| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345314 | A. Building<br>B. Wing | 04/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fair Haven of Forest City, LLC | 830 Bethany Church Road<br>Forest City, NC 28043 |

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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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, Consulting Pharmacist, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to the initiation or increase of the medications for 3 of 5 residents reviewed for unnecessary medications ( Resident #47, Resident #67, and Resident #11).<br><br>The findings included:<br><br>a. Resident #47 was admitted [DATE] with diagnoses of panic disorder, depression, and anxiety disorder.<br><br>Resident #47's physician's orders revealed an order dated 8/31/2024 for sertraline (antidepressant medication) 50 milligrams (mg) by mouth daily for depression.<br><br>Resident #47's physician's orders revealed an order dated 10/25/2024 for alprazolam (antianxiety medication) 1 mg by mouth twice daily for anxiety.<br><br>Resident #47's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #47 had intact cognition and received antianxiety and antidepressant medication during the 7-day look back period.<br><br>A Nurse Practitioner (NP) note dated 10/9/2025 indicated Resident #47 reported anxiety was not well managed and had uncontrolled moderate anxiety in the afternoon, the plan indicated to increase alprazolam to three times daily.<br><br>Resident #47's physician's orders revealed an order dated 10/9/2025 for alprazolam 1 mg by mouth three times daily for anxiety.<br><br>An annual visit NP note dated 11/20/2025 indicated a depression screening was conducted and Resident #47 scored as moderately depressed. This note included a section for education which was left blank.<br><br>Resident #47's physician's order revealed an order dated 11/20/2025 to increase sertraline to 75 mg daily.<br><br>An NP note dated 12/4/2025 indicated Resident #47 reported lack of interest in activities and feeling flat in emotions. The plan included an increase of sertraline to 100 mg daily.<br><br>Resident #47's physician's orders revealed an order dated 12/4/2025 for sertraline 100 mg daily for<br>(continued on next page) |

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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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | depression.<br><br>Resident #47's quarterly MDS dated [DATE] revealed Resident # 47 had intact cognition and received antianxiety and antidepressant medication during the 7-day look back period.<br><br>Resident #47's Medication Administration Record (MAR) from 10/9/2025 to 3/31/2026 indicated Resident #47 was administered alprazolam and sertraline as ordered by the physician.<br><br>A review of Resident #47's medical record revealed no information indicating if Resident #47 was informed in advance of the risks and benefits of increasing sertraline or alprazolam.<br><br>An interview with Resident #47 was conducted on 4/02/2026 at 9:06 AM. Resident #47 stated none of the providers at the facility had discussed side effects, or the risks or benefits of taking or increasing alprazolam or sertraline, but Resident #47 stated she just knew she needed the medications.<br><br>b. Resident #67 was admitted on [DATE] with diagnoses of anxiety disorder and major depressive disorder.<br><br>Resident #67's physicians' orders revealed an order dated 4/11/2025 for buspirone HCl (antianxiety medication) 15 mg by mouth twice daily.<br><br>Resident #67's admission MDS dated [DATE] revealed Resident #67 was severely cognitively impaired. The MDS indicated Resident #67 received antianxiety medication during the 7-day look back period.<br><br>Resident #67's MAR from 4/11/2025 to 3/31/2026 indicated Resident #67 was administered buspirone HCl as ordered by the physician.<br><br>A review of Resident #67's medical record revealed no information indicating if Resident #67's Responsible Party was informed in advance of the risks and benefits of initiating buspirone HCl.<br><br>A telephone interview on 4/2/2026 at 11:39 AM with Resident #67's Responsible Party revealed the Responsible Party did not recall a discussion with the provider or other facility staff regarding the risks and benefits of buspirone HCL when Resident # 67 was admitted to the facility.<br><br>c. Resident #11 was admitted on [DATE] and readmitted on [DATE]. Diagnosis included anxiety disorder and major depressive disorder.<br><br>Resident #11's physicians' orders revealed an order dated 5/09/25 for Xanax (antianxiety medication) 0.5 mg two tablets by mouth three times daily and an order dated 10/13/25 for Zoloft (antidepressant) 150 mg one tablet by mouth at bedtime.<br><br>Resident #11's quarterly MDS dated [DATE] revealed Resident #11 was cognitively intact. The MDS indicated Resident #11 received antianxiety and antidepressant medication during the 7-day look back period.<br><br>Resident #11's MAR from 5/09/2025 to 4/01/2026 indicated Resident #11 was administered Xanax as ordered by the physician. Resident #11's MAR from 10/13/25 to 4/01/26 indicated Resident #11 was administered Zoloft as ordered by the physician.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #11's medical record revealed no information indicating if Resident #11's was informed in advance of the risks and benefits of initiating Xanax or Zoloft.<br><br>An interview on 4/01/2026 at 10:39 AM with Resident #11 revealed she did not recall a discussion with the provider or other facility staff regarding the side effects or risks and benefits of taking Xanax and Zoloft.<br><br>An interview on 4/01/2026 at 12:26 PM with the NP revealed psychotropic medication consents were handled by nursing.<br><br>A telephone interview on 4/02/2026 at 8:25 AM with the Consulting Pharmacist revealed the Consulting Pharmacist did not review psychotropic consents for the facility during her monthly medication reviews. The Consulting Pharmacist verified antidepressants, and antianxiety medications were psychotropic medications and required consents when they were initiated and increased.<br><br>An interview on 4/02/2026 at 10:09 AM with the Medical Director revealed he did not recall having discussions of risks and benefits with residents that were admitted on psychotropic medications prior to the medication being ordered and administered. The Medical Director stated the floor nurses and Rounding Nurse notified residents and resident representatives of medication changes. The Medical Director thought the Rounding Nurse would take care of psychotropic medication consents since the Rounding Nurse entered orders after rounding with the providers. The Medical Director indicated he expected psychotropic medication consents to be completed when psychotropic medications were initiated and increased.<br><br>A telephone interview with the Rounding Nurse on 4/2/2026 at 11:59 AM revealed she was responsible for obtaining consents for residents who had orders for psychotropic medications. The Rounding Nurse stated when residents received a new order for psychotropic medication, she obtained consent from the resident or resident representative. The Rounding Nurse stated the psychotropic medication consent was only obtained for residents who started psychotropic medications after they were admitted to the facility. The Rounding Nurse explained that consents were not obtained for residents that were admitted with orders for psychotropic medications because those residents were taking the psychotropic medication prior to being admitted to the facility. The Rounding Nurse stated she did not obtain consents for residents that started or had an increased dose of antidepressants or antianxiety medications because she did not know those medications were psychotropic medications. The Rounding Nurse verified she had only obtained consents for residents who received orders for antipsychotic medications after they were admitted .<br><br>An interview with the Director of Nursing (DON) on 4/2/2025 at 1:45 PM revealed the Rounding Nurse was responsible for obtaining psychotropic medication consents. The DON explained that the Rounding Nurse was the providers' nurse and worked with the providers and entered any orders. The DON verified that any order entered by the facility was a new order, including medications a resident took prior to admission to the facility. The DON stated she did not know antianxiety and antidepressants required consent to be completed when initiated and increased. The DON believed communication issues and no reeducation when the psychotropic policy was reviewed in January 2026 contributed to staff not being aware of what medications were psychotropics. She explained the policy indicated psychotropic medication consents should be completed when psychotropic medications were initiated and increased.<br><br>An interview on 4/02/2026 at 3:20 PM with the Informatics Nurse revealed he had reviewed the<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | psychotropic policy in January 2026. The Informatics Nurse stated the definition of psychotropic medications were the same as prior to the policy review and included antidepressant and antianxiety medications. The Informatics Nurse stated nurses should know what medications were considered psychotropics. The Informatics Nurse stated he was currently in the process of reviewing all of the facilities policies, then a full reeducation would be conducted.<br><br>An interview with the Administrator on 4/2/2026 at 4:01 PM revealed the Administrator expected consents for psychotropic medications. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II PASRR (Preadmission Screening and Resident Review) evaluation for a resident admitted with an active diagnosis of bipolar disorder for 1 of 3 residents reviewed for PASRR evaluations (Resident #14). The findings included: Review of Resident #14's medical record revealed a PASRR level I completed prior to admission to the facility dated 03/20/18.Resident #14 was admitted on [DATE] with diagnoses which included bipolar disorder.No PASRR level II evaluation had been completed per review of Resident #14's medical record. Resident #14's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had an active diagnosis of bipolar disorder and was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #14's quarterly MDS assessment dated [DATE] revealed he was severely cognitively impaired. He had no behaviors and no signs of depression. Resident #14 was coded for an active diagnosis of bipolar disorder and received anticonvulsant and antidepressant medications daily. Resident #14's physician orders revealed the following active medication orders: mirtazapine (antidepressant medication) 15 milligrams by mouth daily at bedtime for depression and appetite; Lamictal (anticonvulsant medication used as a mood stabilizer) 25 milligrams by mouth daily for bipolar disorder. Resident #14's active care plan dated 06/17/25 revealed a focus area for antidepressant medications with indication of depression and bipolar disorder. The stated goal was that Resident #14 would remain free from side effects of the medication. Interventions included administering medications as ordered, and monitoring for adverse effects of medication. An interview with the Social Worker on 04/02/26 at 9:16 AM revealed that Resident #14 had a level I PASRR when he was admitted to the facility. The Social Worker stated that since he already had a PASRR level I evaluation completed, she did not submit a referral for a Level II PASRR evaluation and was not aware she had to. The Social Worker stated that she was aware Resident #14 had a bipolar disorder diagnosis and acknowledged she did not submit a request for a level II PASRR evaluation for Resident #14. An interview with the Administrator on 04/02/26 at 4:02 PM revealed that it was important that level II PASRR evaluations were completed for residents who met criteria so they could receive the services they needed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and resident, staff, and Medical Director interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the area of respiratory care (Resident #1) and anticoagulant medication use (Resident #32) for 2 of 3 residents whose comprehensive care plans were reviewed. Findings included:<br><br>1. Resident #1 was initially admitted to the facility on [DATE] with a readmission date of 02/23/26. Resident #1's diagnoses included chronic obstructive pulmonary disease (COPD, a progressive, debilitating respiratory disease), chronic respiratory failure with hypoxia (low levels of oxygen in the bodies tissues), and pneumonia due to methicillin resistant staphylococcus aureus (MRSA, a bacterial pneumonia resistant to antibiotics).<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was coded for diagnoses of respiratory failure, chronic obstructive pulmonary disease, and pneumonia.<br><br>A review of Resident #1's active comprehensive care plan most recently updated on 09/30/25, did not include a care plan in place for COPD, respiratory failure, or pneumonia.<br><br>A review of Resident #1's physician orders revealed that since September 2025 Resident #1 received medication daily and as needed to help with COPD and chronic respiratory symptoms and had received multiple rounds of antibiotics for pneumonia.<br><br>A Physician Progress Note dated 10/23/25 revealed Resident #1 had complained of cough, congestion, and respiratory distress and that aggressive treatment for COPD would continue.<br><br>A Physician Progress Note dated 11/03/25 revealed Resident #1 had been hospitalized for pneumonia on 10/29/25, had been readmitted with supplemental oxygen and to continue the current treatment for pneumonia.<br><br>A Physician Progress Note dated 01/29/26 revealed Resident #1 was undergoing treatment for pneumonia, had dyspnea (shortness of breath) and to continue the current antibiotic.<br><br>A review of Resident #1's Pulmonologist consult dated 03/05/26 revealed Resident #1 was seen due to a recent hospitalization for right lower lobe pneumonia. The Pulmonologist note indicated Resident #1 reported ongoing chest congestion, cough, and wheezing, and may have bronchiectasis with mucus impaction (a condition in chronic lung disease when the airway is unable to expel secretions) and recommended continuing antibiotics for 2 more weeks.<br><br>An interview and observation with Resident #1 on 03/30/26 at 1:02 PM revealed she currently had a cough and reported that her respiratory issues were ongoing. Resident #1 had slightly labored breathing during the conversation but denied the need for oxygen or feeling distressed.<br><br>An interview with the Medical Director on 04/02/26 at 10:59 PM revealed that Resident #1 had COPD which is a chronic lung disease. The Medical Director stated he would consider Resident #1's respiratory condition to be severe, chronic, and she required frequent monitoring and treatment of respiratory symptom management by the medical staff.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An interview with the Informatics Nurse was conducted on 04/02/26 at 10:07 AM. The Informatics Nurse revealed he was temporarily in the role of the MDS Nurse and had only been in this role for a few weeks. He stated Resident #1 had a diagnosis of COPD, respiratory failure and had recurrent pneumonia. He explained that COPD should be included in Resident #1's care plan since it was a long-term issue and was unsure why one was not in place.<br><br>An interview with the Director of Nursing (DON) on 04/02/25 at 12:14 AM revealed that she expected the residents' care plans to be accurate and reflect care concerns. The DON stated that Resident #1 should have a respiratory care plan in place due to her ongoing impaired respiratory status. The DON indicated the MDS Nurse who was responsible for updating care plans and had recently quit and this may have contributed to the overlooking Resident #1's respiratory care plan.<br><br>An interview with the Administrator was conducted on 08/28/25 at 4:02 PM. The Administrator stated the care plans should reflect the clinical condition of the residents, including respiratory symptoms or diagnoses.<br><br>2. Resident #32 was admitted to the facility on [DATE] with diagnoses which included myocardial infarction (heart attack) and chronic atrial fibrillation.<br><br>The quarterly Minimum Data Set (MDS) assessment for Resident #32 dated 01/16/2026 indicated Resident #32 was receiving an anticoagulant.<br><br>The active medication orders for Resident #32 revealed an order for Apixaban (an anticoagulant medication) 2.5 milligrams (mg) by mouth twice a day for history of myocardial infarction and deep vein thrombosis (blood clot) prevention. The medication had a start date of 10/11/2025.<br><br>Resident #32's active comprehensive care plan initiated on 10/17/2025 and last revised on 01/21/2026 did not reveal any care plan focus area or interventions related to Resident #32 receiving an anticoagulant medication.<br><br>Review of Resident #32's Medication Administration Record (MAR) from 01/01/2026 through 03/31/2026, revealed Resident #32 received Apixaban 2.5 mgs by mouth twice a day as ordered by the physician.<br><br>An interview was conducted on 04/01/2026 at 10:30 AM with the Informatics Nurse who stated the facility did not currently have an MDS Coordinator and he had been temporarily filling in for the past couple of weeks. The Informatics Nurse stated that Resident #32's quarterly MDS assessment dated [DATE] was accurately coded for anticoagulant use, but her care plan did not address the use of anticoagulant medications. He indicated anticoagulant medications were considered high-risk medications and should be care planned.<br><br>An interview was conducted on 04/02/2026 at 1:45 PM with the Director of Nursing (DON). The DON stated she did not know why Resident #32's anticoagulant medication was not care planned, but she expected that all high-risk medications be care planned including anticoagulant medications.<br><br>An interview was conducted with the Administrator on 04/02/2026 at 2:45 PM who stated she did not know why Resident #32's anticoagulant medication was not care planned, but she expected all resident care plans to be reflective of the resident's clinical condition including the use of anticoagulant medications. The Administrator stated that an anticoagulant care plan should have been implemented for Resident #32. |