STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345425	A. BUILDING _____ B. WING _____	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

(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 survey was conducted on 01/03/23 through 01/04/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6UBQ11.	E 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 observation, record review, resident interview, and staff interviews the facility failed to provide a safe transfer for 1 of 3 residents sampled for accidents (Resident #15). The findings included: Resident #15 was originally admitted on 12/1/17 with diagnoses that included hypertension and hyperlipidemia. Review of Resident #15's admission Minimum Data Set (MDS) dated 10/17/22 revealed Resident #15 was cognitively intact and required extensive assistance of two or more staff with transfers and toilet use. Review of Resident #15's care plan dated 10/31/22 revealed Resident #15 required	F 689	The corrective action was accomplished for the one resident found to have been affected by this deficient practice by completing education for nursing staff involved in this incident. The staff was educated regarding fall risks and transfer status for this resident. Previously the resident was evaluated to require 2 persons to assist during transfers. The residents transfer status was re-evaluated and the resident was identified to having continued need requiring 2 persons to assist with transfers. The nursing staff involved in this incident was educated on fall risks and the requirements for 2 persons to remain present during transfers for this resident. Nursing staff involved in this incident was educated on the requirement for supervision by one	1/24/23

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

Electronically Signed | 01/26/2023

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F 689	Continued From page 1 assistance with activities of daily living (ADL) related to weakness and decreased mobility with admission to hospice services with diagnosis of cerebral atherosclerosis. Resident #15's goal was to be able to participate in ADL care through next review. Interventions included staff to assist with ADL care on a routine basis and as needed. Observation of the inside of Resident #15's closet door on 1/4/23 at 12:30 PM revealed a Transfer/ Mechanical Lift Assessment dated 10/10/22 which indicated Resident #15 was a two person assist with no lift. Review of the facility incident report dated 12/4/22 at 6:43 PM revealed Nurse Aide (NA) #1 observed Resident #15 lose her balance and fell in the bathroom while trying to sit back into the wheelchair around 3:35 PM. The incident report further revealed NA #1 stated, "I was trying to scoot the wheelchair behind her, and she fell and hit her head against the wall". The incident report indicated Resident #15 was assessed and no injuries were noted. An interview conducted with Resident #15 on 1/4/23 at 12:30 PM revealed NA #1 and NA #2 had assisted Resident #15 to the shower room to use the bathroom because Resident #15 preferred more room. Resident #15 further revealed NA #2 walked away while she was being transferred from her wheelchair to the toilet. Resident #15 indicated she became weak, and NA #1 was unable to hold her and assisted her to the floor. Resident #15 stated she usually had two person-assist for transfers and did not know why NA #2 had walked away. Resident #15 revealed she did not recall hitting her head or obtaining any injuries.	F 689	person before the transfer begins and after the transfer is completed for this resident to reduce fall risks using the Safe Resident Handling/Transfers policy. The facility identified no other residents having the potential for this same deficient practice. The facility assessed all residents lift/transfer status and verified them to be current and accurate. All nursing staff was re-educated on lift/transfer status and supervision of resident during transfers. The following measures have been put into place for systematic changes to ensure the deficient practice does not reoccur: - Education was provided to 100% of nursing staff regarding fall risks, lift/transfer status and the requirements per facility protocol. Education was documented using the tool "Interventions to Minimize Falls/Accidents by Following Lift Status" completion date 1/24/23. Any new staff will be trained prior to working on the floor. All staff were reeducated prior to being back in compliance on 01/24/23. -100% audit of all residents lift/transfer status was completed and /documented using the Accident and Supervision tool to identify fall risks and to maintain current and accurate plans of care by the interdisciplinary team to assure safe practices are identified for each resident completion date 1/23/23. Care plans are updated routinely and as needed.	

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F 689	Continued From page 2 Review of progress note dated 12/4/22 revealed Nurse Aide (NA) #1 observed Resident #15 lose her balance in the bathroom while trying to sit back in her wheelchair. The note further revealed vitals were taken and Resident #15 complained of a headache post fall and received Tylenol. An interview was unable to be conducted with Nurse Aide (NA) #1 during the investigation. An interview conducted with Nurse Aide (NA) #2 on 1/4/23 at 11:50 AM revealed he and NA #1 assisted Resident #15 to the restroom in the shower room to use the toilet. NA #2 further revealed NA #1 transferred Resident #15 from the wheelchair to the toilet while he had walked over to the linen cart an estimated 10 feet away from the toilet in the shower room. NA #2 stated he heard a thump and observed Resident #15 on the floor. NA #2 indicated he was aware and re-educated after the fall that Resident #15 was a two person assist for transfers. The interview further revealed residents in the facility had a Kardex located on their closet doors that disclosed required assistance needed for transfers. An interview conducted with Nurse #1 on 1/4/23 at 11:17 AM revealed on 12/4/22 she had walked by the shower room and heard a thump. Nurse #1 further revealed she entered the room and observed Resident #15 and NA #1 on the floor and NA #2 away from the resident at the linen cart. Nurse #1 indicated Resident #15 had fallen forward on her knees and was a two person assist for transfers and both NAs should have been with the resident during the transfer. Nurse #1 revealed Resident #15 was assessed and did	F 689	-The Charge nurse will review incident reports daily to identify any falls that occurred and to ensure proper lift/transfer status was followed. The lift/transfer status will be audited using the Validation Checklist tool. Any discrepancies will be reported to the DON/Administrator by the charge nurse immediately. Any discrepancies with nursing staff failure to follow proper lift/transfer status will be addressed by the DON/Administrator through re-education, competency and disciplinary actions as needed. -The lift/transfer status sheet is updated to reflect the process and requirements of safe transfers with residents requiring 2 persons assistance and total lifts. The Director of Nursing or designee will audit all incident reports daily, Monday-Friday to ensure accuracy of lift /transfer status. Auditing tools will be reviewed for accuracy by interdisciplinary team at High-Risk meetings. This will be completed weekly times 4 weeks; then, bi-weekly x 1 month and at monthly QA meetings x 4 months to ensure that interventions are current and appropriate. Director of Nursing or designee will report findings to monthly QA meeting monthly x 4 months. Documentation of reviews completed at high/risk and QA meetings will be recorded using the Accidents and Supervision audit tool. If any discrepancies are found, the Administrator and Physician will be notified, and concerns will be address in daily Quality Assurance meeting.	

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F 689	Continued From page 3 not have any injuries and she had educated both NAs about safely transferring residents with appropriate assist. An interview conducted with the facility Rehabilitation Manager on 1/4/23 at 2:40 PM revealed Resident #15 was not participating in therapy during the incident on 12/4/22. The Rehabilitation manager further revealed Resident #15 was a two person assist for transfers due to Resident #15 sometimes being weak and knees buckling. The Rehabilitation Manager indicated both NAs should have been with Resident #15 during the transfer to prevent the fall. An interview conducted with the Director of Nursing (DON) on 1/4/23 at 3:15 PM revealed Resident #15 required two-person extensive assistance for transfers. The DON further revealed both NAs should have assisted Resident #15 during the transfer to prevent the fall.	F 689	The corrective action was completed by 01/05/23	