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 _____	11/10/2016

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
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE 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.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to complete a significant change in condition assessment for 1 of 14 sampled residents (Resident #31). The finding included: Resident #31's diagnoses included muscle weakness, spastic hemiplegia, and chronic pain. The annual Minimum Data Set (MDS) dated 5/28/16, specified Resident #31 required limited assistance for transfers, only supervision for bed mobility and toileting and was always continent of bowel and bladder. The quarterly MDS dated 8/26/16, specified Resident #31 required extensive assistance for transfers, bed mobility and toileting and was	F 274	Significant change MDS correction for resident #31 submitted and accepted on 11/22/2016. 100% audit on long term residents completed to assess others potentially affected by the need for a MDS correction for significant change. The audit will review the last two MDS completed. It will review the improvement or decline in ADLs, weight, wounds, and continence. A changed in two or more areas will trigger a significant change MDS to be completed. Audit completed on 11/23/2016. Two additional significant change MDS identified. Corrections to be completed and submitted by 12/6/2016. Resident changes in condition will be	12/6/16

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

Electronically Signed | 12/02/2016

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 _____	11/10/2016

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
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 meetings by the clinical team. The clinical team includes the Director of Nursing, Assistant Director of Nursing, MDS nurses, unit managers, and the wound nurse. All identified assessments and/or documentation will be assigned to be completed during the clinical meeting, and then reviewed at the "stand down" meeting at the end of the day. Weekly "at risk" meetings will include review of weights and wounds by the clinical team. Each resident will be reviewed no less than monthly. These meetings will open communication between the clinical team to ensure significant changes are assessed, and MDS assessments reflect these changes. MDS nurses will audit each other's assessments, including review of ADLs, continence, weights, and wounds to monitor that significant changes were completed when indicated. Three audits will be completed weekly for three weeks, and then one weekly for three weeks, and then randomly for three weeks. They will be turned into and reviewed by the Director of Nursing and/or Administrator at the end of each week. These audits will also be reviewed in the quality assurance meetings for three months, with the next one being scheduled on December 19, 2016.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		12/6/16

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 _____	11/10/2016

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
F 371	Continued From page 2 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to properly secure, label and date opened reusable dry food items, and reusable food items stored in the freezer. The findings included: During the initial tour of the dietary department on 11/7/16 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: a. Instant grits b. Rotini pasta c. Graham cracker crumbs In the freezer there was an opened bag of frozen burritos with 2 items left in the bag. The bag of burritos were not secured, labeled or dated. An interview with the DM immediately following the tour revealed the identified food items were available for use in the dining room. The DM stated his expectation would be for food items to be secured after they were opened and properly labeled and dated per facility protocol. The DM went on to say the dietary staff had been trained	F 371	Food items identified to be opened and not secured, unlabeled / undated in the dry storage area and freezer immediately removed by the Dietary Manager on 11/7/2016. All areas of food storage, including dry storage, and the cooler and freezer checked to ensure no other food items were opened and not secured properly, unlabeled, or undated by the Dietary Manager on 11/7/2016. No other items identified. 100% of dietary staff educated on the proper storage and labeling of food. This education completed on 11/28/2016. All new staff will have education on the proper storage and labeling of food during their orientation process. This will be documented on job duty checklist. This education will also be completed annually and as needed for all staff to maintain compliance. The Administrator or dietary manager will complete three audits weekly for six weeks, and then randomly for three	

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 _____	11/10/2016

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
F 371	Continued From page 3 on labeling standards for the dietary department. The food items found opened, not labeled or dated were removed by the DM. On 11/10/16 at 11:37 AM an interview with the Administrator revealed his expectations were for opened items in the kitchen to be securely closed, labeled and dated.	F 371	weeks, to monitor compliance with proper food storage and labeling. The audits will be reviewed in the quality assurance meetings for three months, with the next being scheduled on December 19, 2016.	