he would have een called by staff if the ory of seizures, had a seizure in 5-10 minutes and EMS	F	309	a. One nurse was in-se on 9/11/14- (see but points a-i above). b. The other nurse has suspended at this tip pending an abuse al of neglect- she was suspended on 9/11/ nurse's employmenterminated on 9/16 the allegation of ne was substantiated. 3. The Nurse Managers we serviced by the Clinical Following: a. 24 Hour Report how to use the b. Alert Charting For Concept	been me legation 14. The t was /14 and glect re in- desource - and m Process its dition ich clan lich clan follow up s cedures- ement	
	compliance:	ng oregina enegatori or			h. Care of a Resid	ent in	<u> </u>

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	ETED
		345434	B. WING			1	1/2014
MANG OF DE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FE	OVIDER ON SOLT LICH				1 EAST CARVER STREET		
CARVER	IVING CENTER		1	่อเ	URHAM, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	facility. IDENTIFYING OTHI 1. A 100% audit w again on 9/11/14 by (director of nursing, 2 unit managers, wo a. The audit consinursing notes in the residents experience have had an apprope interventions, as indefor further guidance of EMS immediately 1. 2 residents wer appropriate assess physician notificatio 2. 2 resident had assessment, interventification 3. 1 hospice resid assessments, interventification 4. No other concestortness of breath of consciousness. 2. On 9/10/14 and manager has been observing all facility those units for any condition. 1. No concerns w notification or fallunchange of conditior	ried in longer resides at this ER RESIDENTS AT RISK as completed on 9/10/14 and the nurse management team assistant director of nursing, and nurse) sted of reviewing 100% of the past 24 hours to ensure all ing any change of condition riete nursing assessment and icated; physician notification as indicated and activation if indicated. The started on an antibiotic with ment, intervention and in a fall with appropriate antion and physician The ention and physician The serious with appropriate rention and physician The serious and change in level assigned to each unit residents which reside on concerns and or change in the related to shortness of	F	309	Emergency Si which include limited to- in assessment (and subjective symptoms), it injuries, lacer suspected from burns, choking shortness of chest pain, so seizures, dizabetic coma/ketoace insulin shock reaction, accupsychotic be ingestion of physician not i. Emergency Fill which include physician not i. Emergency Fill which include physician not i. Emergency Fill which include physician not i. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which include physician not ii. Emergency Fill which is a complete of its	ed but not itial objective re nead rations, actures, breath, yncope, ciness, cidosis, cimess, cidosis,	
	breath, selzures an	d change in level of			speaking to	**	
	consciousness.		1		THISES TEPS	odioe aov	

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TATEMENT O	F DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		COMPL	
NO PLAN OF	CORRECTION	102 per la Grandiana	A. BOILO					;
		345434	B. WNG				09/	1/2014
	A JOSE AN AUDOLICA	1 0,000		ST	REET ADDRESS,	CITY, STATE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER			32	1 EAST CARVE	R STREET		
CARVER L	IVING CENTER			D	URHAM, NC 2	7704		
	2000	TATEMENT OF DEFICIENCIES	ID	۱	PRO	OVIDER'S PLAN OF CORRECTION	1	(X5)
(X4) ID PREFIX	/EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		(EACH	CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE	BE	COMPLETION DATE
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION)	TAG	•	CROSS-	DEFICIENCY)		
~ 000	a di di Famina	20	F	309			£	
F 309	Continued From pag]0 29	'	000		resident change	e or	
	3, The MD and/or	r his nurse practitioner are in				conditions and		
	the facility Monday	Friday and while in the facility there. When they are not in	İ			physician notifi		
	staff will notify them	will be contacted through the	ļ			for further guid	lance.	
	the facility then uley	notification is documented				In addition, the	nurse	}
	On-can service. Wit	harting in the medical record.				manager will re	ound on	
	a. If the MD or NF	is on-site they will				any residents v	vhich	
	immediately be call	ed to the resident's room if a				have had an id	entified	
	change of condition	related to shortness of				change of cond	dition.	
	breath, seizures an	d change in level of				c. A nurse mana		
	consciousness is no	oted.				review the 24		
	4. The MD is not	fied immediately in non-life				report, alert ch		
	threatening emerge	encles for further guidance and				log and nursin		
	after EMS is activate	ted in life threatening				to ensure all c		
	emergencies.				1	conditions hav		1
						communicate		
	PROCESSES IMP	LEMENTED TO PREVENT			1			
	FURTHER OCCUP	r the nurses was started on				physician, tha	l	
	1. In-servicing to	ical Resource Nurse and DON.				guidance has	1i	
	At this point 40 pur	ses out of 52 have been				been provided		
	in control No pu	rse will be able to work the				documented i		
	floor until they are	in-serviced. The in-service				medical recor		
	addressed the follo				ĺ	the nurse cha		1
	a. 24 Hour Repo				5.	On 9/30/14 a "Quality	,	
	b. Alert Charting	Process			1	Assurance Worksheet		
	c. Change of Co	ndition Guidelines- which				Status Change" audit	form was	
	included physician	notification				implemented. The au		
	d. Documentation	n Guidelines- which included				will be completed by		
	physician notificati	on				management team. T		
	e. Appropriate a	ssessment, interventions, follow				form includes, but is r		d
	up to interventions	S. Colores Colores			1	to, ensuring immedia		
		rocedures- Seizure	1			activation of emerger		
	Management	sident in Emergency Situations-				medical services, app		
	g, Care of a Kes	t not limited to- initial			1	nursing interventions		
	Which included bu	ctive and subjective symptoms),	Ì			nursing interventions	t AMILIE	1
	assessment (obje	erations, suspected fractures,				awaiting the arrival o	1	
	hurns choking st	nortness of breath, chest pain,	Ì			emergency medical s	ervices,	
	2587(02-99) Previous Versions		DMRH		Facility ID: 923077	immediate physician	ntinuation sh	eet Page 30

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STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	1 '		ONSTRUCTION	(X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	A BUILD	NG	<u> </u>		
		345434	B, WING			09/	, 11/2014
		340434	10,,,,,,,	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 200	.,
NAME OF PE	ROVIDER OR SUPPLIER				EAST CARVER STREET		
CARVER L	IVING CENTER			· ·	RHAM, NC 27704		
		THE OF DECIDIENDIES	(D	<u> </u>	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 309	1		F	309	notification and docu	mentation	
	syncope, seizures,	, dizziness, diabetic			of the change of con-	lition in	
	coma/ketoacidosis	, Insulin shock/insulin reaction,			the medical record.		
		haviors, ingestion of toxins and			form will be used dai	ly by the	
	physician notificati	on.			nurse management t		
	h. Emergency P physician notificati	rocedures- which included			Monday through Frid		1
}	2. Two nurses v	vere identified in this deficiency.		-	12 weeks, then the n		
	a. One nurse wa	as in-serviced on 9/11/14 (see		1	managers will use th		
	bullet points a-h a	bove}		1	form on 5 random ch		
	b. The other nur	se has been suspended at this			weekly times 4 week	.	
ļ	time pending an a	buse allegation of neglect- she			6. On 9/17/14 and 9/18		
	was suspended or	n 9/11/14,			servicing for all facili	ty staff	
	3. The Nurse Ma	anagers were in-serviced by the			(which included but	not limited	
	l .	Nurse on 9/10/14 on the		l	to nurses, nurse alde		1
]	following: a. 24 Hour Repo	ort- and how to use them			certified nursing ass		,
	b. Alert Charting				started on the follow		
	c. Infection Rep				a, Resident Pr		
	d. Change of Co	ondition Guidelines- which		- 1	System- Pro		
	included physicial	n notification			Abuse and		
		on Guidelines- which included		}	b. Observation	•	
	physician notificat	tion			Resident ar		
]		assessment, interventions, follow			Reporting I		
1	up to intervention	s Procedures- Seizure			Informatio	=	
	Management	100000100 0012011	1		Their Care,		
	h. Care of a Re	sident in Emergency Situations-		l	or Behavio		
	which included by	ut not limited to- initial			c. What to Ok		
	assessment (obje	ective and subjective symptoms),			Report		
	head injuries, lac	erations, suspected fractures,			d. When to Re	eport	
	burns, choking, s	hortness of breath, chest pain,			e. Who to Re	•	
	syncope, seizure	s, dizziness, diabetic			f. Quality ass		
	coma/ketoacidos	is, insulin shock/insulin reaction, behaviors, ingestion of toxins and			and Assura		,
	physician notifica	ition			1	nice. 1 9/30/14 it	
	Physician ilutilica	Procedures- which included			i. Oi		
	physician notifica	ation				as etermined	
	4. The nurse r	nanagers will continue with the			I .		
1	AM Clinical Mee	ting Monday - Friday			1	at all	

respected in the second and the second in th

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	COMPL	
		345434	B. WING			· ·	1/2014
	ROVIDER OR SUPPLIER			321	REET ADDRESS, CITY, STATE, ZIP CODE EAST CARVER STREET RHAM, NC 27704		
0/1111							~~
(X4) ID PREFIX TAG	/FACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	986	(X5) COMPLETION DATE
F 309	a. On Saturday ar will be in the facility of the physical rounds unit, every AM, prior nurse manager will be nurses regarding an conditions and physical guidance. In additional round on any reside identified change of c. A nurse managreport, alert charting ensure all change of communicated to the been provided and record under the nurse Management Team a. The Nurse Mar DON, ADON, 2 Unit Coordinators. b. The AM Clinical Monday-Friday at 8 c. On Saturday a will be in the facility areas listed in #2. 2. During the AM discrepancies identification or discipstaff member respondents. The Clinical Reducation or discipstaff member respondents.	and Sunday a nurse manager each day. Is will be completed on each to AM Clinical Meeting. A present to the floor yresident change of ician notification for further on, the nurse manager will ents which have had an condition. It will review the 24 hour elegand nursing notes to fronditions have been and the medical rise charting tab. Clinical Meeting all areas completed by the Nurse elegant Team consists of the team and an each day to complete the conditional Meeting any iffed will be documented, preceded immediately by the team. Clinical Meeting any iffed will be documented, preceded immediately by the team. Team.	F	309	have this i This will i allov retu untii serv com ii. Any emp hire rece edu rega item 6 a- the	loyees d will ive cation ording the os listed in f during ntation cess. ss, nurse or the aining for and (h) onsfer, lents or ty the DVD oved by h Services ted in- eted for	

intermental source - strangent morning or all or or or source del confermit politica as read mentional mentioned mention or a consequent

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CC	INSTRUCTION	(X3) DATE S	
AND PLAN OF		IDENTIFICATION NUMBER:	1			COMPL	
						C	
		345434	B. WING			09/1	1/2014
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
				1	EAST CARVER STREET		
CARVER L	IVING CENTER			DUF	RHAM, NC 27704		
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 32	F	309	certified nursing as	sistants on	
		, weekly times 4 weeks, to			identifying change		
]	ensure there is app	ropriate MD notification and			that requires emer		
	guidance has been	provided for any change of	1		medical treatment		
	condition.				This directed in-ser	-	
	5. If trends or dis-	crepancies are noted this QA			completed by a No		
	process will be revi	sed by the QA committee. les and trends are identified	1		Board Certifled Int		
	through these CA	audits further education and		1	Medicine Physician		
	training will be prov				affiliation to Carve	•	
<u> </u>	7. The facility will	continue to involve the			Center or Apex He		
	Medical Director in	the facility processes in order			Solutions.		
	to seek quidance a	nd support.			Solutions		
	8. Amember of t	he Home Office staff will be		- 1	Measures that will be imple	emented to	
	on-site weekly for	at least the next 30 days to		Ì	monitor the continued effe		
	1 "	pport, training and monitoring of			the corrective action taken		
	this plan.	pex hired a new Clinical			that this deficiency has bee		
	Resource Nurse v	who will continue to provide	1	1	and will not recur:	4411.04144	
	guidance, support.	training and monitoring to the			1. During the AM Clin	ical Meetine	
	DON and Nurse M	anagement Team.			all areas listed in #		
				1	completed by the I		
	The facility alleges	the immediacy of these			Management Tean		
	discrepancies have	e been abated on 9/11/14.			a. The Nurse		
	On 00/44/4 4 5/ 6/4	5 PM, the credible allegation				ent Team	
	Un US/11/14 at 0.4	aff interviews with licensed		1	•	f the DON,	
	nurses revealed th	ne facility had implemented		- 1		Unit Manager:	
	corrective measur	es which included in-services of		1	and 2 MD	-	
	licensed nurses re	garding proper facility			Coordinal		
	procedure and pro	tocal for residents experiencing		ŀ	b. The AM C		
	seizures, respirato	ory distress, changes in levels of	l		Meeting i		
	consciousness (L	OC), emergency situations,			-	Friday at 8:45	
	physician notiticat	ion, activation of emergency and appropriate resident care		Į	AM.	i i iday at bi43	
	medical services	respiratory distress, change in				day and	1
1	LOC or any emer	nency situation.			c. On Saturo Sunday a		
E 500	483.75(o)(1) QAA		Ì	F 520	<u>.</u> "	will be in the	
F 021	COMMITTEE-ME	MBERS/MEET				war be in the ich day to	
202,	, , , , , , , , , , , , , , , , , , , ,	-			•	the areas	

and the contraction of the contraction and and and the contraction of

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	CIPLE (CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
		345434	8. WING			09/1	; 1/2014
		340434	1		REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER				1 EAST CARVER STREET		
CARVER L	IVING CENTER			1	URHAM, NC 27704		
	CHUMADV C	TATEMENT OF DEFICIENCIES	ID.	<u></u>	PROVIDER'S PLAN OF CORRECT	ION	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DESICIENC	LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE OPRIATE	DATE
F 520	Continued From pag	ıe 33	F	520	listed in #4.		
1 040	QUARTERLY/PLAN					al Meeting	
	GOVILLEVELL CLUB	•			2. During the AM Clinic any discrepancies ide		
					be documented, inve	eticated	
	A facility must maint	ain a quality assessment and			and corrected imme		
	assurance committe	e consisting of the director of			the Nurse Managem		
	nursing services; a p	physician designated by the			3. From any discrepand		
		3 other members of the		:	identified further ed	testion or	
	facility's staff.				1		
	The quality assessn	nent and assurance			disciplinary action w		
	The quality assessing	least quarterly to Identify			with the staff memb	er	
[issues with respect	to which quality assessment			responsible.	. Missaum a 11-141	
	and assurance activ	/itles are necessary; and			4. The Clinical Resource		
	develops and imple	ments appropriate plans of			review the daily aud		1
1	action to correct ide	ntified quality deficiencies.			nursing notes, BM li		
					telephone orders) c		
	A State or the Secr	retary may not require			the Nurse Managem		
	disclosure of the re-	cords of such committee			weekly times 4 wee		
	except insofar as su	uch disclosure is related to the			there is appropriate		
		committee with the			notification and guid		
	requirements of this	5 50 GUUII.			been provided for a	ny change o	f
1	Cond faith attempts	s by the committee to identify			condition.		1
	and correct quality	deficiencies will not be used as			5. If trends or discrepa		
	a basis for sanction	18,			noted this QA proce		
		•			revised by the QA c	ommittee.	
					6. As discrepancies an		
	This REQUIREME	NT is not met as evidenced			identified through t		
	by:				audits further educ		
1	Based on record of	eview and staff interviews, the	ļ		training will be prov		
	facility's Quality As	sessment and Assurance	1		7. The facility will con		
	Committee failed to	o maintain implemented			involve the Medical		
	procedures and mo	onitor these interventions that	1		the facility processe		,
1	the facility put in pl	ace in July 2014. This was for ncies which were originally	1		seek guidance and		
	two tederal deticies	4 on a Recertification survey					
	and regited on a ci	urrent Recertification revisit,					+
1	complaint survey of	of September 11, 2014. The			staff will be on-site		15
1	deficiencies were	recited in the areas of Care &			least the next 30 da	ys to offer	

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STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S		
AND PLAN OF	CORRECTION	(DEM HUNGHOW MOWIDER)	A. BUILDI	NG			
		245424	B. WING			!	, 11/2014
	0.0000	345434	12.11.10		TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	1 21 20 14
NAME OF P	ROVIDER OR SUPPLIER			!	21 EAST CARVER STREET		
CARVERI	IVING CENTER				URHAM, NC 27704		
					PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 520	Services and Physici continued failures of Recertification revisit show the facility's ina Quality Assurance properties of the Immediate Jeop 5:30 am for Resident found by the staff in respiratory distress. Temoved on 9/11/14 provided and implem allegation of compilia out of compliance at (no actual harm with minimal harm) that is ensure monitoring sy effective and include Assurance Program. This tag is cross refered ta. F 309: Care and Recertification survecited: Based on receited:	an notification. The the facility during a , complaint survey of records ability to sustain an effective rogram. ardy (IJ) began on 8/18/14 at t #186 when the resident was continuous seizures and The immediate jeopardy was at 6:45 pm when the facility nented an acceptable credible ince. The facility will remain a scope and severity of [D] the potential for more than a not immediate jeopardy to ystems put in place are id in the facility's Quality . Findings included:	F	520	monitoring of this plan. 9. On 8/25/14, Apex Health Solutions, the managing company for Carver Living Center, hired a new Clining Resource Nurse, who will continue to provide guide support, training and most to the DON and Nurse Management Team. 10. The Quality Assurance Committee will review to progress monthly on the identified concerns. 11. Facility alleges compiliar this deficiency on 10/15	ng ical lance, onitoring acility e	

I need miles satisfies white administration is east in declared in manufactures of the control o

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	CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVICENCIES (X1) PROVIDERS SUPPLIERCIA (X2) MULTIPLE GONSTRUCTION (X3) DATE SURVICENCIES (X4) PROVIDERS SUPPLIERCIA (X4) MULTIPLE GONSTRUCTION					
AND PLAN OF		IDENTIFICATION NUMBER:	A BUILDING) <u> </u>	C	
		345434	B. WING			1/2014
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 321 EAST CARVER STREET DURHAM, NC 27704	E	
(X4) ID PREFIX TAG	(CAOH DEELOIS	STATEMENT OF DEFICIENCIES NOY 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)	ASHOULD BE APPROPRIATE	(XS) COVPLETION DATE
F 520	Recertification revected for F 309 for treatment for seize including immedia medical services a for 1 of 3 resident (Resident #186) - for investigation during the July 17 indicated above in b. F 157: Physicial During the Recertification and nutracility failed to more nurse practition loose stools which medical treatmer for Clostridium Diphysician of misseresident with a city (Resident #263). The facility on Scresident's physician for resident's physician for not #186) - see F 16 investigation de'during the July Indicated in b.	otember 11, 2014 during a lisit, complaint survey was or failure to provide emergency ures and respiratory distress, are initiation of emergency and notification of the physician is reviewed for wellbeing see F 309 per the CMS-2567 letails. F 309 was originally cited of 2, 2014 recertification survey as in 1a. In Notification of Changes – tification survey of July 2014 the Based on record review, staff, rise practitioner interviews, the office of the physician intervity or consult with the physician intervity or consult with the physician intervity of 2 residents reviewed lifficile and failed to notify the sed doses of potassium for 1 of 1 ritical potassium level of 2.3 expression 1, 2014 during a exist, complaint survey was failure to immediately notify the clan of respiratory distress and ures for 1 of 3 sampled residents ification of change (Resident 57 per the CMS-2567 for tails. F 157 was originally cited 17, 2014 recertification survey as	F 5	Corrective action for resident #186 no longer facility. Corrective action for reside affected by this defice. 1. A 100% audit we 9/10/14 and ago by the nurse managers, wou aloue a review nursin past 2 all resident experience assessint ervindication of the review indication sides at this Idents that may lency: as completed on ain on 9/11/14 anagement team sing, assistant sing, 2 unit and nurse) adit consisted of ving 100% of the genotes in the 4 hours to ensure idents iencing any see of condition and an apriate nursing sment and ventions, as ated; physician cation for further ince, as indicated activation of EMS ediately, if		
	Director of Nurs	ing (DON) in the presence of the				

SAME SOME INTERNAL DESCRIPTION OF THE PROPERTY

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTIO	l' '		X3) DATE SURVEY COMPLETED	
				•			(2	
		345434	B. WNG				09/	11/2014	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRES	S, CITY, STATE, ZIP CODE			
AABUEDI	SUMA ARTITED			32	1 EAST CARV	ER STREET			
CARVER	IVING CENTER			DI	URHAM, NC	27704			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	<u>' </u>	P	ROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG			CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIV DEFICIENCY)		COMPLETION DATE	
F 520	Continued From page	3 6	F	520		with	nnriato		
	Administrator reveale	d she was part of the quality		1			opriate		
		nittee. The DON stated she		I		physi 			
		nts that had taken place		ĺ			cation		
		nd acknowledged she had		I			idents		
		in its entirety dated 8/18/14,				had a	ı fall		
	prior to the entry of th			[with			
		ey. The DON stated after ote written by Nurse #1, she					opriate		
	-	was a time lapse from the				physi	clan		
	-	ident was identified with				notifi	cation		
	-	B7 percent and the time the				3. 1 hos	pice		
		he hospital. She stated she				resid	ent		
		deficient concerns from the				expir	ed with		
	nurses notes nor had			ļ		appro	priate		
	interviews with the nu	rsing staff (Nurse #1, Nurse				physi	•		
		eeded to be re-trained. The					cation		
		e was no discussion in the				4. No o			
		on 8/29/14, regarding				conc			
		Improvement, surrounding				were			
		d 8/18/14. She further stated		1		ident			
		186) was discussed on			2.	On 9/10/14 and 9/11/14,			
		g team meeting but she did			۷.				
		lurse #2 in to talk to them natic care concerns. The				facility nurse manager ha			
	,	ne, she did not see a quality				assigned to each unit obs			
	assurance problem si					all facility residents which			
·		acility. The DON indicated "I		ļ		on those units for any con			
		frame on the nurses' note	1	l		and/or change in condition			
	but was not concerne	d because sometimes it		1		1. No co	oncerns		
		abilize a resident. I thought		ŀ		were			
		re to seizure activity." The					ified in		
		the QA committee meeting				regar	ds to		
		was no identified problems				physi	cian		
		186, that needed to be	1			notifi	cation.		
		d related to continued		1	3.	The physician and/or his	nurse		
		distress or proper response	1	1		practitioner are in the fac			
		ency situation. The DON	1			Monday - Friday and whi			
		e of the QA is to identify ough chart review, nurses'				The state of the s			

and out our soul stands and while were some out which were some such solutions and the area and all the area with a finite construction

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR			(X3) DATE SURVEY COMPLETED	
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		345434	B. WING			09/	11/2014	
4, ,	OVIDER OR SUPPLIER VING CENTER			321 EAST	DDRESS, CITY, STATE, ZIP CODE CARVER STREET I, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION DATE	
	plan for identified prolomeasures and monitor measures and monitor measures and monitor of the property of the concern to the detection of the concern to the concern to the concern to the concern to the concern to the concern to have to developed immediate staff and systems put the concern to have to developed immediate staff and systems put the Administrator and were notified of the in 19/11/14 at 10:45 am. Was removed on 9/11 facility provided an activation part read: "Credible Allegation of the in part read: "Credible Allegation of the in part read: "Credible Allegation of the in part read: "Credible Allegation of the in part read: "Credible Allegation of the in part read: "Credible Allegation of the in part read: "The addit consist the part read that in part read: "The audit consist the part read that in part read: "The audit consist the part read that in part read:	setings and develop a QA belems, with corrective oring. Im, in an interview, the she expected such a (speaking of the nurse's critten by Nurse #1) to have a cuality Assurance (QA) secussion and a plan initiated or sure safe care of the ent any reoccurrences. The ed after reviewing the lated 8/14/14, she expected leen QA'd and a plan letter of Nursing in place for monitoring. If the Director of Nursing mediate jeopardy on the imm	F		Assurance Performance Improvement (QAPI) Ac Plan. 2. The DON will submit all on physician notification change of condition mo the QA to be reviewed a revised as needed. 3. The administrator will so audits on abuse and negaliegations monthly to the reviewed and revised Indicated. 4. A QAPI Action Plan will implemented whenever is identified during AM Meeting and/or Departs Head Meeting. 5. The QA Committee will findings submitted by the different sub-committee monitor continued com and opportunities for improvement. 6. The administrator and/or Clinical Resource Nurse monitor the QA process to ensure Identified issu monitored and revised it correct quality deficience. 7. On 9/17/14 and 9/18/1 servicing for all facility started on the following a. Resident Protes System- Preventices.	audits audits and anthly to and abmit all glect he QA to l as oe an issue clinical ment review he es to pliance or will weekly es are o ies. 4 in- staff was g: ction		

Sanita harawan kan indi ing katapang parakan an tatap indina dan dalah kan kan dan kan mangalah ing mengang ka

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	345434	B. WING_			09/	11/2014
NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER			32	REET ADDRESS, CITY, STATE, ZIP CODE 11 EAST CARVER STREET URHAM, NC 27704		:
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
appropriate physician not 2. 2 resident had a fall a physician notification 3. 1 hospice resident ex physician notification 4. No other concerns w 2. On 9/10/14 and 9/11/ manager has been assign observing all facility resid those units for any conce- condition. 1. No concerns were id notification. 3. The MD and/or his n the facility Monday - Frida- staff will notify them there the facility then they will b on-call service. MD notifi- under the nursing charting 4. The MD is notified in threatening emergencies after EMS is activated in it emergencies. 5. An abbreviated QA& conducted on 9/11/14 to a concerns physician notific condition (seizures, short in level of consciousness unresponsiveness) from t (Revisit). PROCESSES IMPLEMEL FURTHER OCCURRANCE	nursing assessment and d; physician notification ndicated and activation dicated. Ited on an antibiotic with diffication with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with appropriate expired with a second expired	F	520	the facility staff will notification. When they are not facility then they will be contacted through the or service. Physician notification documented under the number of the medical results. 4. The physician is notified immediately in non-life threatening emergencies further guidance and after is activated in life threater emergencies. 5. An abbreviated Quality Assurance (QA) meeting conducted on 9/11/14 to address the identified comphysician notification, che condition (seizures, short breath, change in level of consciousness to include unresponsiveness) from the follow-up survey (Revisit) Measures that will be put into players that this deficiency does not recur: 1. To enhance current compoperations and under the direction of the administrative Facility Department Facility Department Facility Department Facility Department Facility Department Facility Department Facility Department Facility The In-service reviewed the QA Process Improvement and the Quite Table 1.	t in the an-call cation is ursing ecord. for er EMS ening exerts ange of the cot ecot ecot ecot ecot ecot ecot ecot	

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NAME OF PROVIDER OR SUPPLIER CARVER LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 321 EAST CARVER STREET DURHAM, NC 27704				
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F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			321 EAST CARVER STREET DURHAM, NC 27704 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT		rtant out lition e and o ent 0/14 it ined ees one ceived service. ployee be i to o work e in- g is ted. w ees ill on		

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7 a-f during the orientation process.

- 8. On 9/24/14, the Director of Quality Assurance and Compliance Officer from Apex HealthCare Solutions completed an in-service with the Administrator, Director of Nursing and other members of the Department Head Team regarding an effective QA committee and process, discussion included a meeting agenda and review of the Federal Regulatory Groups for Long Term Care facilities.
- 9. On 10/7/14 the QA Committee will be educated on the QA Program Plan. The QA Committee will follow the QA Program Plan going forward. QA tools discussed included but were not limited to the following: 1. QAPI Annual Reporting Schedule 2. Meeting Agenda 3. Quality Assurance Summary Report 4. QAPI Action Plan.
- 10. By 10/15/14 all nurses, nurse aides and certified nursing assistants will receive the directed in-service training for citations at 483.25 (a) and (h) (1-2) that involves transfer, ambulation and accidents or falls involving mobility problems by viewing the DVD

which has been approved by

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The Division of Health Services Regulation.

11. On 10/15/14 a directed inservice will be completed for nurses, nurse aides and certified nursing assistants on identifying change in condition that requires emergency medical treatment and services. This directed in-service will be completed by a North Carolina Board Certified Internal Medicine Physician, with no affiliation to Carver Living Center or Apex HealthCare Solutions.

Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

- 1. The Quality Assurance Committee will review facility progress monthly on the identified concerns.
- 2. Facility alleges compliance with this deficiency on 10/15/14.