STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345314	A. BUILDING _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVEN OF FOREST CITY, LLC	830 BETHANY CHURCH ROAD FOREST CITY, NC 28043

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/10/25 through 02/13/25. The facilty was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 2E7Z11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/10/25 through 02/13/25. Event ID# 2E7Z11. The following intakes were investigated: NC00222283, NC00219616, and NC00219488. 5 of the 5 complaint allegations did not result in deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a safe transfer for Resident #344. On 6/14/24 Nurse Aide (NA) #1 attempted to do a stand and pivot transfer with Resident #344 resulting in Resident #344 having to be lowered to the ground. Resident #344 was to be transferred by a mechanical lift. This deficient practice was identified for 1 of 1 resident reviewed for supervision to prevent accidents.	F 689	POC 2025 F689 Free of Accident Hazards/Supervision/Devices Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to the	3/1/25

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

Electronically Signed | 02/28/2025

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F 689	Continued From page 1 The findings included: Resident #344 was admitted to the facility on 5/6/24 and was discharged on 6/20/24. She was admitted to the facility with diagnoses of heart failure, lumbago with sciatica and alveolar hypoventilation (failure to breathe rapidly or deeply enough). The admission Minimum Data Set (MDS) dated 5/28/24 revealed that Resident #344 had moderate cognitive impairment and was dependent for chair to bed transfer. The Comprehensive Care Plan dated 6/4/24 had a focus area stating that Resident #344 had limited physical mobility related to her medical and physical condition. One of the interventions was that Resident #344 was dependent on staff to transfer from a bed or chair to chair requiring the use of a mechanical lift. A health status note written on 6/14/24 at 6:28 AM by Nurse #1 revealed that Nurse #1 heard NA #1 yell "help". Nurse #1 went to NA #1's location which was Resident #344's room. NA #1 was holding Resident #344 underneath her arms attempting to transfer her from the bed to wheelchair. Nurse #1 attempted to help and was unable to and Resident #344 was lowered to the ground without injury. NA #1 left to get the mechanical lift and sling to move Resident #344 from the floor to the wheelchair. Resident #344 denied any pain or discomfort. An accident report prepared by Nurse #1 indicated that the family representative and physician were notified on 6/14/24.	F 689	alleged deficient practice. Resident #344 was the only resident affected by the alleged deficient practice. Every resident requiring assistance with transfers is identified as potentially being affected by the alleged deficient practice. An audit was conducted on all falls in the last 30 days on 2/28/25 and no other residents were noted to be affected. A change in staffing and procedures was completed in August of 2024 with 100% completion by all nurses and CNAs employed at that time. And education completed via Relias (an education portal where staff can go on and read the education and attest understanding). CNAs were placed as partners in order to ensure that staff are readily available to assist with any transfers and/or care requiring 2 person assist. Education was completed on 2/28/25 as a result of the alleged allegation from state survey with all CNAs and Nurses via Relias (an education portal where staff can go on and read the education and attest understanding) concerning transfers and transfer status. 100 % completion by all CNAs and Nurses has been verified. All new hire CNAs and Nurses receive hands on education on lifts, transfers, and policies during their orientation period. 10 random audits of transfers will be completed weekly for 4 weeks beginning	

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F 689	Continued From page 2 On 2/12/25 at 9:50 AM a telephone interview was conducted with Nurse Aide (NA) #1. NA #1 She stated she had worked at the facility for 5 years and always worked on the rehabilitation unit for both the second and third shift. NA #1 stated that each residents' transfer status was posted on the inside of the residents' closet. NA #1 stated that if the transfer information was not there you would ask the charge nurse. If the resident was a new admission, then you would need to wait until therapy came to do a transfer evaluation. NA #1 could not remember what the transfer status was for Residents #344. NA #1 could recall the incident that happened on 6/14/24. NA #1 stated she was walking by Resident #344's room and noticed she was attempting to get out of her bed, so she went over to stop her from falling. NA #1 stated she was not trying to transfer Resident #344. NA #1 stated she yelled for assistance and Nurse #1 came and they ended up lowering Resident #344 to the floor. Afterwards Nurse #1 gave NA #1 training on proper transfer. NA #1 tried to explain to Nurse #1 that she was not transferring Resident #344. NA #1 stated that this was the first time that Resident #344 tried to transfer herself without assistance. On 2/11/25 at 7:25 PM a telephone interview was conducted with Nurse #1. She stated that early morning on 6/14/24 she heard NA #1 call out for help. Nurse #1 went to Resident #344's room and observed NA #1 trying to transfer Resident #344 from the bed to a wheelchair without using the proper equipment. NA #1 was attempting to do a stand and pivot transfer. Nurse #1 tried to help get Resident #344 into the wheelchair but was unable to do so. Both the NA #1 and Nurse #1 ended up having to lower Resident #344 to the	F 689	3/1/25, then monthly beginning 4/1/25 for 2 months. The audits will consist of staff randomly going into resident rooms when a transfer is taking place and ensure that all safety protocols are met. Audits will be completed by DON, ADON, or designee. Audits will be reviewed and monitored in the facility□s quality assurance meetings by the DON, ADON or appointed designee for the next 3 months beginning 3/1/25 to ensure compliance is maintained. Completion Date: 03/01/25	

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F 689	Continued From page 3	F 689		

floor. NA #1 left to go get the mechanical lift. They then used the lift and got Resident #344 into her wheelchair. Nurse #1 stated that Resident #344 did not have any injuries. Immediately after the incident Nurse #1 educated NA #1 on using the proper equipment for transfers. Nurse #1 asked NA #1 why she was attempting to transfer without a mechanical lift and NA #1 did not have an explanation. Nurse #1 stated that she informed 2 nursing supervisors of the incident.

On 2/12/25 at 10:20 AM an interview was conducted with NA #2. NA #2 stated that she did work on 6/14/24 but was not assigned to Resident #344. She did not remember Resident #344, nor did she hear anything about Resident #344 that day. NA #2 stated that all residents' transfer status was posted on the inside of the closet door. If a resident was a new admission you would need to wait until therapy did their evaluation before doing a transfer. Other ways to get transfer information was from the computer or shift nurse. If staff noticed a change of condition in a resident, the staff could put in a "Hey Therapy" card to notify them. This would alert therapy that a resident was having a change in condition.

On 2/12/25 at 11:10 AM an interview was conducted with the Therapy Manager. She stated she could not remember Resident #344 but would look back on any information regarding her. The Therapy manager was able to find two mechanical lift evaluations dated 5/6/24 and 5/21/24 and both stated that Resident #344 was a total lift for transfer.

On 2/12/25 at 11:30 AM an interview was conducted with NA #3 and NA #4. Both NAs

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F 689	Continued From page 4	F 689		

stated they had been trained on how to properly use a mechanically lift prior to working on the floor. If the NAs need to know the transfer of a resident it was on the back of the closet door or they could ask therapy or nurse supervisor.

On 2/12/25 at 2:15 PM an interview was conducted with a Nursing Supervisor. She stated that Nurse #1 had reported to her about NA #1 transferring Resident #344 improperly. The Nursing Supervisor stated that Resident #344 required total assistance for her transfer and needed a mechanical lift to be used.

On 2/13/25 at 2:51 PM an interview was conducted with the Director of Nursing (DON) and the Administrator. They were both aware of the 6/14/24 incident with Resident #344 and they both agreed that it would be expected that staff would follow the proper transfer.