STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	03/05/2020

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, the facility failed to provide showers as scheduled for 2 of 2 sampled residents reviewed for choices (Resident # 121 & #128). Findings included: 1. Resident #121 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed under preferences that it was very important for her to choose between a tub bath, shower, bed bath or sponge bath. The quarterly MDS assessment dated [DATE] revealed that Resident #121's cognition was intact, and she was totally dependent for bathing. The assessment further indicated that the resident had no behavior of rejection of care. Review of Resident #121's care plan that was last reviewed on 1/29/20 revealed that the resident required staff assistance to complete activities of daily living (ADL) tasks daily due to BKA. The goal was resident's ADL needs to be met daily. The approaches included to anticipate and to meet resident's needs and to provide bath with one- person assist. Review of the facility's shower schedule revealed that Resident #121 was scheduled to have a shower every Tuesday, Thursday and Saturday on PM shift. The monthly resident council minutes were reviewed. The January 23, 2020 minutes listed a concern about showers not provided consistently. The facility's response was to put a shower team in place to provide showers. During the resident council meeting on 3/4/20 at 2:30 PM, residents were still complaining that showers were not provided as scheduled including Resident #121. On 3/5/20 at 9:04 AM, Resident #121 was interviewed. She stated that concern with showers not provided as scheduled had been discussed in the resident council meeting. She reported that her shower schedule was every Tuesday, Thursday and Saturday in the afternoon shift, and she would prefer to have a shower 3 times a week. When she mentioned about shower to the staff, she would get a bed bath instead. On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She stated that the facility had set up a shower team a month ago, but the NAs assigned to do showers were part time employees and when they worked most of the time they were assigned to work on the floor. When asked for shower documentation for Resident #121 for the last 3 months, the Scheduler provided 1 shower documentation dated 2/6/20. On 3/5/20 at 4:30 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected residents to receive shower as scheduled. She reported that the shower team was put in place a month ago due to concerns from the resident council that showers were not provided as scheduled. The NAs assigned to the shower team were part time employees. She was aware that most of the time, they were assigned to work on the floor. 2. Resident #128 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed under preferences that it was somewhat important for him to choose between a tub bath, shower, bed bath or sponge bath. The quarterly MDS assessment dated [DATE] revealed that Resident #128's cognition was not assessed and he was totally dependent for bathing. The assessment further indicated that the resident had no behavior of rejection of care. A nurse's note dated 1/16/20 at 8:01 PM indicated that Resident #128 was alert and was able to make his needs known. Review of Resident #128's care plan that was last reviewed on 2/4/20 revealed that the resident had activity of daily living (ADL) self-care deficit related to [MEDICAL CONDITION]. The goal was for the resident to maintain his current level of function in his abilities to perform ADLs. The approaches included staff assistance with bathing/showering as necessary. Review of the facility's shower schedule revealed that Resident #128 was scheduled to have a shower every Tuesday, Thursday and Saturday on AM shift. The monthly resident council minutes were reviewed. The January 23, 2020 minutes listed a concern about showers not provided consistently. The facility's response was to put a shower team in place to provide showers. During the resident council meeting on 3/4/20 at 2:30 PM, residents were still complaining that showers were not provided as scheduled including Resident #128. On 3/5/20 at 9:25 AM, Resident #128 was interviewed. He stated that concern with showers not provided as scheduled had been discussed in the resident council meeting. He reported that his shower schedule was every Tuesday, Thursday and Saturday on day shift, and he would prefer to have a shower 3 times a week. Resident #128 revealed that he was not offered shower as scheduled. On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She stated that the facility had set up a shower team a month ago, but the NAs assigned to do showers were part time employees and when they worked most of the time they were assigned to work on the floor. When asked for shower documentation for the last 3 months for Resident #128, the Scheduler provided 2 shower documentation dated 1/28/20 and 2/12/20. On 3/5/20 at 4:30 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected residents to receive shower as scheduled. She reported that the shower team was put in place a month ago due to concerns from the resident council that showers were not provided as scheduled. The NAs assigned to the shower team were part time employees. She was aware that most of the time, they were assigned to work on the floor.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to replace a mattress that was ripped in the center and failed to provide a mattress that fit the bed size for 2 of 2 residents (Resident # 61 and Resident # 123) reviewed for a safe and clean homelike environment. Findings included: 1.Resident # 61 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed, Resident # 61 was cognitively impaired. Resident # 61 was coded as totally dependent on two-person assistance for activities of daily living. Resident was bowel and bladder incontinent. Observation of Resident # 61's bed on 3/03/20 at 10:04 AM, revealed the mattress was ripped and torn in the center. During an interview on 3/03/20 at 10:04 AM, Resident # 61's family member indicated that the resident's mattress was ripped and was not replaced by staff. Observation on 3/04/20 at 8:25 AM revealed Resident # 61 sitting in his Geri chair in the hallway. Observation of the Resident 61's bed in his room revealed the mattress was ripped in the center. Observation on 3/4/20 at 11:27 AM revealed the housekeeping staff were cleaning the resident's bed and mattress. The housekeeping staff #1 was interviewed. Housekeeping staff #1 indicated the bed and mattress were deep cleaned frequently. She indicated if the mattress was ripped, she would inform her manager and replace it. Stated she had just noticed the mattress was ripped. During an interview on 3/4/20 at 11:35 AM, the housekeeping manager stated the resident's beds and mattress were cleaned monthly and as needed. She was not aware the Resident 61's mattress was torn or ripped. She stated the nurse aides (NA) were responsible for making resident's beds and should notify housekeeping if any mattress was torn or needed to be replaced. She further stated if the housekeeping staff noticed any mattress torn or ripped during their deep cleaning, it should be replaced immediately. She confirmed that there were adequate mattresses in the storage to replace. During an interview on 3/4/20 at 11:45 AM, NA # 11 stated she usually made Resident # 61's bed

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) after breakfast. She indicated she had not noticed the mattress was ripped. NA # 11 stated she was unsure how to place a work order for bed mattress replacement. During an interview on 3/4/20 at 11:50 AM, Nurse # 9 stated she was the nurse supervisor for the hallway, where Resident #61 was resided. She stated any staff could place the bed mattress replacement work orders for the maintenance or housekeeping on the computer using the program TELS. She stated the work orders would go directly to the assigned department. Based on the type of work order placed, the priority of the work order was set. She further stated she could assist any staff in placing the work orders. Nurse # 9 confirmed she was unaware of the mattress being ripped and has not received any request for a bed mattress replacement. 2. Resident # 123 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed, Resident # 123 was cognitively intact. Resident # 61 was coded as independent for activities of daily living except for dressing and toilet use were resident needed one-person supervision. Resident was bowel and bladder incontinent. On 3/2/20 at 8:00 PM, during the observation and interview, Resident #123 was observed lying in bed, well dressed and groomed. The bed mattress was shorter than the bed length. The resident's legs did not reach the gap between mattress and foot board. The resident indicated that he was comfortable on his bed mattress and did not have any issue. During an interview on 3/4/20 at 11:40 AM, the maintenance director indicated the bed was too big for the resident and the mattress was small for the bed. He indicated the bed needed to be replaced with the size appropriate for the resident. The maintenance director stated the nursing staff were responsible to place a work order on the computer, so that the maintenance staff could fix the issue. He indicated he was not aware that the bed was not the correct size for the resident. During an interview on 3/4/20 at 11:45 AM, NA # 11 stated Resident # 123 was cognitively intact and was independent with activities of daily living. NA # 11 stated the resident usually made his own bed. NA # 11 confirmed that the bed linens were changed weekly and as needed by her. NA # 11 stated she had not noticed the mattress was small for the length of the bed. During an interview on 3/4/20 at 11:50 AM, Nurse # 9 stated she was the nurse supervisor for the hallway, where Resident #123 was resided. She stated any staff could place the bed mattress replacement work orders for the maintenance or housekeeping on the computer using the program TELS. She stated the work orders would go directly to the assigned department. Based on the type of work order placed, the priority of the work order was set. She further stated she could assist any staff in placing the work orders. Nurse # 9 confirmed she was unaware of the bed was too big for the resident. During an interview on 3/05/20 at 4:29 PM, the administrator stated the staff should notify the maintenance or housekeeping department about any issues related to residents' rooms. The administrator further stated that all staff had access to place a work order in the system.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to comprehensively assess the residents in the areas of cognition and mood for 3 of 35 sampled residents reviewed (Residents # 109, #126 & # 128). Findings included: 1. Resident # 109 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that sections C (cognition) and section D (mood) were not assessed. The nurse's note dated 1/21/20 at 3:36 AM indicated that Resident #109 was readmitted back to the facility and was alert and verbal. On 3/4/20 at 1:10 PM, Social Worker #1 was interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She indicated that she could not find any documentation as to why she did not complete sections C and D. She further reported that she normally writes a note as to why the interview was not completed but she did not for Resident #109. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D. 2. Resident #126 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] was reviewed and revealed that sections C (cognition) and section D (mood) were not assessed. A nurse's note dated 3/3/20 at 3:07 PM revealed that Resident #126 was alert and verbally responsive. On 3/4/20 at 1:10 PM, Social Worker #1 was interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She indicated that her documentation revealed that she went to Resident #126's room to assess the resident and she was informed that the resident was out of the facility and so she coded sections C and D as not assessed. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D. 3. Resident #128 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. A nurse's note dated 1/16/20 at 8:01 PM indicated that Resident #128 was alert and was able to make his needs known. On 3/5/20 at 10:20 AM, Social Worker #1 was interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She reported that the MDS Nurse had added Resident #128 on the list of MDS to be completed and she did not have the time to complete sections C and D, and so she coded the sections as not assessed. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to refer a resident with [DIAGNOSES REDACTED].#126). Findings included: Resident #126 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident #126 was admitted to the facility with PASARR level 1 screen dated 2015. The doctor's progress note on admitted d 1/28/20 revealed that Resident #126 was sent o the hospital on [DATE] for acute agitation secondary to a sensation he had bugs crawling on his skin. He was ruled out for acute infection and was admitted to the geri-psych unit with gabapantine (used to treat nerve pain) and [MEDICATION NAME] (an anti-psychotic drug). The note further stated that the resident was status [REDACTED]. He was stable and to continue [MEDICATION NAME] and to place referral to psych. Resident #126's admission care plan problem revealed that the resident was on [MEDICAL CONDITION] medications related to history of hallucinations (that bugs were crawling over his skin). The approaches included to administer the [MEDICAL CONDITION] medications as ordered. Resident #126's doctor's orders were reviewed. On 1/27/20 (admission), the resident had an order for [REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #126 was not referred to the state for a Level 11 PASARR screening. On 3/4/20 at 11:13 AM, Social Worker #1 was interviewed. She stated that she was responsible for submitting information to the state for PASARR screening. The SW verified that Resident #126 had a level 1 PASARR on admission and she was aware that the resident had [DIAGNOSES REDACTED]. She further indicated that she did not refer Resident #126 to the state for PASARR level 11 screening since the resident was stable and had no behaviors. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she was not familiar of the regulations regarding PASARR screening, but she expected the social worker to follow the regulations regarding referral of residents for PASARR level 11 screening. On 3/5/20 at 4:01 PM, the Administrator was interviewed. She stated that she expected the regulations regarding PASARR screening to be followed.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a care plan for nutrition for 2 of 5 sampled resident reviewed for nutrition (Residents #19 & #24). Findings included: 1. Resident #19 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].#19 had severe cognitive impairment and she needed extensive assistance with eating. On 12/4/19, Resident #19 had a doctor's order for mechanical soft diet with thin liquids and on 2/4/20, the diet

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) was changed to mechanical soft with nectar thick liquids. The care area assessment (CAA) dated 12/26/19 revealed that nutrition was triggered due to elevated body mass index (BMI). Her BMI was above normal at 28%. Her weight, BMI and other nutritional needs were monitored by the facility's dietician with assistance from the rest of the interdisciplinary team (IDT). Will proceed to care plan. Review of Resident #19's care plan revealed that there was no care plan developed for nutrition. Resident #19's weight on admission (12/4/19) was 159 pounds (lbs.) and was 150 lbs. on 2/4/20. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the Dietary Manager (DM) was responsible for developing the care plan for nutrition. She verified that she had checked Resident #19's care plan and there was no care plan developed for nutrition. The MDS Nurse further stated that Resident #19 should have a care plan developed for nutrition due to the presence of pressure ulcer, potential for weight loss and she was on therapeutic diet. On 3/4/20 at 4:33 PM, the Dietary Manager (DM) was interviewed. He stated that he was responsible for developing the care plan for nutrition. The DM reviewed the resident's care plan and verified that there was no care plan for nutrition and he stated that he did not know why it was missed. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected a care plan for nutrition developed for Resident #19. 2. Resident #24 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #24 had severe cognitive impairment and needed extensive assistance with eating. Review of the physician orders [REDACTED]. The care area assessment (CAA) dated 5/27/19 revealed that nutrition was triggered due to low BMI of 16.212. Will proceed to care plan. Review of Resident #24's care plan revealed that there was no care plan developed for nutrition. Resident #24's weight on 12/9/19 was 122 pounds (lbs.) and on 2/21/20 was 116 lbs. A 4.67% weight loss in 3 months. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the Dietary department was responsible for developing the care plan for nutrition. She verified that she had checked Resident #24's care plan and there was no care plan developed for nutrition. On 3/4/20 at 4:33 PM, the dietary staff was interviewed. He stated he was a certified dietary manager and both he and the dietitian were responsible for developing the resident's nutrition care plan. He reviewed Resident # 24's care plan and verified that there was no care plan for nutrition, and that the care plan was missed. During an interview on 3/5/20 at 3:28 PM, the dietitian stated the resident was triggered for nutrition care plan based on the CAA, which indicated a low BMI. The dietitian confirmed that the resident's nutrition care plan was missed. During an interview on 3/5/20 at 4:29 PM, the Administrator stated all care plans for residents should be completed on time, especially when CAA's were triggered for an area.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to provide range of motion (ROM) exercises and to apply the splints consistently as ordered for 2 of 2 sampled residents reviewed for range of motion (Residents # 109 & #25). Findings included: 1. Resident # 109 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had limitation in ROM on both upper and lower extremities and was not on restorative nursing program. Resident #109 was evaluated and treated by the Occupational therapist (OT) for management of right and left elbow/hand contractures on 1/22/20. On 1/28/20, OT had discontinued treating Resident #109 and had recommended ROM exercises and splint application to right and left elbow for 4-5 hours in order to prevent decline. The OT note dated 1/28/20 indicated that the staff were educated and demonstrated competency with bilateral upper extremity (BUE) splint wear schedule and proper application of splint and perform skin checks post splint application. Resident #109's care plan last reviewed on 1/24/20 revealed a problem resident has [MEDICAL CONDITION] affecting his bilateral upper and lower extremities. The goal was the resident will be able to function at the fullest potential possible as outlined by the treatment plan. The approaches included maintain good body alignment to prevent worsening of contractures and to use braces and splints as ordered. Resident #109 had a doctor's order dated 2/4/20 for staff to perform BUE ROM exercises 2 sets of 10 repetitions (reps) then do elbow extension splint to one upper extremity at a time with resident to wear splint for 4 - 6 hours per day 7 times a week and for the staff to perform skin checks upon splint removal. The Treatment Administration Records (TARs) for February and (NAME)2020 were reviewed. The TARs listed the order for the staff to perform the BUE ROM exercises and the splint application to be provided during the 7-3 shift. The February 2020 TAR revealed that the ROM exercises and the splint application were not provided for 14 days (2/5, 2/6, 2/7, 2/13, 2/17, 2/18, 2/19, 2/20, 2/21, 2/24, 2/25, 2/26, 2/27, and 2/28). The (NAME)2020 TAR revealed that the ROM exercises and the splint application were not provided on 3/2, 3/4 and 3/5. On 3/2/20 at 7:30 PM, Resident #109 was observed in bed. His upper extremities were observed to be contracted and there was no splint/brace noted in place. On 3/4/20 at 8:45 AM and on 3/5/20 at 8:30 AM, Resident #109 was again observed in bed. There was no splint noted on both UE. On 3/4/20 at 8:50 AM, Nurse Aide (NA) # 8, assigned to Resident #109, was interviewed. She stated that the therapy department was responsible for splint application. NA #8 added that she didn't know if Resident #109 had an order for [REDACTED].#109 on 1/22/20 and discharged the resident on 1/28/20 with the recommendation for ROM exercises and splint application. The Rehab Director stated that the facility used to have a restorative aide who provides the restorative nursing such as ROM exercise and splint application but since she started working at the facility in October 2019, the facility did not have a restorative aide so nursing was responsible for the ROM exercise and the splint application. On 3/4/20 at 11:55 AM, Nurse #6, assigned to Resident #109, was interviewed. She stated that she didn't know Resident #109 was supposed to have a splint. Nurse #6 indicated that the NAs were responsible for applying the splint if ordered. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that the order for the splint application was listed on the TARs and the nurses had access to the TARs. She expected the nurses to inform the NAs of residents with orders for splint application and she expected the NAs to apply the splint as ordered. 2. Resident #25 was admitted on [DATE]. Review of his Quarterly Minimum Data Set assessment, dated 12/17/19, indicated his intact cognition. Resident ' s [DIAGNOSES REDACTED]. Review of Resident 25 ' s plan of care, dated 12/17/19, revealed his limited physical mobility due to right hand contracture with appropriate goals and interventions, included splinting to right upper extremity. Review of the physician's order [REDACTED]. Record review revealed the occupational therapy discharge summary, dated 1/18/19, indicated the recommendation for Functional Maintenance Program, to apply splint on right hand every morning for six hours as tolerated to manage contracture development. The occupational therapy staff trained the nursing staff to apply splint. Record review of the care tracker for February 2020 revealed that Resident #25 received right hand splint applications six times, he refused it three times and did not receive the splint applications twenty times. Review of the Treatment Administration Records (TAR) for February 2020 revealed that Resident #25 received right hand splint applications seventeen times in February 2020. Other twelve days in February 2020 were left blank for splint applications. Three times in February 2020, the TAR indicated that Resident #25 received splint applications on the days he refused it, according to care tracker report. Record review of the nurses ' notes for February 2020 revealed no splint application documentation for Resident #25. On 3/2/20 at 7:55 PM, during the observation/interview, Resident #25 was in bed, well dressed and groomed. The resident did not have splint on his right hand at the time of observation. The resident indicated that he did not receive splint today. On 3/3/20 at 8:55 AM, during the observation/interview, Resident #25 was in his bed. He had right hand splint applied. The resident indicated that the staff applied the hand splint to his right hand not every day but often. He continued that he could tolerate it for 4-6 hours and the staff would take it off. On 3/3/20 at 9:45 AM, during an interview, Nurse #3 indicated that Resident #25 had right hand contracture and received splint to right hand. The nurse aides were responsible for splint application in the morning and splint removal in six hours. The nurses documented right splint application in the TAR. Nurse #3 stated when she worked with Resident #25, she always checked if the resident received his right-hand splint. On 3/4/20 at 2:10 PM, during an interview, Rehabilitation Director indicated that Resident #25 received occupational therapy for right hand contracture, including splinting, and was discharged to Functional Maintenance Program on 1/18/19. The therapy staff trained the floor nurse aides to perform range of motion in preparation to splint application, to apply the splint on his right hand for six hours daily and check

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) the skin before and after the procedure. On 3/4/20 at 2:30 PM, during an interview, Nurse Aide #1 indicated that she assigned to work with Resident #25 this shift and was not aware of his splint application requirements. Nurse Aide #1 explained that she did not check Kardex at the beginning of the shift and missed the splint application for Resident #25. On 3/4/20 at 2:50 PM, during an interview, Assistant Director of Nursing (ADON) indicated that the facility did not have restorative program. The therapy department discharged residents to the Functional Maintenance Program and trained the nurse aides to continue correct splint application regiment. The nurse aides could check the Kardex and clarify splint application with the nursed. The nurse aide documented the splint applications in the Kardex and reported to the nurse if the resident refused it. The nurses documented splint application in the TAR. ADON could not explain the discrepancies between TAR and care tracker report in February 2020 in regard to splint application. The staff did not report any issues with splint application for Resident #25. On 3/4/20 at 3:10 PM, during an interview, the Administrator expected the staff to follow the orders and plan of care for splint application, document it appropriately in the Kardex and TAR.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to provide therapeutic diet (thickened liquids) as ordered to 1 of 5 sampled residents reviewed for nutrition (Resident #19). Findings included: Resident #19 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED].#19 was not on therapeutic diet. Resident #19 had a doctor's order dated 12/4/19 for mechanical soft diet with thin liquids. On 1/18/20, there was a doctor's order to change Resident #19's diet to mechanical soft with nectar thick liquids. Resident #19 did not have a care plan developed for nutrition. On 3/4/20 at 8:45 AM, Resident #19 was observed up in wheelchair in her room. Nurse #6 was observed to offer the resident a cup of thin water to drink. After drinking from the cup, Resident #19 was observed to start coughing. On 3/4/20 at 8:50 AM, Nurse #6 was interviewed. She stated that she did not know that Resident #19 was on thickened liquids. Nurse #6 reviewed the electronic doctor's orders and verified that Resident #19 was supposed to have nectar thick liquids. On 3/4/20 at 8:51 AM, Resident #19 was observed up in wheelchair in her room. Her breakfast tray was observed in front of her. The tray contained a glass with thin orange juice. The dietary card revealed mechanical soft diet with nectar thick liquids. Nurse Aide (NA) # 9 was at the resident's bedside ready to feed the resident. On 3/4/20 at 8:52 AM, NA #9 was interviewed. The NA stated that she did not know that Resident #19 was on thickened liquids. NA #9 read the dietary card and stated that the resident was supposed to have nectar thick liquids. At 8:53 PM, Nurse #6 was observed to remove the thin orange juice from the resident's tray. On 3/4/20 at 12:00 Noon, the Dietary Manager (DM) was interviewed. He stated that nursing staff were responsible for providing liquids to the resident's trays prior to serving the trays to residents every meal. The dietary department had to provide the beverages (pitchers with juice, water, tea, coffee) on the cart and the nursing staff poured the beverage for each resident. The thickened liquids were kept in the cooler at each resident's rooms with order for thickened liquids and in the nourishment refrigerators on each hall. On 3/5/20 at 8:20 AM, the NAs (NAs #8 & #9) were observed passing the breakfast trays. The breakfast cart was observed to have pitchers of regular juices, water and coffee. The NAs were observed to pour beverage to the glass prior to serving the tray to each resident. There was no NA observed reading the dietary card prior to serving the beverages. On 3/5/20 at 8:30 AM, NAs #8 and #9 were interviewed. They both stated that they gave and received verbal reports between shift and they were not informed that Resident #19 was on nectar thick liquids. They also reported that they had not been reading the dietary cards for each resident. On 3/5/20 at 8:35 AM, Nurse # 6 was interviewed. She stated that nurses gave and received verbal report from shift to shift and she was not informed that Resident #19 was on nectar thick liquids. Nurse #6 reported that resident's diet was not listed on the MAR. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. She expected the nursing staff to read the dietary card prior to serving the trays to residents.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on record review and staff interview, the facility failed to post the nurse staffing information accurately in the area of Registered Nurse (RN) coverage for 13 of 60 days reviewed. Findings included: The daily nurse staffing information posting and the schedule were reviewed for January and February 2020. The posting and the schedule were reviewed with the Assistant Director of Nursing (ADON) and the following inaccuracies were noted: January 1 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 2 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 3 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 18 - 2 RN coverage on the posting, the schedule had 1 RN coverage - Nurse #8 January 19 - 1 RN coverage on the posting, the schedule had no RN coverage January 23 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 26 - 2 RN coverage on the posting - the schedule had 1 RN coverage - (ADON) January 30 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) February 1 - no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #9 February 2 - no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #9 February 8 - 2 RN coverage on the posting, the schedule had 1 RN coverage - Nurse #10 February 9 - 2 RN coverage on the posting, the schedule had no RN coverage February 15- no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #11 On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was responsible for completing the daily nurse staffing information sheet Monday through Friday and the weekend supervisor was responsible Saturday and Sunday. The ADON further reported that at times she did not have time to complete the staffing information sheet, so the scheduler did it for her. She indicated that she did not know why the posting and the schedule did not match. On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She revealed that the ADON was responsible for completing the staffing information however at times she was busy, so she did it for her. She acknowledged that the daily staffing information was not completed accurately for the RN coverage. She did not know that the ADON could be counted as RN coverage and she did not know some nurses were RNs and not License Practical Nurses (LPNs). On 3/5/20 at 4:16 PM, the ADON was interviewed. She stated that she expected the daily staffing information posting to be accurate.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews the facility failed to remove one expired [MEDICATION NAME] tablets container, one container of [MEDICATION NAME] Oral Suspension, one Breo Ellipta inhaler, stored in 2 of 5 medication administration carts (100 hall and 300 hall); failed to remove one expired multi-vial [MED] container, stored in 1 of 3 medication storage rooms; failed to provide the date of opening for one multi-vial [MED] container and two [MED] pen injectors, stored in 2 of 5 medication administration carts (100 and 300 halls); failed to discard several loose pills that were identified in the medication carts draws for 3 of 5 medication administration carts (100 and 300 halls). Findings Included: 1a. On 3/2/20 at 6:40 PM, observation of the Back Medication Administration Cart on 300 hall, with Nurse #1 revealed one half empty container of [MEDICATION NAME], 25 tablets, expired in 10/19/19 and one opened [MEDICATION NAME]pen-injector, 100 units/ml, 3 ml, half empty with no date of opening. Review of the manufacturer ' s literature/information recommended to discard the [MEDICATION NAME]pen-injector 28 days after opening. In the second draw of the medication cart there were noted two white round shape loose pills. On 3/2/20 at 6:45 PM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to check the expiration date on containers with tablets and remove expired medications from the medication administration cart. The nurse had not checked the expiration date on container of [MEDICATION NAME] tablets in her medication administration cart at the beginning of her shift. The nurse did not administer the expired [MEDICATION NAME] tablets this shift. b. On 3/2/20 at 7:30 PM, observation of the Front Medication Administration Cart on 300 hall, with Nurse #2 revealed: in the second draw of the medication cart there were noted one yellow, one pink, two blue round shape loose pills, one white loose capsule; in the third draw of the medication cart there were noted one white, one blue and one pink loose pills. On 3/2/20 at 7:35 PM, during an interview, Nurse #2 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #2 did not clean the cart before her shift. c. On 3/3/20 at 7:40 AM, observation of the medication administration cart on 100 hall, with Nurse #3 revealed the following expired medications were found: the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	03/05/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) half empty container of [MEDICATION NAME] Oral Suspension, 120 ml, expired on October 2019 and Breo Ellipta inhaler, 100/25 mcg, opened on 1/5/20. Review of the manufacturer ' s literature/information recommended to discard the Breo Ellipta inhaler 42 days after opening, which would have been on 2/16/20. There were two opened [MEDICATION NAME] pen-injectors, 100 units/ml, 3 ml each, with no date of opening. Review of the manufacturer ' s literature/information recommended to discard the [MEDICATION NAME] pen-injector 28 days after opening. In the second draw of the medication cart there was noted one white round shape loose pill. On 3/3/20 at 7:45 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to mark the date of opening on the [MED] pen and remove expired medications from the medication administration cart. The nurse confirmed that [MEDICATION NAME] pen-injectors were opened. The nurse had not checked the expiration date on [MEDICATION NAME] Oral Suspension or Breo Ellipta inhaler in her medication administration cart at the beginning of her shift. The nurse did not administer [MEDICATION NAME] pen-injections this shift. Nurse #3 could not identify one white pill in the draw but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. 2. On 3/2/20 at 7:10 PM, observation of the medication storage room on 300 hall with Nurse #1 revealed in refrigerator one multi vial container of [MEDICATION NAME] ([MED]), 100 units/ml, 10 ml, half-empty, opened on 1/24/20. Review of the manufacturer ' s literature/information recommended to discard the [MEDICATION NAME]multi vial container 28 days after opening, which would have been on 2/21/20. On 3/2/20 at 7:15 PM, during an interview, Nurse #1 indicated that all the nurses were responsible to check and remove the expired medications from the medication storage room. Nurse #1 did not check the refrigerator in the medication storage room during her shift. On 3/3/20 at 10:55 AM, during an interview, the Assistant Director of Nursing indicated that all the nurses were responsible to put date of opening on [MED] pens-injectors and multi vial containers, check all the medications in medication administration carts/medication storage rooms for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.
F 0947 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on record review and staff interview, the facility failed to provide a required dementia management training for 4 of 5 nurse aides (NA) reviewed for required annual training. (NA # 2, # 3, #4 and #5). The findings included: Review of the employee file revealed NA #3 was hired on 8/16/19 and NA #5 was hired on 12/11/2019. Review of the in-service training information of NA #3 and NA #5 indicated they did not receive any dementia in-service training since their hire dates. During an interview on 3/2/20 at 7:33 PM, NA #3 stated she had not received any dementia training since she was hired or during orientation. During a telephone Interview on 3/3/20 at 11:48 AM, NA #5 stated she had not received any dementia training since she was hired or during orientation. Review of the employee file revealed NA #2 hire date was 9/30/97. NA #4 hire date was 5/19/17. Review of the training information revealed NA #2 did not receive dementia training during the period of 9/30/2018 through 9/30/2019. NA #4 did not receive dementia training during the training period of 5/19/2018 through 5/19/2019. The employee file did not have an in-service or training record indicating when NA #3 or NA #4 had been last trained on dementia management. During an interview on 3/2/20 at 7:08 PM, NA #4 stated she had not received dementia training in the past year. NA #4 further stated she had some dementia training when hired. NA#4 indicated she could not remember the last time she was trained on dementia management. During an interview on 3/2/20 at 8:00 PM, NA #2 stated she had not received dementia training in the past year. NA #2 added she had not received any in-service or dementia training in more than a year. Interview was conducted on 3/4/20 at 3:30 PM, with the Assistant Director of Nursing (ADON) who was responsible for training, stated she was responsible for training and keeping up a file for each nurse aide. The ADON stated all employees were required to receive dementia training during orientation and annually. The ADON reviewed the annual in-service records and the employee files of the 4 identified nurse aides. The ADON confirmed the required dementia training for new hires and the annual dementia training had not been done. Interview was conducted on 3/4/20 at 4:01 PM, with the Administrator who stated all employees should be trained on dementia upon hire. The nurse aides should receive training during orientation and annually. The Administrator reviewed the most recent dementia training on 1/9/20 and confirmed the identified nurse aides as well as other staff had not been trained annually on dementia. Administrator stated the ADON was expected to follow-up and ensure all employees training records were updated and maintained.