

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Fair Haven of Forest City, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 830 Bethany Church Road Forest City, NC 28043	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000</p> <p>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.</p> <p>The findings included:</p> <p>Resident #344 was admitted to the facility on [DATE] and was discharged on [DATE]. She was admitted to the facility with diagnoses of heart failure, lumbago with sciatica and alveolar hypoventilation (failure to breathe rapidly or deeply enough).</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #344 had moderate cognitive impairment and was dependent for chair to bed transfer.</p> <p>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.</p> <p>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.</p> <p>An accident report prepared by Nurse #1 indicated that the family representative and physician were notified on 6/14/24.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>On 2/12/25 at 11:30 AM an interview was conducted with NA #3 and NA #4. Both NAs 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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