STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 000	INITIAL COMMENTS The survey team entered the facility on 5/14/25 to conduct a complaint investigation. The survey team was onsite 5/14/25 through 5/15/25. Additional information was obtained offsite from 5/19/25 through 5/20/25. An onsite validation of the allegation of Immediate Jeopardy removal was conducted on 5/22/25. Therefore, the exit date was changed to 5/22/25. Event ID# NEPG11. The following intakes were investigated NC00230084, NC00239951 and NC00230100. 7 of the 7 complaint allegations did not result in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (J) Immediate Jeopardy began on 5/15/25 and was removed on 5/16/25.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		6/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/05/2025

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and	F 580	F580 SS=D Notify of Changes	

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F 580	Continued From page 2 Responsible Party (RP) interviews, the facility failed to notify the Responsible Party (RP) of Resident #1's change in condition after a new diagnosis of peripheral vascular disease (PVD) with the lack of pedal pulses in both feet and failed to notify the Medical Director, who was the resident's attending physician, of a new diagnosis of PVD, and failed to notify the Medical Director of the identification of a new wound and transfer to the hospital for 1 of 8 residents (Resident #1). The findings included: 1a. Resident #1 was admitted on 7/9/2019 with a diagnosis of diabetes mellitus, dementia, contractures of the right knee, left wrist, left hip, and left knee, malnutrition, and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body. Review of the quarterly Minimum Data Set (MDS) dated 4/11/2025 revealed that Resident #1 was severely cognitively impaired. Review of a Podiatry Consult note dated 1/30/2025 revealed Resident #1 was given a new diagnosis of PVD. The consultation note also discussed lack of pedal pulses in both feet. A review of Resident #1's medical revealed no documentation that Resident #1's RP was informed of Resident #1's new diagnosis of PVD or that the resident had absent pedal pulses. An interview was conducted with the Podiatrist on 5/20/2025 at 10:45AM. The Podiatrist stated that Resident #1 presented physically with signs and symptoms of PVD based on a clinical	F 580	(Injury/Decline/Room, etc.) 1. Corrective action for those residents found to have been affected by the deficient practice The facility failed to notify the Responsible Party (RP) and the attending physician of Resident #1's new diagnosis of peripheral vascular disease (PVD) and failed to notify the physician of a new wound and hospital transfer. Resident #1 was discharged from the facility on 4/30/2025, and no longer resides at the facility. The Medical Director and nursing staff involved in the care of Resident #1 have been re-educated on the importance of communicating all significant changes, including new diagnoses from consultant reports, to both the attending physician and the responsible party in accordance with facility policy. Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice A facility-wide audit of all residents discharged or transferred to the hospital during the previous 30 days was completed on 06/04/2025 by the Director of Nursing, Assistant Director of Nursing, and Unit Managers. The audit reviewed records for evidence that notification of significant changes in condition, new diagnoses, or new wounds were communicated to the responsible party and physician in accordance with facility policy and regulatory requirements. No other issues were identified during this	

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F 580	Continued From page 3	F 580		

assessment. The Podiatrist further stated during the visit on 1/30/2025 Resident #1 had no pedal pulses in both feet, capillary fill time (the time it takes for blood to flow to a specific area after pressure is released) was +3 seconds (normal time is less than 2 seconds) bilaterally, staining of the skin, thickening of nails, and all signs and symptoms of PVD. The Podiatrist had not informed Resident #1's RP of the new diagnosis of PVD because she expected the facility staff to inform the RP.

Review of medical record revealed an order on 4/30/2025 at 1:00PM to transfer Resident #1 to the emergency room for "wound on right smallest toe one time".

A review of Resident #1's hospital records dated 4/30/2025 revealed Resident #1 received a diagnosis of high fever, severe sepsis likely to infection of right fifth toe possible osteomyelitis.

An interview conducted with Resident #1's RP over the telephone on 5/14/2025 at 11:09AM. The RP stated that on 4/30/25 the facility called her and informed her that Resident #1 needed to go to the hospital because of a fever and a wound. The RP requested more information from the facility and stated she did not receive any more information. The RP stated that she attended a care conference with the facility over the telephone on 4/8/2025 and there was no mention of any wounds or diagnosis of PVD with Resident #1. The RP stated she was not informed of Resident #1 having a lack of pedal pulses. The RP indicated she came to the facility after Resident #1 was admitted to the hospital and spoke with the Director of Nursing (DON) to inquire about Resident #1's wound development.

review.
Compliance Date: 06/05/2025

3. Measures or systemic changes to ensure the deficient practice will not recur
All licensed nursing staff, including agency staff, received focused education on the requirements for timely notification of responsible parties and physicians when there is a new diagnosis, significant change in condition, new wound, or hospital transfer. This education was provided by the Director of Nursing and Nursing Leadership team, including the Assistant Director of Nursing and Unit Managers, between 06/04/2025 and 06/05/2025. Any staff who missed the initial in-service was required to complete the education prior to their next scheduled shift. Education on notification requirements was also included in orientation for all newly hired nursing staff.
Compliance Date: 06/05/2025

4. How the facility will monitor its performance to ensure solutions are sustained
To ensure ongoing compliance, the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will audit 10 resident charts weekly for four weeks, specifically reviewing documentation of notification to responsible parties and physicians in cases of new diagnoses, new wounds, significant changes in condition, or transfers to the hospital. After the initial four-week period, audits will transition to monthly for three months. Results of these audits will be reviewed

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F 580	Continued From page 4 An additional interview was conducted with Resident #1's RP over the telephone on 5/19/2025 at 3:24PM. The RP was unaware of the diagnosis of PVD and stated she was never informed of any vascular disease or any new diagnosis. The RP stated that the only time she was informed Resident #1 had any skin issues was the day Resident #1 was sent to the emergency room on 4/30/2025. An interview occurred with the Social Service Coordinator on 5/20/2025 at 10:06AM. The Social Service Coordinator stated there was a care conference on 4/8/2025 via telephone with the RP to discuss Resident #1's individual care plan. The Social Service Coordinator discussed not being aware of Resident #1's new diagnosis of PVD or that Resident #1 had a lack of pedal pulses. She stated she discussed with the RP Resident #1's care plan which she stated did not include any goals or interventions related to Resident #1's diagnosis of PVD or lack of pedal pulses. The Social Service Coordinator stated when a consultation was completed, the provider would give her any new orders that she would then deliver to the Unit Manager/nurse. She explained if the provider of the consultation did not have any orders, the provider would upload their consultation directly into the facility's electronic computer system. The Social Service Coordinator did not view the Podiatry note from 1/30/2025 for Resident #1. An interview was conducted with the Director of Nursing (DON) on 5/15/2025 at 6:27AM. The DON stated that she had a conversation with the RP at the facility regarding Resident #1's wound after he was admitted into the hospital. The DON	F 580	during monthly Quality Assurance and Performance Improvement (QAPI) meetings to assess the effectiveness of the corrective actions and to determine if further interventions are needed. The monitoring process will be documented and tracked, and monitoring will be included in QAPI. Compliance Date: 06/05/2025 and ongoing	

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F 580	Continued From page 5	F 580		

did not state to the RP that Resident #1 had a diagnosis of PVD. The DON discussed the RP should have been made aware of the new diagnosis by the Medical Director. The DON indicated consultations were available on their computer system to be reviewed by any staff member. She stated once the consultation documentation was available in the computer system, the Medical Director should have been informed and was not. The DON was not able to speak to who would or should review consultations and inform the Medical Director of any changes in a resident's diagnosis/change of condition.

b. Review of the medical record revealed no documentation the Medical Director was notified of Resident #1's new diagnosis of PVD or the lack of pedal pulses after his Podiatry consultation on 1/30/25.

An interview conducted with the Medical Director on 5/14/2025 at 1:23PM. The Medical Director stated she was not aware of the new wound on Resident #1's right foot or being transferred to the hospital on 4/30/25 until 5/14/2025. The Medical Director discussed not being informed of Resident #1's new diagnosis of PVD or the lack of pedal pulses. She also stated she was not aware Resident #1 had been seen by a Podiatrist in January 2025. The Medical Director stated she had not looked at the consultations that were in the facility's computer system.

An interview was conducted with the Director of the Nursing (DON) on 5/15/2025 at 6:27AM. The DON did not know if notification was made to the Medical Director of Resident #1's change in condition and new diagnosis of PVD and lack of

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F 580	Continued From page 6 pedal pulses from the 1/30/2025 Podiatry Consult. The DON indicated she did not notify the Medical Director of Resident #1's transfer to the hospital on 4/30/2025 until 5/14/2025.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		6/5/25

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F 583	Continued From page 7 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect residents' healthcare information by leaving confidential medication information unattended, visible, and accessible to others on the computer screen for 2 of 5 (upper and lower medication carts on the 100-hall) medication carts observed. Findings included: A continuous observation of the upper 100-hall medication cart occurred on 5/15/25 at 5:15am. The medication cart was in the hallway unattended, and it was observed to have the computer screen showing resident information such as resident name, resident diagnosis, medications, date of birth, and room number. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants walked past the cart. Nurse #5 was interviewed on 5/15/25 at 5:18am. Nurse #5 confirmed she was the nurse responsible for the upper 100-hall medication cart. The nurse immediately stated she knew what was wrong and said, "I should have put the privacy screen up on the computer". Nurse #5 explained she did not think about completing the task before leaving the cart to provide medication to a resident. A continuous observation of the lower 100-hall medication cart occurred on 5/15/25 at 5:20am. The observation revealed the computer screen showed resident information such as resident	F 583	F583 SS=D Personal Privacy/Confidentiality of Records 1. Corrective action for those residents found to have been affected by the deficient practice The medication cart computers were immediately secured by the licensed nurses responsible, and screens were logged out to prevent further unauthorized access. The nurses assigned to the upper and lower medication carts were counseled by the Director of Nursing on the importance of securing electronic records and maintaining resident confidentiality at all times. There is no evidence that any unauthorized access or disclosure of protected information occurred. Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice On June 4, 2025, a review of all medication carts and portable electronic devices used for resident care was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to ensure no other instances of unattended, visible confidential information were present. No additional issues were identified during this review. Compliance Date: 06/05/2025	

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F 583	Continued From page 8 name, resident diagnosis, medications, date of birth, and room number. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants had walked past the cart. Nurse #1 was interviewed on 5/15/25 at 5:23am. Nurse #1 confirmed she was the nurse responsible for the lower 100-hall medication cart. The nurse explained she was an agency nurse but was aware she should have placed the computer screen on the privacy screen prior to walking away. Nurse #1 stated, "I just didn't think about it". The Director of Nursing (DON) was interviewed on 5/15/25 at 6:38am. The DON explained that the Quality Assurance Nurse was responsible for the education but stated she was not sure what education was provided. She further explained that each shift had a shift supervisor who was responsible for ensuring staff were following facility rules. The DON stated she did not know why Nurse #5 and Nurse #1 left their computer screens open to resident information. During an interview with the Quality Assurance Nurse on 5/15/25 at 8:33am, the Quality Assurance Nurse explained that the Unit Managers were responsible for education staff on their specific job assignments. The Administrator was interviewed on 5/15/25 at 1:43pm. The Administrator discussed staff needing to take responsibility for their actions and in keeping the residents safe. He stated he could not say why Nurse #5 and Nurse #1 had left their computer screens showing resident information.	F 583	3. Measures or systemic changes to ensure the deficient practice will not recur All licensed nursing staff, including agency staff across all shifts, received education on the facility's expectations for protecting the privacy and confidentiality of resident information. This education included instruction on logging off or locking screens whenever medication carts or workstations are unattended, as well as the importance of never leaving confidential information visible to unauthorized individuals. The education was provided in person on June 4, 2025, by the Director of Nursing and Nursing Leadership team, including the Assistant Director of Nursing and Unit Managers. Any staff who missed the initial in-service was required to complete the education prior to their next scheduled shift. This topic was also included in orientation for all newly hired nursing staff. Compliance Date: 06/05/2025 4. How the facility will monitor its performance to ensure solutions are sustained The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will conduct rounds on all units across all shifts three times per week for four weeks, specifically checking for unattended medication carts and ensuring that computer screens are not left unattended with confidential information visible. After the initial four-week period, these audits will be conducted monthly for three months. Results of these rounds will be reviewed during monthly Quality	

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F 583	Continued From page 9	F 583	Assurance and Performance Improvement (QAPI) meetings to assess compliance and determine if additional interventions are needed. Documentation of monitoring will be maintained, and ongoing monitoring will be included in QAPI. Compliance Date: 06/05/2025 and ongoing	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		6/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 10	F 585		

to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by

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F 585	Continued From page 11 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to implement their grievance policy and procedures when Resident #2 reported his catheters and wheelchair charger were missing for 1 of 3 residents reviewed for grievances (Resident #2). Findings included: The facility's policy titled "Grievances/Complaints, Filing" which was not dated read in part Residents and their representatives have the	F 585	F585 SS=D Grievances 1. Corrective action for those residents found to have been affected by the deficient practice Upon identification that Resident #2s grievance regarding missing personal property had not been addressed in accordance with facility policy, the grievance process was immediately initiated. The concern was investigated,	

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	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

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F 585	Continued From page 12 right to file grievances, either orally or in writing, to the facility staff. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint Resident #2 was admitted to the facility on 4/9/25 with diagnoses of heart failure and paraplegia (paralysis that can affect all or part of the trunk and legs). The admission Minimum Data Set (MDS) dated 4/11/25 revealed Resident #2 was cognitively intact and was documented as having an electric wheelchair. Resident #2 was interviewed on 5/14/25 at 10:18am. The resident discussed he had a box of self-Cath catheters in his room and stated while he was sleeping "someone came in and took them". Resident #2 also discussed "someone" taking his electric wheelchair charger. The resident explained that this happened about 2 weeks ago and that he informed the Director of Nursing (DON) and the Administrator "immediately". Resident #2 voiced being upset because he had not heard of any resolution and he still did not have his self-Cath catheters or his electric wheelchair charger. During an interview with Unit Manager #1 on 5/15/25 at 1:00pm, the Unit Manager discussed Resident #2 had informed her about 2 weeks ago that his self-Cath catheters were missing along	F 585	documented, and resolved. Resident #2 received a written response summarizing the findings and actions taken. The staff involved in the initial handling of Resident #2s grievance received targeted in-service training on the grievance process at the time of identification. Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice The Administrator and Social Services staff reviewed all grievance logs, complaint records, and resident council minutes from the past 60 days to ensure that no other grievances were missed or unresolved. No other additional concerns were identified. Compliance Date: 06/05/2025 3. Measures or systemic changes to ensure the deficient practice will not recur The Administrator completed targeted in-service training to Social Services staff, Nursing Leadership (including Unit Managers, Assistant Director of Nursing, Quality Assurance Nurse), and all other department heads on June 4, 2025. Training included the steps for promptly investigating, documenting, and providing written resolutions for all grievances, as well as ensuring residents are informed of their rights and the grievance process. Compliance Date: 06/05/2025	

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F 585	Continued From page 13	F 585		

with his charger for his electric wheelchair. She explained that she immediately told the Social Worker and the Administrator but had not filled out a grievance form. The Unit Manager stated she had attempted to find the items herself but was unable to locate them.

The Social Worker (SW) was interviewed on 5/15/25 at 1:21pm. The SW confirmed Resident #2 was on her case load. She stated about 2 weeks ago she was informed by Unit Manager #1 that Resident #2 self-Cath catheters were missing but was also told that nursing was ordering him new ones, so she did not fill out grievance or follow up. The SW discussed not learning about the charger for Resident #2 electric wheelchair until today. She stated she could not recall Unit Manager #1 telling her 2 weeks ago and that she learned about the charger from the resident today. The SW stated she did fill out a grievance today for the catheters and the charger. She explained that anyone can file a grievance.

During an interview with the Administrator on 5/15/25 at 1:35pm, the Administrator stated he had not heard about Resident #2 missing items 2 weeks ago. He explained Resident #2 had told him about his missing self-Cath catheter and his charger for his wheelchair on 5/9/25. The Administrator stated he did not think every concern needed to have a grievance filed but confirmed that concerns/grievances needed to be resolved within 5 days. He stated he ordered Resident #2's self-Cath catheter's today, and that staff are continuing to look for the charger. He stated the resolution for the charger was not yet determined. The Administrator stated he would have expected a grievance to be filed once the

4. How the facility will monitor its performance to ensure solutions are sustained

The Administrator and Social Services staff will audit all new grievance submissions and resolutions weekly for four weeks, and then monthly for three months, to verify compliance with policy and timeliness of written responses. Findings will be reported at monthly QAPI meetings, and further retraining or corrective action will be implemented as indicated. Compliance Date: 06/05/2025 and ongoing

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F 585	Continued From page 14 items had not been found and stated that 2 weeks was too long to go without a resolution.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a	F 641	F641 SS=D Accuracy of Assessments 1. Corrective action for those residents	6/5/25

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F 641	Continued From page 15 resident's active diagnosis of peripheral vascular disease (PVD) for 1 of 8 residents whose Minimum Data Set was reviewed (Resident #1). The findings included: Resident #1 was admitted on 7/9/2019 with a diagnosis of diabetes mellitus, dementia, contractures of the right knee, left wrist, left hip, and left knee, protein malnutrition, and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body. Review of a Podiatry Consult note dated 1/30/2025 revealed Resident #1 was given a new diagnosis of PVD. An interview was conducted with the Podiatrist on 5/20/2025 at 10:45AM. The Podiatrist stated that Resident #1 presented physically with signs and symptoms of PVD based on a clinical assessment. The Podiatrist further stated during the visit on 1/30/2025 Resident #1 had no pedal pulses in both feet, capillary fill time (the time it takes for blood to flow to a specific area after pressure is released) was +3 seconds (normal time is less than 2 seconds) bilaterally, staining of the skin, thickening of nails, and all signs and symptoms of PVD. The quarterly Minimum Date Set (MDS) assessment dated 4/11/2025 indicated Resident #1 was severely cognitively impaired. The MDS did not indicate Resident #1 was diagnosed with PVD. An interview was conducted with the Social	F 641	found to have been affected by the deficient practice Resident #1 was identified as having an inaccurate Minimum Data Set (MDS) assessment regarding the coding of peripheral vascular disease (PVD). Resident #1 was discharged from the facility on 4/30/2025 and is not currently admitted to the facility. The MDS nursing staff involved with Resident #1s assessment were re-educated on accurate coding and documentation at the time of identification of the inaccuracy. Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice The MDS Coordinator and MDS nurses audited the last three months of podiatry consults for all current residents. For each resident with a new diagnosis of peripheral vascular disease (PVD) identified during this period, the most recent MDS assessment was reviewed to ensure the diagnosis was correctly coded. Any issues identified during this review were addressed, and resident records were updated accordingly. Compliance Date: 06/05/2025 3. Measures or systemic changes to ensure the deficient practice will not recur All MDS nursing staff received focused education on the requirements for accurate coding of active diagnoses and	

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F 641	Continued From page 16 Service Coordinator on 5/20/2025 at 10:06AM. The interview indicated that the Social Service Coordinator received the written consultations and if there was an order from the consultation, the order was given to the Unit Manager. The Social Service Coordinator discussed that once she received the consultation, she would give the consultation to medical records who would then upload the consultation into the electronic health care system. The Social Service Director was not able to confirm if any new diagnosis for Resident #1 from his podiatry visit was added to the MDS as an active diagnosis but stated the MDS nurses have access to the consultations. A telephone interview with MDS Nurse #2 and MDS Nurse #1 on 5/20/2025 at 11:26AM revealed they were both unaware of the diagnosis of PVD for Resident #1. The MDS Nurses reviewed the quarterly MDS dated 4/11/2025 and the diagnosis of PVD was not marked for Resident #1. During the interview with MDS Nurse #2 and MDS Nurse #1, they stated that for a diagnosis to be coded on the MDS it must be active in the last 60 days and there needed to be treatment for the diagnosis. MDS Nurse #2 stated that she spoke with her Regional MDS consultant and who felt that not coding the 4/11/2025 quarterly MDS with a diagnosis of PVD was accurate. MDS Nurse #2 and MDS Nurse #1 explained they reviewed the residents' medical records, including consultations for any new information.	F 641	thorough documentation in the MDS on June 4, 2025. This education was provided in person by the Director of Nursing. Any staff who missed the initial in-service will be required to complete the education prior to their next scheduled shift. Education on MDS accuracy and documentation will also be included in orientation for newly hired MDS staff. Compliance Date: 06/05/2025 4. How the facility will monitor its performance to ensure solutions are sustained The Director of Nursing and/or MDS Coordinator will audit five completed MDS assessments weekly for four weeks to verify the accuracy of diagnosis coding and documentation. After the initial four-week period, audits will be conducted monthly for three months. Results of these audits will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to monitor compliance and determine if additional interventions are needed. Audit findings and ongoing monitoring will be documented and maintained as part of the QAPI process. Compliance Date: 06/05/2025 and ongoing	
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		6/5/25

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F 711	Continued From page 17 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical Director interviews, the facility failed to ensure that during provider visits the provider reviewed the total plan of care for 1 of 8 residents (Resident #1) newly diagnosed peripheral vascular disease (PVD). Resident #1 was examined by the Medical Director and the Medical Director failed to recognize Resident #1 did not have active pedal pulses in both feet. An interview with the Medical Director revealed that there was no examination of the feet during her visit on 3/25/2025. Resident #1 needed an assessment of his feet based on the new diagnosis of PVD to recognize the need for further treatment, review the plan of care, and consultations. This deficient practice occurred for 1 of 3 residents reviewed for Physician visits (Resident #1). The findings included: Resident #1 was admitted on 7/9/2019 with a diagnosis of diabetes mellitus, dementia,	F 711	F711 SS=D Physician Visits: Review Care/Notes/Order 1. Corrective action for those residents found to have been affected by the deficient practice Resident #1 was identified as not having a complete review of the total plan of care during the physician visit, specifically related to the new diagnosis of peripheral vascular disease (PVD). Resident #1 is no longer a patient in the facility. The Medical Director was notified of the findings and received immediate re-education on May 15, 2025, from the Administrator and/or Director of Nursing regarding the regulatory requirement to review the total program of care and conduct relevant physical assessments during physician visits. Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected	

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F 711	Continued From page 18 contractures of the right knee, left wrist, left hip, and left knee, malnutrition, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left side of the body and PVD. A review of the quarterly Minimum Data Set (MDS) assessment dated 4/11/2025, revealed Resident #1 was severely cognitively impaired and unable to make decisions for himself. Record review of the Podiatrist consult note from 1/30/2025 were obtained for review. The Podiatrist notes stated Resident #1 was newly diagnosed with, "indicated peripheral vascular disease. Patient was not a referral to a vascular surgeon as they do not meet any one of the following guidelines for referral: 1. Critical limb ischemia, 2. Claudication that affects quality of life, 3. Symptoms are unresponsive to conservative management. They do however, meet the qualifications for routine or at risk footcare." Further record review of the Podiatrist clinical note indicated that Resident #1 had "Pedal pulses absent in both feet, Capillary refill +3 seconds, and pigmentary changes on both feet." An interview was conducted on 5/19/2025 at 4:02PM with Nurse #3. Nurse #3 indicated that when a consultation was received from a provider the licensed nursing staff would give information to the medical director if needed. Nurse #3 further revealed that they would contact the Medical Director by phone, place information in the provider's book, and/or copy of the order left for the provider. Nurse #3 was asked if the Medical Director was notified of the new diagnosis of PVD	F 711	by the same deficient practice The Director of Nursing and Nurse Managers audited the most recent podiatry consult for all current residents on June 4, 2025. For each resident with a new diagnosis or significant change in condition related to podiatric care, the corresponding physician visit documentation was reviewed to ensure the total plan of care, relevant assessments, and orders were addressed. No issues were identified during this audit. Compliance Date: 06/05/2025 3. Measures or systemic changes to ensure the deficient practice will not recur All physicians and advanced practice providers received focused education on June 4, 2025, from the Administrator and/or Director of Nursing on the regulatory requirements for physician visits, including the necessity to review the total program of care, complete relevant physical assessments based on resident diagnoses or changes in condition, and to document progress notes and orders appropriately. The education included specific instruction on assessing new diagnoses such as PVD and ensuring complete documentation of all findings. The Medical Director reinforced these expectations with all contracted providers. Any provider who missed the initial training was required to complete it prior to conducting further resident visits. Compliance Date: 06/05/2025 4. How the facility will monitor its	

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F 711	Continued From page 19 for Resident #1 and she could not recall. Resident #1 was last evaluated by the Medical Director on 3/25/2025. Review of the progress notes revealed general information about medications and diagnosis but there was no follow up plan or discussion of Resident #1's recent diagnosis of PVD. An interview was conducted with the Medical Director on 5/14/2025 at 1:23PM. The Medical Director confirmed she last saw Resident #1 on 3/25/2025. The Medical Director stated she reviewed Resident #1's medications and progress notes. She discussed examining Resident #1 at that time but had not looked at his feet or felt for pedal pulses (pulses that are on the top of the foot). The Medical Director stated she was unaware the Podiatrist had seen Resident #1 in January 2025, so she had not reviewed the consultation. She discussed not being aware, from the Podiatrist consultation, that Resident #1 did not have any pedal pulses in his feet or that the Podiatrist had diagnosed Resident #1 with a new diagnosis of PVD. She further discussed not being made aware by the facility staff that Resident #1 had the Podiatrist consultation or the findings.	F 711	performance to ensure solutions are sustained The Director of Nursing and/or Nurse Managers will audit five physician visits weekly for four weeks, specifically reviewing documentation to ensure that the total program of care, relevant assessments, and orders are addressed and documented as required. After the initial four-week period, audits will transition to monthly for three months. Audit results will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to monitor compliance and determine if additional interventions are necessary. All findings and corrective actions will be documented and maintained as part of the facility's QAPI process. Compliance Date: 06/05/2025	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/5/25

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F 761	Continued From page 20 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to secure residents' medications in a locked medication cart for 2 of 5 (upper and lower carts on hall 100) medication carts reviewed. Findings included: a. A continuous observation of the upper 100-hall medication cart occurred on 5/15/25 at 5:15am. The medication cart was in the hallway unattended and was observed to have a resident's insulin pen sitting on top of the cart, the cart was unlocked, and the bottom drawer of the medication cart was open. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants walked past the cart. Nurse #5 was interviewed on 5/15/25 at 5:18am. Nurse #5 confirmed she was the nurse	F 761	F761 SS=D Label/Store Drugs and Biologicals 1. Corrective action for those residents found to have been affected by the deficient practice The responsible licensed nurses immediately secured the medication carts and ensured all medications were properly locked in accordance with facility policy and regulatory requirements. No evidence was found that unauthorized individuals had accessed the medications, and no resident harm occurred as a result of this deficiency. The nurses responsible for the medication carts received immediate re-education from the Director of Nursing regarding the requirement to keep all medications secured at all times.	

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F 761	Continued From page 21 responsible for the upper 100-hall medication cart. The nurse immediately stated she knew what was wrong and said, "I should have put the medication away, closed the drawer and locked my cart". Nurse #5 explained she did not think about completing the tasks before leaving the cart to provide medication to a resident. b. A continuous observation of the lower 100-hall medication cart occurred on 5/15/25 at 5:20am. The observation revealed the cart was unlocked. The medication cart was observed for 3 minutes and during that time 2 Nursing Assistants had walked past the cart. Nurse #1 was interviewed on 5/15/25 at 5:23am. Nurse #1 confirmed she was the nurse responsible for the lower 100-hall medication cart. The nurse explained she was an agency nurse but was aware she should have locked her medication cart prior to walking away. Nurse #1 stated, "I just didn't think about it". The Director of Nursing (DON) was interviewed on 5/15/25 at 6:38am. The DON explained that the Quality Assurance Nurse was responsible for the education but stated she was not sure what education was provided. She further explained that each shift had a shift supervisor who was responsible for ensuring staff were following facility rules. The DON stated she did not know why Nurse #5 and Nurse #1 left their medication carts unlocked. During an interview with the Quality Assurance Nurse on 5/15/25 at 8:33am, the Quality Assurance Nurse explained that the Unit Managers were responsible for educating staff on their specific job assignments. The Quality	F 761	Compliance Date: 06/05/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice A facility-wide audit of all medication carts and medication storage areas was conducted on June 4, 2025, across all shifts by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to ensure that all drugs and biologicals were secured in locked compartments. No further concerns were identified during this audit. Compliance Date: 06/05/2025 3. Measures or systemic changes to ensure the deficient practice will not recur The Director of Nursing provided focused education on June 4, 2025, to all licensed nursing staff, including agency staff, on the proper labeling and storage of drugs and biologicals. The education emphasized the requirement to keep all medications locked when not in use and to allow access only to authorized personnel. Any staff who missed the initial in-service was required to complete the education prior to their next scheduled shift. This topic was included in the orientation program for all newly hired nursing staff. Compliance Date: 06/05/2025 4. How the facility will monitor its performance to ensure solutions are sustained The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

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F 761	Continued From page 22 Assurance Nurse stated she did not know what education was provided to the employee by the Unit Managers. The Administrator was interviewed on 5/15/25 at 1:43pm. The Administrator discussed staff needing to take responsibility for their actions and in keeping the residents safe. He stated he could not say why Nurse #5 and Nurse #1 had left their medication carts unlocked.	F 761	will audit a minimum of five medication carts and storage areas each week for four weeks, covering all shifts. Audits will specifically check that all drugs and biologicals are secured in locked compartments, that only authorized personnel have access, and that all storage areas comply with state and federal requirements. After the initial four-week period, audits will be conducted monthly, with a minimum of five audits per month for three months. Results will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings to monitor compliance and determine if additional-interventions are necessary. All findings and corrective actions will be documented and maintained as part of the QAPI process. Compliance Date: 06/05/2025 and ongoing	
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/5/25

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	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

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F 880	Continued From page 23 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 24 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with staff and the Medical Director, the facility staff failed to utilize a resident's assigned blood glucose meter (glucometer) and instead used a loose, unassigned, and unlabeled glucometer located in the medication cart to check Resident #8's blood glucose (sugar) level. In addition, the staff member did not disinfect the glucometer before or after obtaining Resident #8's blood glucose level and would have had no way to know if another staff member had previously disinfected the loose, unassigned, and unlabeled glucometer. This occurred while there were 11 residents identified with a known bloodborne pathogen in the facility with 4 of the 11 residents requiring blood glucose levels. Loose, unlabeled glucometers can be contaminated with blood and must be disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer of the glucometer has the high likelihood to expose residents to the spread of bloodborne infections. Care must also be taken by personnel handling	F 880	F880 SS=J Infection Prevention & Control 1. Corrective action for those residents found to have been affected by the deficient practice On 5/15/2025, it was identified that an agency nurse used an unlabeled, unassigned glucometer on Resident #8 without disinfecting it before or after use, in violation of infection control protocols. Resident #8's responsible party and physician were immediately notified. Baseline bloodborne pathogen testing (HIV, Hepatitis B, Hepatitis C) was ordered and completed for Resident #8 per health department recommendations. The unassigned glucometer was immediately removed and discarded. The agency nurse involved was terminated. A facility-wide review confirmed all other residents requiring blood glucose monitoring had individually assigned, labeled glucometers. No additional residents were identified as affected, and	

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F 880	Continued From page 25 and storing glucometers to protect the glucometers against cross-contamination via contact with other meters or equipment. The deficient practice occurred for 1 of 3 residents observed to have his blood glucose (sugar) level checked (Resident #8). Immediate jeopardy began on 5/15/25 when Nurse #1 was observed to perform blood glucose testing for Resident #8 using a loose, unlabeled, unassigned glucometer without disinfecting the glucometer. Immediate jeopardy was removed on 5/16/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) for the facility to complete agency and employee staff training with monitoring to ensure appropriate interventions are put into place. Findings included: The facility's policy and procedure titled "Obtaining a Fingerstick Glucose Level" that did not contain a date read under the title "Steps in the Procedure" always ensure the blood glucose meter intended for reuse is clean and disinfected between resident use following the manufacturers instructions and the current infection control standards of practice. The manufacturer instructions for cleaning and disinfecting the (Brand Name) glucometer used at the facility were summarized in a Technical Brief (Revised 9/24). The Technical Brief read in part, "To minimize the risk of transmitting bloodborne pathogens, the cleaning and disinfecting	F 880	no adverse effects were reported for Resident #8. Compliance Date: 05/15/2025 2. How the facility will identify other residents with the potential to be affected by the same deficient practice An immediate audit of all residents receiving blood glucose monitoring was completed on May 15, 2025, by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers to ensure every resident had an individually assigned and properly labeled glucometer stored correctly. No other issues were identified. The infection control breach and potential exposure were reported to the local health department, and all recommended follow-up actions were implemented. All licensed nursing staff received retraining on May 16, 2025, by the Director of Nursing, Assistant Director of Nursing, and Unit Manager on the updated infection control procedures for blood glucose monitoring, assignment and storage of glucometers, and disinfection protocols. Compliance Date: 05/16/2025 3. Measures or systemic changes to ensure the deficient practice will not recur As a further systemic measure, the Director of Nursing (DON) and nursing leadership team provided education on June 4, 2025, based on recommendations from the infection control consultant. This education covered the comprehensive “Glucometer Procedure: Use, Cleaning &	

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F 880	Continued From page 26 procedures should be performed as recommended in the instructions below. The (Brand Name) meter may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens ...Clean and disinfect the meter following step-by-step instructions in the Quality Assurance (QA) / Quality Control (QC) Reference Manual." Cleaning and Disinfecting Procedures specified in the glucometer's QA/QC Reference Manual (Revised 10/24) included, in part: --Cleaning: Step 1 (of 7): Wear appropriate protective gear such as disposable gloves. Step 3 (of 7): Wipe the surface of the meter to clean blood and other body fluids ... Step 4 (of 7): If blood is visible on the meter, it should be cleaned prior to each disinfection step. --Disinfecting: Step 5 (of 7): Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. Step 6 (of 7): Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. The manufacturer's Technical Brief for the	F 880	Infection Control" policy, with a focus on device assignment, storage, and the use of a two-wipe disinfection method. The Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, and Unit Managers ensured only labeled, resident-specific glucometers are available on medication carts. The facility's policy was revised to clarify storage and labeling, and only the Director of Nursing will distribute replacement meters (no stock meters on units). For after-hours access, a nurse will notify the nursing manager on duty, who has an access code to the Director of Nursing's office to retrieve a new glucometer. Visual cue cards outlining glucometer cleaning steps were placed on all carts and in medication rooms, with brightly colored reminders affixed to cart surfaces. Unit Managers were made responsible to verify that all visual cues are in place before carts are returned to service. Agency nurses were no longer assigned to the floor until they had received training on the facility's glucometer procedure and had demonstrated competency in cleaning and storage. The staffing agency agreed to include this education for all new agency staff assigned to the facility. The facility will verify this training by obtaining a signed competency checklist from the agency for each new agency nurse prior to their first shift. A check-off of glucometer cleaning was implemented to be completed with each ordered blood sugar finger stick in the medication administration record (MAR). All new and current staff received return	

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F 880	Continued From page 27 glucometer listed the disinfectant wipes used at the facility as one of the EPA-registered wipes recommended to clean and disinfect the (Brand Name) glucometer. The instructions on the label of the disinfectant wipes read in part: "To clean and disinfect and deodorize hard, nonporous surfaces: Wipe surface to be disinfected. Use enough wipes to treat surface to remain visibly wet to the contact time listed. Let Dry." Special instructions for cleaning and decontamination against human immunodeficiency virus (HIV), hepatitis B and hepatitis C indicated, "Allow surfaces to remain wet for one minute, let air dry. For all other organisms, see directions for contact time." The Director of Nursing provided education for Nurse #1. The education was dated 2/4/25 with a return competency completed on 2/5/25. The education titled glucometer testing included how to store, disinfect before and after each use, and using the resident's designated glucometer. A continuous observation from 5:10am to 5:25am occurred on 5/15/25 in the 100 Hall hallway. The observation revealed Nurse #1 walking away from her medication cart (lower 100-hall medication cart) with a glucometer in her hand. Nurse #1 entered Resident #8's room, stood on the left side of the bed, lifted the cover exposing Resident #8's left hand, the nurse wiped one finger on Resident #8's hand with an alcohol pad, used a lancet device to prick Resident #8's finger, and then held the glucometer (with the test strip already in the machine) to the resident's finger obtaining his blood sugar. Nurse #1 was observed to walk out of the resident's room, place the used lancet into the secure needle container, throw her gloves into the trash receptacle, and	F 880	demonstration and direct-observation competency checks, and cleaning and storage competency was repeated for all new and agency staff prior to floor assignment. Compliance with these measures will be tracked and trended by the Director of Nursing and Quality Assurance Nurse and reviewed in Clinical Operations huddle and QAPI. Compliance Date: 06/05/2025 4. How the facility will monitor its performance to ensure solutions are sustained The Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, and/or Unit Managers will directly observe at least five blood glucose monitoring procedures per week for four weeks, across all shifts, to ensure proper assignment, labeling, and two-wipe disinfection of glucometers, as well as completion of the cleaning check-off in the MAR. Weekly cart audits will be conducted for four weeks to confirm all medication carts are free of unassigned or unlabeled meters and that all visual cue cards and reminders are present and procedures are being followed. After the initial four-week period, these audits will transition to monthly for three months, with at least five audits per month. All new and agency staff education and competency will be reviewed weekly in the Clinical Operations huddle and monthly in QAPI meetings, with trends and any corrective actions tracked by the Director of Nursing and Quality Assurance Nurse.	

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F 880	Continued From page 28 place the glucometer on top of the medication cart. The glucometer was observed to not have any label. At 5:15am, Nurse #1 was observed to place the glucometer in the top drawer of the medication cart without disinfecting it. Nurse #1 was observed for another 10 minutes with no other residents receiving blood sugar checks. Nurse #1 an agency nurse who worked the 7:00pm to 7:00am shift was interviewed on 5/15/25 at 5:25am. Nurse #1 discussed every resident having their own glucometers that were kept in the top drawer of the medication cart in a plastic container. Nurse #1 opened the top drawer of her medication cart and there was an individual plastic container labeled with each resident's name. There was also a loose unlabeled glucometer in one of the compartments on the left side of the drawer. Nurse #1 confirmed she had just obtained a blood sugar from Resident #8 with the loose unlabeled glucometer that was on the left side of the drawer. Nurse #1 showed the surveyor that Resident #8 had his own glucometer. She stated she had obtained the loose unlabeled glucometer from the bottom drawer of the medication cart. Nurse #1 explained she did not know why she had not used Resident #8's dedicated glucometer "I don't know, I just saw this one and used it." She discussed not knowing if the glucometer was disinfected before she used it and stated she had not disinfected it herself prior to obtaining Resident #8's blood sugar. Nurse #1 also confirmed she had placed the glucometer back into the top drawer of the medication cart in the left compartment without disinfecting it. The nurse explained she did not disinfect it because she was going to take it to the nursing station to throw it away. She explained she was going to throw it away because Resident	F 880	Ongoing supervisory rounds and random direct observation will be conducted across all shifts (day, evening, night, and weekends) to monitor compliance, and any variance will result in immediate re-education. Compliance Date: 06/05/2025 and ongoing	

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F 880	Continued From page 29	F 880		

#8 already had his own. Nurse #1 stated she had received education on the proper care/disinfecting glucometers before and after use but said "I'm agency. I don't work here all the time". She confirmed there was no visual cues on the medication cart to help her remember how/when to disinfect the glucometers and stated, "I have never seen anything on the cart."

Upon request, the facility provided a Diagnosis Report for its current residents (dated 5/15/25 at 9:42am). The Diagnosis Report indicated 11 residents were identified as having at least one bloodborne pathogen, which included hepatitis C and HIV. Upon review of the 11 residents, it was discovered that 4 of the residents required blood sugar monitoring with one (1) of the 4 residing on hall-100.

The Quality Assurance Nurse/Infection Preventionist was interviewed on 5/15/25 at 8:33am. The Nurse explained that she was responsible for having staff sign an acknowledgement form on the computer that staff would adhere to all the facility's rules, expectations, and procedures. She stated the Unit Managers were responsible for any specific training for the nurses/staff. The Quality Assurance Nurse/Infection Preventionist confirmed Nurse #1 had signed the acknowledgement form.

Observation of the lower 100-hall medication cart with Nurse #6 occurred on 5/15/25 at 9:43am. A loose unlabeled glucometer was observed in the bottom drawer of the medication cart in a small white basket. The observation also revealed there were EPA wipes present in the bottom drawer, but there was no visual cue cards present on the

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F 880	Continued From page 30	F 880		

medication cart for disinfecting the glucometers.

Nurse #6 was interviewed on 5/15/25 at 9:44am. Nurse #6 explained he worked the 7:00am to 7:00pm shift. The nurse confirmed there was a non-labeled loose glucometer in the bottom drawer of his medication cart. He explained the glucometer was for emergencies only and used only on non-diabetics. Nurse #6 discussed not knowing if the glucometer had been disinfected but stated, "it should be cleaned before using". He was unable to answer how long it took to clean the glucometer. He stated he had never had to use the loose unlabeled glucometer. Nurse #6 stated he had received education on storing/disinfecting glucometers and stated he thought it was in February 2025. Nurse #6 confirmed there was no visual cues on the medication cart to help him remember how/when to disinfect a glucometer and said he did not remember ever seeing a visual cue on the medication cart.

A telephone interview occurred with the Medical Director on 5/15/25 at 10:21am. The Medical Director discussed being aware of staff not disinfecting glucometers a few months ago but nothing recently. She stated the concern of not disinfecting glucometers before and after use was the spread of diseases. The Medical Director explained she expected staff to follow infection control practices when using glucometers.

The Director of Nursing (DON) was interviewed on 5/15/25 at 11:31am. The DON explained during the facility's last annual survey in February 2025 there had been an issue with staff not disinfecting shared glucometers before and after use between residents. She stated when that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 31	F 880		

occurred the facility began monitoring/auditing glucometer use to ensure staff were disinfecting as required, placed visual cue cards on the medication carts to help staff remember the steps in disinfecting the glucometers, and provided education to all the staff including agency staff. The DON also stated the facility purchased plastic cases and assigned each resident their own glucometer. The DON discussed the facility was continuing to do monitoring and audits of the medication carts for visual cue cards and ensuring each resident had their own glucometer. She stated this was being done by the Unit Managers and/or the Quality Assurance Nurse. She explained that no medication cart should have a loose unlabeled glucometer and was unaware there had been one on the lower 100-hall medication cart. The DON also stated she was not aware the visual cue cards were no longer present on the medication carts. She stated all staff including agency staff had been educated on glucometer use back in March 2025 and could not speak to why Nurse #1 had used a loose glucometer and not disinfected it. The DON stated Nurse #1 should have used Resident #8's designated glucometer and thrown away the loose unlabeled glucometer. The DON explained the loose unlabeled glucometer could be thrown away because if a staff member needed a new one, there were new ones located in the medication room.

During an interview with the Administrator on 5/15/25 at 2:00pm, the Administrator explained during the facility's last annual survey in February 2025 there had been an issue with staff not disinfecting shared glucometers before and after use between residents. He explained right after the February survey, the facility purchased plastic

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CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32	F 880		

containers and more glucometers so each resident could have their own designated glucometer, the facility began monitoring/auditing, and education was provided. The Administrator discussed the on-going monitoring and audits related to glucometer use. He also discussed the education that was completed and included agency staff. The Administrator stated "this was an unforeseeable" action and could not comment on what he thought caused Nurse #1 to not disinfect a glucometer.

The facility's Administrator was informed of the immediate jeopardy (IJ) on 5/15/25 at 2:30pm.

The facility provided the following plan for IJ removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
On May 15, 2025, it was observed that a facility staff member (an agency nurse) used an unlabeled glucometer (blood glucose meter) on Resident #8 without disinfecting the glucometer before or after use. The Director of Nursing (DON) promptly called and left a voicemail with the Responsible Party (RP) for Resident #8 regarding this incident.

Upon interview, the nurse stated she did not use that particular unlabeled glucometer for any other residents. The glucometer used was not a "shared" facility glucometer designated for multiple residents; rather, it was an unlabeled glucometer discovered in the medication cart. The nurse acknowledged her awareness that Resident #8 had an individually assigned, labeled, and properly stored glucometer present in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

medication cart. She indicated she used the unlabeled glucometer because she was nervous about being observed by the surveyor. This agency nurse had received training on February 5, 2025, as part of a previous Directed Plan of Correction (DPOC). She stated she failed to disinfect the glucometer involved in the May 15, 2025, incident due to being nervous while under observation by the surveyor. The nurse's failure to use the individually assigned glucometer for Resident #8 and her failure to disinfect the unassigned glucometer before and after use are significant deviations from established infection control procedures.

The facility's system mandates individually assigned glucometers for each resident requiring blood glucose monitoring. These glucometers are labeled with the resident's name, and each resident's glucometer is stored in an individual plastic container on the medication cart. The system failed in this instance because the unlabeled glucometer should not have been present in the medication cart, making it available for potential use, and the trained staff member failed to adhere to established procedures regarding use of resident-specific glucometer and proper disinfection.

A review of resident records who were receiving blood glucose monitoring through the use of glucometers was conducted by the Minimum Data Set (MDS) Nurse on the morning of May 15, 2025. The review identified there were at least four residents currently residing in the facility, and having their blood glucose monitored with a glucometer, who had been diagnosed with one or more bloodborne pathogens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34	F 880		

Failure to clean and disinfect shared or improperly maintained medical equipment, such as glucometers, according to manufacturer's instructions and with a disinfectant registered with the national environmental protection agency (EPA), created a significant risk of cross-contamination and exposure to bloodborne pathogens. Shared or improperly cleaned blood glucose meters can become contaminated with blood and bodily fluids. This practice potentially exposes any resident undergoing blood glucose monitoring with a shared, improperly disinfected device to the spread of bloodborne pathogens.

Resident #8, and any other resident who the facility might have determined (though none were identified) to have had their blood glucose tested using an unassigned and improperly disinfected glucometer, are considered likely to suffer a serious adverse outcome (e.g., transmission of bloodborne pathogens) as a result of this noncompliance. An immediate audit was initiated on May 15, 2025, by the Director of Nursing (DON) to identify all residents requiring blood glucose monitoring and to ensure each had an individually assigned and properly labeled glucometer. This audit confirmed all residents requiring blood glucose monitoring had an individually assigned and properly labeled glucometer, and no other issues were identified.

Immediate Actions Taken for Affected and At-Risk Residents (Completed: May 15, 2025):

A series of immediate actions were completed on May 15, 2025, for affected and at-risk residents. Firstly, the medical provider for Resident #8 was notified of the potential exposure on May 15, 2025, by the DON. Secondly, the one unlabeled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35	F 880		

glucometer identified was immediately removed from the medication cart and discarded on May 15, 2025, by the DON, ensuring no further use was possible. Thirdly, an immediate inventory check was completed on May 15, 2025, by the DON and nursing leadership (Assistant Director of Nursing (ADON), Quality Assurance (QA) Nurse, Unit Managers), which confirmed that sufficient individually assigned, and resident-labeled, glucometers, and appropriate EPA-registered disinfectant wipes were available for all residents requiring blood glucose monitoring.

Reporting (Completed: May 15, 2025):

This infection control breach and the potential for exposure to bloodborne pathogens were reported to the local health department on May 15, 2025, by the Director of Nursing (DON). The health department recommendations included testing for Human Immunodeficiency Virus (HIV), Hepatitis B, and Hepatitis C for any potentially exposed residents.

Action Taken on Health Department Recommendations (Completed: May 15, 2025):

In response to health department recommendations, several actions were completed on May 15, 2025. Orders for baseline testing for HIV, Hepatitis B, and Hepatitis C were obtained from the medical provider for Resident #8. Subsequently, specimens for these ordered tests for Resident #8 were ordered on May 15, 2025, and collected on May 16, 2025, as per facility policy and state regulations. Any follow-up on results and further medical intervention for Resident #8 will be managed by their attending

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 880	Continued From page 36	F 880		

physician and documented in their medical record.

The facility acknowledges this is a repeat Immediate Jeopardy (IJ) citation. A previous Directed Plan of Correction (DPOC) had been implemented. This DPOC included comprehensive training for all nursing staff, including the involved agency nurse on February 5, 2025, covering infection control practices for glucometer use. This training emphasized principles from established guidelines (e.g., statewide infection control and epidemiology guidelines (SPICE)), such as the use of single-use, auto-disabling disposable lancets; proper hand hygiene; individual assignment of glucometers; and correct disinfection of devices using EPA-registered wipes with appropriate contact time (noting alcohol pads are for skin preparation only and unsuitable for device disinfection).

A thorough root cause analysis was conducted by the Administrator, Director of Nursing (DON), Regional Director of Operations, and Regional Nurse Consultant following the May 15, 2025, incident. The recurrence of the deficient practice was determined to be due to a combination of factors. Firstly, a System Failure in Glucometer Control occurred, as an unauthorized, unlabeled glucometer was present on a medication cart, indicating a weakness in previous inventory control processes. Secondly, Individual Staff Performance under Stress was a factor, wherein the individual agency staff member, despite prior training and knowledge of correct procedure (and the availability of the resident's assigned glucometer), failed to adhere to established and previously trained procedures when under the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

perceived pressure of surveyor observation. Thirdly, there was a lapse in Environmental Reinforcement, as visual aids related to glucometer procedures were not replaced by pharmacy staff after a medication cart upgrade, potentially weakening environmental reinforcement of correct procedures (though the nurse involved did not state this as a factor for her specific actions).

The employment of the agency nurse involved in the incident was terminated by the Director of Nursing (DON) on May 15, 2025. No other staff members have been identified as committing the same deficient practice.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The following systemic changes were implemented to immediately alter the deficient practice, prevent recurrence, and ensure ongoing compliance, thereby removing the immediate jeopardy. All actions listed below were completed by the end of day on May 15, 2025, unless otherwise specified.

System for Glucometer Control, Assignment, and Policy
To strengthen the system for glucometer control, assignment, and policy, several actions were completed by May 15, 2025.

Firstly, the facility's "Glucometer Procedure: Use, Cleaning, and Infection Control" was reviewed and updated. This procedure now reflects all current corrective actions, emphasizing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880		

critical importance of using only individually assigned, labeled glucometers and adherence to new surveillance. Following this, all licensed nursing personnel acknowledged receipt and understanding of this updated policy and its implications for daily practice. This was presented by the DON and nursing leadership (ADON, QA Nurse, Unit Managers).

Secondly, an initial system-wide glucometer audit was performed. A comprehensive audit was conducted by the DON and nursing leadership (ADON, QA Nurse, Unit Managers), ensuring every resident requiring blood glucose monitoring had an individually assigned, correctly labeled glucometer, stored in its designated clean, individual, hard container within the medication cart. As noted, this audit found no deficiencies. All unauthorized/unlabeled glucometers (the single one identified) were removed from circulation and discarded by the DON and nursing leadership.

Thirdly, a strict protocol for the introduction of new or replacement glucometers became effective May 15, 2025. The Director of Nursing (DON), or Nursing Leadership (ADON, QA Nurse, Unit Manager) in the DON's absence, is responsible for obtaining new glucometers for the facility. The Administrator notified and trained the DON on this new process on May 15, 2025. All new glucometers will be delivered directly to DON's office. The glucometers will then be labeled for a specific resident and distributed by the DON or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, before being placed into service on any medication cart. New glucometers not yet in use (unassigned) will be stored exclusively in the DON's office. No unassigned or unlabeled "stock" glucometers will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

be permitted to be stored on medication carts or in general nursing units outside of the DON office's control. For new admissions requiring a glucometer after hours or on weekends, the assigned nurse will notify the Unit Manager or other member of the nursing leadership team (ADON, QA Nurse), who will obtain the glucometer from the DON's office. In an emergency after hours, if a current resident suddenly requires a glucometer, the DON's office has an access code (communicated to nursing leadership: ADON, QA Nurse, Unit Managers, and Administrator); the nurse would notify the nursing manager on duty, who will obtain the glucometer from the DON office. Unused glucometers for discharged residents will be removed from the medication cart by the Unit Manager within 24 hours during routine audits and discarded. On May 15, 2025, the Administrator in-serviced the Central Supply Clerk regarding the new protocol, specifically that all glucometers were to be delivered to the DON office upon receipt at the facility. The DON and the nursing leadership team (ADON, QA Nurse, Unit Managers) were also included in this in-service and communication regarding the new glucometer control protocol.

System for Maintaining Visual Aids and Equipment Management

Effective May 15, 2025, laminated visual reminders outlining critical steps from the "Glucometer Procedure: Use, Cleaning, and Infection Control" policy, including disinfection steps, were reviewed and confirmed to be accurately placed on all medication carts and in medication rooms by the DON and nursing leadership.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

Furthermore, the facility's equipment management protocol has been updated. Following any medication cart modification, replacement, or significant repair that may impact visual aids, the Director of Nursing (DON) or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, is responsible for ensuring all necessary signage and visual aids, including the 'Glucometer Procedure: Use, Cleaning, and Infection Control' reminder cards, are promptly verified as present and correctly reinstalled before the medication cart is returned to service. The Administrator trained the Director of Nursing on this updated process. This ensures direct oversight by nursing leadership for this critical component.

Education and Competency Validation

All actions regarding education and competency validation were completed on May 15, 2025. Medication aides do not perform blood sugar checks and therefore are not included in this specific glucometer competency training. Immediate In-service Training was conducted for all licensed nursing staff (including agency nurses) on May 15, 2025. This training was conducted by the Director of Nursing (DON) and Administrative Nurses (DON, ADON, Unit Managers). The training covered the facility's comprehensive "Glucometer Procedure: Use, Cleaning, and Infection Control" policy, which includes the new protocol detailed in this plan of correction, covering several key areas. Emphasis was placed on the critical importance of adhering to infection control principles. The facility's policy on blood glucose monitoring was reviewed, stressing the use of individually assigned glucometers for each resident, stored in an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41	F 880		

individually labeled, hard storage container, and the strict prohibition of using unlabeled or shared glucometers. The process for gathering equipment and supplies was detailed, ensuring gloves, glucometer, alcohol pads, gauze pads, single-use, auto-disabling, disposable lancet, blood glucose testing strips, approved disinfecting wipes, and paper towels/tissues are available. Hand hygiene procedures were reinforced: performing hand hygiene before entering the resident's room, before handling supplies, after removing gloves, and after cleaning is complete. The resident-interaction portion of the training on May 15, 2025, conducted by the Director of Nursing (DON) and Administrative Nurses (ADON, Unit Managers) for all licensed nursing staff (including agency nurses), covered protocols for explaining the blood glucose monitoring procedure to the residents and ensuring their privacy was maintained throughout the process. The procedure for obtaining the capillary blood sample according to facility policy and manufacturer guidelines, including donning gloves, was reviewed. The critical steps for cleaning and disinfection of the glucometer were explicitly detailed: retrieving two approved disinfecting wipes (noting alcohol pads are for skin preparation only and not suitable for device disinfection, per SPICE guidelines and manufacturer instructions for EPA-registered disinfectant wipes); using the first wipe to clean the glucometer, removing any visible blood, dirt, or contaminants; using the second wipe to disinfect, ensuring the surface remains wet for at least 3 minutes (or per the disinfectant's contact time instructions); and allowing the glucometer to air dry completely.

Regarding storage and labeling, the training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

reiterated the prohibition of using unlabeled or extra glucometers found in medication carts. As part of the comprehensive "Glucometer Procedure: Use, Cleaning, and Infection Control" in-service training on May 15, 2025, conducted by the Director of Nursing (DON) and Administrative Nurses (ADON, Unit Managers) for all licensed nursing staff (including agency nurses), staff were explicitly educated on this prohibition. The training included the updated procedure to follow if a resident does not have a labeled glucometer: nursing staff are to immediately notify nursing leadership (DON, ADON, QA Nurse, Unit Manager) to retrieve a new, properly labeled glucometer and approved storage container from DON's office before any use. Instructions were provided for placing glucometers on a clean, dry paper towel or tissue if set on a bedside table or medication cart, and proper storage and handling of all associated supplies were reviewed. Finally, the risks associated with noncompliance, including the potential for transmission of bloodborne pathogens, were thoroughly discussed. All staff were required to sign an acknowledgement form confirming receipt and understanding of this training.

Competency Validation was completed for all licensed nursing staff (including agency nurses) through direct observational competency validation for blood glucose monitoring on May 15, 2025. This validation, conducted by the DON or other qualified nursing leadership (ADON, Unit Managers), ensured adherence to all steps outlined in the "Glucometer Procedure: Use, Cleaning, and Infection Control" training. This included correct identification and use of the resident's individually assigned glucometer and labeled hard storage container; correct procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43	F 880		

for cleaning and disinfecting the glucometer (two-wipe method, 3-minute contact time, air dry); proper hand hygiene at all required steps; and correct disposal of used lancets, test strips, and wipes.

Ongoing Training requirements were established on May 15, 2025. This comprehensive education and competency validation will be incorporated into the orientation program for all new nursing hires and agency staff prior to them performing any resident care assignments independently. Annual competency refreshers will also be conducted. This training will be conducted by the DON or Nursing Leadership (ADON, QA Nurse, Unit Manager) in her absence, or the Staff Development Coordinator.

A Tracking System was implemented. As of May 15, 2025, the DON, ADON, and scheduler were assigned responsibility for maintaining records of all completed training, signed acknowledgement forms, and competency validations. They are responsible for ensuring all nursing staff have completed the required training and demonstrated competency before they are assigned to resident care duties involving blood glucose monitoring.

Ongoing Supervisory Support and Procedural Adherence
Commencing May 15, 2025, and on an ongoing basis, the facility is committed to a comprehensive plan of direct supervisory support and surveillance of licensed nurses, including agency nurses, to ensure continued adherence to the correct blood glucose monitoring procedures. This will involve active engagement with all nursing staff performing this procedure, across all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44	F 880		

shifts (day, evening, night, and weekends). These supportive surveillance activities will be conducted by Nursing Leadership (DON, ADON, Unit Managers, Regional Nurse Consultant), ensuring a visible leadership presence and resource availability.

This initiative focuses on creating "supervisory moments" through "on-the-spot" observation and evaluation of staff performance during actual blood glucose monitoring tasks. This direct observation is prioritized over retrospective record audits for immediate procedural verification, ensuring that correct procedures, as outlined in the facility's "Glucometer Procedure: Use, Cleaning, and Infection Control" policy and recent training, are consistently followed. This includes, but is not limited to, use of the correct resident-specific glucometer, proper hand hygiene, correct cleaning and disinfection of the glucometer (two-wipe method, appropriate contact time, air dry), and correct disposal of materials.

If any questions arise or deviations from the established procedure are observed, the observing supervisor will provide immediate, supportive "on-the-spot" re-education, guidance, and correction. These interactions are intended as coaching opportunities and will be documented and reviewed by the DON and QA Nurse to identify any trends or needs for further focused training or system adjustments. To ensure consistent support for nursing staff beyond typical Monday-Friday, administrative hours, designated shift supervisors and on-call nursing leadership will be specifically responsible for conducting these supervisory surveillance activities and providing this on-the-spot support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

and procedural clarification during evening, night, and weekend shifts. This multi-faceted approach ensures that all staff, regardless of their shift, receive ongoing support, mentorship, and validation of correct procedures, thereby reinforcing the training and systemic changes implemented.

Responsible Individual for Ensuring Immediate Correction:

The Director of Nursing (DON) was responsible for overseeing the implementation and completion of these immediate corrective actions and the establishment of ongoing surveillance systems.

Immediate Jeopardy Removal Date: May 16, 2025. (This date signifies that all immediate actions necessary to remove the identified jeopardy were completed and verified, and ongoing systemic changes were implemented.)

The facility's credible allegation of immediate jeopardy removal was validated on 5/22/25. The validation was evidenced by nurse observations and/or interviews conducted on each hallway regarding the required infection control practices for the disinfection of glucometers. Record reviews of training, and audits were reviewed.

All the nursing staff who were interviewed reported they had received the required in-service training prior to beginning their shift. They were able to verbally demonstrate knowledge of the glucometer infection control policy and procedure, nurse on all shifts were interviewed.

The education provided stressed the importance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46	F 880		

of using individually assigned glucometers for each resident requiring blood glucose monitoring and storing these glucometers in an individual, re-sealable plastic box with the resident's name. A list of all residents who were ordered blood glucose checks were reconciled with individual labeled boxed glucometers. Disinfection wipes were observed in all medication carts. Medication carts had visual instructions in bright pink secured to the top of the medication cart.

The in-service training also included a review of the manufacturer's instructions for the facility's glucometer and disinfectant wipes related to glucometer disinfection, as well as completing a return demonstration of the proper procedures for effective glucometer disinfection. Nurses observed to conduct blood glucose checks and subsequent glucometer disinfection completed the task without difficulty. The nursing practices observed included the proper handling and storage of glucometers to protect the meters from potential cross-contamination via contact with other meters or surfaces.

A list of both agency and facility licensed nursing staff was reconciled with the acknowledgement of the training.
There were no concerns identified during either the interviews or observations or record review.

The immediate jeopardy removal date of 5/16/25 was validated.