	-	ID HUMAN SERVICES			FORM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
	345314		B. WING		11/10/2016	
NAME OF P	ROVIDER OR SUPPLIER	I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		C	٤	330 BETHANY CHURCH ROAD		
	EN OF FOREST CITY, LI	-0	F	FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE		F 274		12/6/16	
	A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)					
	by: Based on record rev facility failed to comp condition assessmen residents (Resident # The finding included: Resident #31's diagn weakness, spastic he The annual Minimum 5/28/16, specified Re assistance for transfe mobility and toileting bowel and bladder. The quarterly MDS da Resident #31 require	31). oses included muscle miplegia, and chronic pain. Data Set (MDS) dated sident #31 required limited ers, only supervision for bed and was always continent of ated 8/26/16, specified d extensive assistance for		Significant change MDS correction for resident #31 submitted and accepted of 11/22/2016. 100% audit on long term residents completed to assess others potentially affected by the need for a MDS correct for significant change. The audit will review the last two MDS completed. It review the last two MDS completed. It review the improvement or decline in ADLs, weight, wounds, and continence changed in two or more areas will trigg a significant change MDS to be completed. Audit completed on 11/23/2016. Two additional significant change MDS identified. Corrections to completed and submitted by 12/6/2016	tion will e. A jer be	
	transfers, bed mobilit	y and toileting and was		Resident changes in condition will be		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE	
Electroni	cally Signed				12/02/2016	

Electronically Signed

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	OMB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345314			A. BUILDING	COMPLETED		
		B. WING	11/10/2016			
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR HAV	EN OF FOREST CITY, LI	LC		330 BETHANY CHURCH ROAD FOREST CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIO	
F 274	Continued From page 1 frequently incontinent of bowel and bladder. The MDS also indicated the resident was cognitively intact. MDS Coordinator #1 and #2 were interviewed on 11/10/16 at 10:58AM, about this resident's significant change in activities of daily living. Both MDS Coordinators agreed the 8/26/16 assessment should have triggered a Significant Change in Condition assessment, but it had been missed. On 11/10/16 at 11:24 AM, the Director of Nursing said a Significant Change in Condition assessment should be done when there are two or more areas of decline or improvement.		F 274 reviewed in daily clinical meeting clinical team. The clinical team i the Director of Nursing, Assistan of Nursing, MDS nurses, unit ma and the wound nurse. All identifi assessments and/or documenta be assigned to be completed du clinical meeting, and then review "stand down" meeting at the end day. Weekly "at risk" meetings w review of weights and wounds b clinical team. Each resident will reviewed no less than monthly." meetings will open communicati between the clinical team to ens significant changes are assesse MDS assessments reflect these MDS nurses will audit each other assessments, including review of continence, weights, and wound monitor that significant changes completed when indicated. Thre will be completed weekly for three and then one weekly for three w then randomly for three weeks." be turned into and reviewed by the		vides irector gers, will the at the the nclude e se and anges. DLs, re udits veeks, s, and	
F 371 SS=E	483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from		F 371	Director of Nursing and/or Administr the end of each week. These audits also be reviewed in the quality assu meetings for three months, with the one being scheduled on December 2016.	will rance next	

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FOR MEDICARE & N					RM APPROVED	
DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
345314		B. WING			11/10/2016	
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
NOF FOREST CITY, LL	С		FOREST CITY, NC 28043			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
considered satisfactor authorities; and 2) Store, prepare, dis	ry by Federal, State or local stribute and serve food	F 3	71			
by: Based on observation acility failed to proper oppened reusable dry f ood items stored in the The findings included: During the initial tour of 11/7/16 beginning at S Manager (DM) the foll be opened and not se he dry storage area: a. Instant grits b. Rotini pasta c. Graham cracker of number freezer there was purritos with 2 items le purritos were not secu An interview with the I he tour revealed the i available for use in the stated his expectation be secured after they	ns and staff interviews the rly secure, label and date food items, and reusable ne freezer. of the dietary department on 0:23 AM with the Dietary lowing items were found to occured, labeled or dated in crumbs as an opened bag of frozen eft in the bag. The bag of ured, labeled or dated. DM immediately following identified food items were e dining room. The DM i would be for food items to were opened and properly		 not secured, unlabeled / undated dry storage area and freezer in removed by the Dietary Manage 11/7/2016. All areas of food storage, inclue storage, and the cooler and freechecked to ensure no other food were opened and not secured unlabeled, or undated by the D Manager on 11/7/2016. No other identified. 100% of dietary staff educated proper storage and labeling of education completed on 11/28/ new staff will have education of proper storage and labeling of their orientation process. This were documented on job duty check education will also be completed and as needed for all staff to m compliance. The Administrator or dietary material staff and as needed for all staff to material staff. 	ed in the mediately ler on ding dry ezer od items properly, ietary er items on the food. This 2016. All n the food during will be list. This ed annually waintain		
	VIDER OR SUPPLIER I OF FOREST CITY, LL SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page considered satisfactor uthorities; and 2) Store, prepare, dis inder sanitary conditi This REQUIREMENT by: Based on observation acility failed to proper pened reusable dry for conditems stored in the the findings included: 0 0 0 0 1/7/16 beginning at S Manager (DM) the follow the opened and not see the dry storage area: 1. Instant grits 2. Rotini pasta 3. Graham cracker of the finder see the event ourritos with 2 items for the tour revealed the in- trated his expectation the secured after they abeled and dated per	ORRECTION IDENTIFICATION NUMBER: JA5314 VIDER OF SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 considered satisfactory by Federal, State or local muthorities; and 2) Store, prepare, distribute and serve food inder sanitary conditions his REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the acility failed to properly secure, label and date ipened reusable dry food items, and reusable bood items stored in the freezer. The findings included: During the initial tour of the dietary department on 1/7/16 beginning at 9:23 AM with the Dietary Manager (DM) the following items were found to be opened and not secured, labeled or dated in the dry storage area: 1. Instant grits 2. Instant grits	ORRECTION IDENTIFICATION NUMBER: A. BUILDIN 345314 B. WING_ VIDER OR SUPPLIER ID IOF FOREST CITY, LLC ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 2 F 3 considered satisfactory by Federal, State or local uthorities; and F 3 2) Store, prepare, distribute and serve food inder sanitary conditions F 3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the acility failed to properly secure, label and date ppened reusable dry food items, and reusable bood items stored in the freezer. The findings included: During the initial tour of the dietary department on 1/7/16 beginning at 9:23 AM with the Dietary Aanager (DM) the following items were found to ee opened and not secured, labeled or dated in the dry storage area: 1. Instant grits Graham cracker crumbs n the freezer there was an opened bag of frozen nurritos with 2 items left in the bag. The bag of uurritos were not secured, labeled or dated. n interview with the DM immediately following the tour revealed the identified food items were vailable for use in the dining room. The DM tated his expectation would be for food items to be escured after they were opened and properly abeled and dated per facility protocol. The DM	DERRECTION DENTIFICATION NUMBER. A BUILDING 346314 B. WING VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10F FOREST CITY, LLC STREET ADDRESS, CITY, NE ADD	Dentertion DENTIFICATION NUMBER: A BUILDING Co 345314 #. WING STREET ADDRESS, CITY, STREE, 2IP CODE STREET ADDRESS, CITY, STREE, 2IP CODE IOF FOREST CITY, LLC STREET ADDRESS, CITY, N.C. 2803 PROVENTY CHURCH ROAD FOREST CITY, N.C. 2803 INMARY STATEMENT OF DEFIDENCES (EACH ORDERCINCY WIST REPROCEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREX (EACH ORDERCINC WIST REPROCEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREX (EACH CORRECTING ACTION STOLED BE (EACH ORDERCINC ACTION STOLED BE (EACH CORRECTING ACTION STOLED	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 12/06/2016 FORM APPROVED B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345314	B. WING			11/10/2016	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT	E, ZIP CODE		
FAIR HAVEN OF FOREST CITY, LLC				830 BETHANY CHURCH ROA FOREST CITY, NC 28043	AD.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 371	The food items found dated were removed On 11/10/16 at 11:37	of for the dietary department. opened, not labeled or by the DM. AM an interview with the d his expectations were for itchen to be securely	F 3		uality assurance onths, with the next		

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Event ID: PO7U11

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