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 ______	C 11/16/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/13/23 through 11/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# VS1B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/13/23 through 11/16/23. Event ID# VS1B11. The following intakes were investigated NC00197125 and NC00205546. Two (2) of 2 complaint allegations did not result in a deficiency.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		12/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/11/2023

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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F 690	Continued From page 1 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews the facility failed to secure a catheter bag to prevent the catheter bag from resting on the floor for 1 of 2 residents (Resident #36) were reviewed for urinary catheter. The findings included: Resident #36 was admitted to the facility on 10/25/23 with diagnoses which included urinary retention. Review of Resident #36's significant change Minimum Data Set (MDS) dated 11/01/23 revealed Resident #36 was cognitively intact and required extensive assistance with a majority of activities of daily living (ADL). The MDS further revealed Resident #36 was coded for having an indwelling urinary catheter. Review of Resident #36's care plan dated	F 690	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. Resident #36 was the only resident affected by the alleged deficient practice.¿ Every resident requiring a catheter is identified as potentially being affected by the alleged deficient practice. An audit was completed on 11/17/23 and no other residents were noted to be affected. All catheters will be placed in a protective bag to ensure that the catheters are not able to touch the floor. The protective bag may touch the floor to protect the catheter from touching the floor. Education to be provided to all Nursing	

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F 690 Continued From page 2

11/06/23 revealed Resident #36 had an indwelling urinary catheter there was a goal was for the resident to show no signs or symptoms of urinary infection through review date. Interventions included monitoring and documenting intake and output as per facility policy.

An observation conducted on 11/14/23 at 1:25 PM revealed Resident #36 outside of the dining room in his wheelchair. It was further observed Resident #36's catheter bag to be partially full with the bag resting on the floor.

Observation and interview conducted with Resident #36 and Director of Nursing (DON) on 11/14/23 at 2:45 PM revealed Resident #36's catheter bag was observed to be resting on the floor. Resident #36 indicated nursing staff hung his catheter bag daily under his wheelchair and he was not aware his catheter bag was laying on the floor. The DON stated Resident #36's catheter bag should not have been laying on the floor.

Interview conducted with Nurse #2 on 11/14/23 at 4:05 PM revealed she had cared for Resident #36 on 11/14/23 and did not recall the resident's catheter bag on the floor. Nurse #2 further revealed she had been educated for it to be off the floor to avoid contamination.

Interview conducted with Nurse Aide (NA) #4 on 11/13/23 at 4:15 PM revealed she had given Resident #36 a shower that morning at 6:30 AM and had hung his catheter bag on the bar below the seat on the resident's wheelchair. NA #4 further revealed she had observed Resident #36's catheter bag on the floor before. The NA indicated she hangs the resident's catheter bag

F 690

staff concerning catheter bags and their correct placement and ensuring all are in a protective bag. This education will be completed by the DON, ADON, or appointed designee via Relias no later than 12/11/23. Relias is an education portal where staff can go on and read the education and attest understanding. CNAs and Nurses will not be allowed to work following 12/11/23 until education is completed. DON will ensure that no CNA or Nurse works following 12/11/23 until education has been completed. All new hires are educated on proper catheter placement during their orientation process.

Audits to be completed weekly for 4 weeks, then monthly for 2 months. The audit will consist of looking at all residents who require catheters to ensure that they are placed in a protective covering and the catheter bag itself does not touch the floor. Audits to be completed by the Director of Nursing, ADON, or designee.

Audits will be reviewed and monitored in the facility's quality assurance meetings by the DON, ADON, or appointed designee for the next three months to ensure compliance is maintained.

Completion Date: 12/11/2023

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F 690	Continued From page 3 on the bar under the wheelchair, but it sometimes slid to the floor. The NA stated she had been educated to place Resident #36's catheter bag off the floor. Interview conducted with NA #5 and NA #6 revealed on 11/14/23 at 4:40 PM revealed they had placed Resident #36's catheter on a bar that crosses under the resident's wheelchair seat. The NAs further revealed the bag sometimes slid and had been observed resting on the floor before. The NAs indicated they had not been educated on exact location to hang Resident #36's catheter bag to prevent it from touching the floor. An interview conducted with Nurse #3 on 11/15/23 at 2:15PM revealed she had observed Resident #36's catheter bag hanging under the resident's wheelchair and the catheter bag was hitting the floor. Nurse #3 further revealed she moved the catheter bag up and educated NAs where to hang the catheter bag. Nurse #3 indicated a residents catheter bag should kept off the floor to prevent contamination. A further interview conducted with the Director of Nursing on 11/14/23 at 3:50 PM revealed Resident #36's catheter bag was expected to be off the floor and the staff would be educated.	F 690		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		12/11/23

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F 812	Continued From page 4 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure items stored ready for use were labeled and dated and/or failed to remove expired food items in 1 of 1 pantry and 1 of 2 nourishment rooms (B Hall). These practices had the potential to affect food served to residents. Findings included: a. An initial tour of kitchen and interview with the Dietary Manager (DM) dated 11/13/23 at 10:15 AM revealed a cardboard box of 200 hard taco shells that was opened and not covered with the discard date of 09/16/23. The DM stated she checked the pantry daily and was not aware the hard taco shells were out of date and not covered. The DM indicated dietary staff check the kitchen pantry daily and expired items should be discarded. b. An observation and joint interview conducted with Nurse Aide (NA) #1, NA #2, and NA #3 on 11/13/23 at 10:45 AM revealed in the nourishment	F 812	Disclaimer: The following information is provided by request, in follow-up to the survey conducted, and does not represent the facility admitting to, or agreeing to the alleged deficient practice. No residents were affected by the alleged deficient practice.¿ An audit was completed on 11/17/23 to ensure no further items were noted to be out of date. Education to be provided to all nursing staff and dietary staff concerning monitoring expiration dates on items, ensuring all items are dated and stored properly, and proper continuous checking of all food items to ensure that no items are out of date. This education also included who was responsible to checking the nutrition rooms and kitchen on a daily basis to ensure there are not out of date items. This education will be completed by	

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F 812	Continued From page 5 room on the B Hall a tube feeding container not labeled or dated with 4 ½ milliliters (ML) used sitting on the counter. Observation further revealed a 4 ounce carton of orange juice with discard date 11/1/23, two 8 ounce nutritional vanilla shakes with discard date 10/28/23, and five 4 ounce cartons of lemon flavor thickened water with discard date 09/19/23 stored in the refrigerator. NA #1, NA #2, and NA #3 indicated they did not know why the tube feeding container was left on the counter and did not recall any expired items in the refrigerator. The NAs revealed the dietary department checked the nourishment rooms daily and was responsible for discarding outdated items. An interview conducted with the Director of Nursing (DON) on 11/13/23 at 12:05 PM revealed the dietary department was responsible for checking nourishment rooms daily, but nursing staff had been educated to also discard outdated items if found. The DON further revealed the tube feeding container should have been labeled, dated, discarded, and not left on the nourishment room counter.	F 812	the DON, ADON, dietary manager, or appointed designee via Relias no later than 12/11/23. Relias is an education portal where staff can go on and read the education and attest understanding. CNAs, Nurses, and Dietary staff will not be allowed to work following 12/11/23 until education is completed. DON will ensure that staff members do not work following 12/11/23 until education is completed. Audits to be completed weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly for 1 months. The audit will consist of checking both nutrition rooms, items in the kitchen storage area, and all resident refrigerators that contain thickened liquids. Audits to be completed by the Dietary manager, Team Lead, or designee. Audits will be reviewed and monitored in the facility's quality assurance meetings by the dietary manager or appointed designee for the next four months to ensure compliance is maintained. Completion Date: 12/11/2023	