STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on July 11, 2023-July 12, 2023.	C 000	In Regards to 10A NCAC 13 G, 0206 Capacity Residents were immediately assessed to determine their ability to evacuate independently in the event of a fire or disaster.	7/12/23
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007	This assessment included a review of Residents' assessments, FL-2s and Careplan. All documentation stated that residents could ambulate independently with or without assistive devices. Upon admission to the facility Resident #3's FL-2 and assessment stated that he could ambulate with the aide of a can and to use a wheelchair for long distances outside. This was verified by the administrator upon entry into the facility by resident 3 demonstrating the following: •The resident must independently ambulate with a walker or cane as follows •Push off a chair or bed to come to a standing position . •Hold the cane walker on the hand grips for stability. •Lift the cane walker. Placing it in front of them while leaning their body slightly forward . Walk with the cane or walker. Supporting their body weight on their hands when advancing permitting partial weight bearing or non-weight bearing as prescribed •Balance themselves on their feet. •Lift the walker or cane. and place it in front them again •Look up as they walk . The use of a wheelchair by resident #3 was not due to the inability to ambulate but served as a confidence toold for resident when walking long distances outside the facility and to ease the discomfort of client's right ankle pain due arthritis and some edema.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Regina B. Williamson — TITLE: Administrator — (X6) DATE: 8/14/23

Reviewed and acknowledged 08/09/23.
kg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on July 11, 2023-July 12, 2023.	C 000	In Regards to 10A NCAC 13 G, 0206 Capacity Residents were immediately assessed to determine their ability to evacuate independently in the event of a fire or disaster.	7/12/23
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007	This assessment included a review of Residents' assessments, FL-2s and Careplan. All documentation stated that residents could ambulate independently with or without assistive devices. Upon admission to the facility Resident #3's FL-2 and assessment stated that he could ambulate with the aide of a can and to use a wheelchair for long distances outside. This was verified by the administrator upon entry into the facility by resident 3 demonstrating the following: •The resident must independently ambulate with a walker or cane as follows •Push off a chair or bed to come to a standing position . •Hold the cane walker on the hand grips for stability. •Lift the cane walker. Placing it in front of them while leaning their body slightly forward . Walk with the cane or walker. Supporting their body weight on their hands when advancing permitting partial weight bearing or non-weight bearing as prescribed •Balance themselves on their feet. •Lift the walker or cane. and place it in front them again •Look up as they walk . The use of a wheelchair by resident #3 was not due to the inability to ambulate but served as a confidence toold for resident when walking long distances outside the facility and to ease the discomfort of client's right ankle pain due arthritis and some edema.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 007	Continued From page 1 building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 2 of 4 sampled residents (#2 and #3) who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 07/11/23. Review of the facility's fire rehearsal schedule revealed: -A fire rehearsal form was conducted on 11/12/22 at 10:00am; 5 residents exited in 2 minutes. -A fire rehearsal form was conducted on 12/03/22 at 1:00pm; 5 residents exited in 3 minutes and 30 seconds. -A fire rehearsal form was conducted on 01/24/23 at 2:00pm; 5 residents exited in 2 minutes and 10 seconds. -A fire rehearsal form was conducted on 02/28/23 at 3:00pm; 5 residents exited in 2 minutes and 15 seconds. -There were no other fire rehearsal forms available to be reviewed.	C 007	Resident 3 was walking prior to admission facility. When resident 3 began to show a decline in his ability to ambulate in mid June, the administrator contacted the family to inform them of his decrease in his ambulatory status and how he was beginning to need some additional assistance more than a few times per week. The administrator gave resident 3's family a notice of discharge on June 28, 2023 due to resident's problems with ambulation. **The administrator contacted the family to determine the status of resident 3 to another the facility. The administrator along with resident 3's family contacted his family physician to change his placement level to accommodate the facility that the family had found.** **The administrator also provided for additional staff to be assist resident 3 should he need one on one assistance until he was transferred.** **This additional staffer was available 24 hours a day and was resided on the grounds of the facility.** **Resident #3 was transferred from the facility on July 31, 2023.** Resident #2 family was contacted about the resident not responding to the fire alarm. The administrator ask the family to bring Resident 2 hearing aides. As a result of resident 2 wearing his hearing aides he was then able to exit the facility for each fire drill that has occurred at least 3 times a week since 4/14/23.	4/13/23 and beyond 7/31/23 7/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 007	Continued From page 2 Interview with the medication aide (MA) on 07/11/23 at 4:10pm revealed: -She did monthly fire drills. -She did not recall when she had last done a fire drill. -She did not know why the last fire rehearsal form completed was dated 02/28/23; she would locate the more recent fire rehearsal forms. -She had done fire drills on different shifts, including third shift. Interview with the facility's Owner/Administrator on 07/11/23 at 4:24pm revealed: -Fire drills were performed monthly, sometimes twice a day. -Residents received no assistance from the staff to exit the facility. -She knew there was one resident who could not exit the facility without assistance and the resident had been given a discharge notice. -She did not recall the date the notice was given, but it was "about two weeks ago." -She had not notified construction there was a non-ambulatory resident at the facility. -She notified the resident's family and the primary care provider. -She did not know she needed to notify construction. Review of Resident #3's discharge notice provided by the Administrator on 07/12/23 at 11:25am revealed Resident #3 had been given a 30-day notice on 06/28/23. [Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.]	C 007	The facility will re-assess and re-evaluate the ambulatory status of all residents. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents are found incapable of the ability to ambulate and exit the facility independently, the administrator will notify OHSR and the facility will follow directives, Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules. All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulating will not be admitted.	**7/14/23 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 3	C 022	In regards tp 10 A NCAC 13 G. 0302 (b) Design and Construction Staff received in-service training on the facility fire safety and evacuation plan. The training included review of the facility disaster plan. the procedures for evacuation during a fire and other disasters, demonstration of evacuation procedures, fire drill procedures and the training on the- proper documentation of drills and rehearsals. The importance. of proper and accurate, documentation of drills was stressed as these reflect the staff competency and residents capability to evacuate and the accessibility of the facility for resident evacuation. The training focused on the following facility policy: Additionally, the administrator or dcsignee will conduct unannounced drills to insure staff competency and residents evacuation ability.	7/17/23 and ongoing
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 4 sampled residents (#2 and #3) who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire rehearsal schedule revealed: -A fire rehearsal form was conducted on 11/12/22 at 10:00am; 5 residents exited in 2 minutes. -A fire rehearsal form was conducted on 12/03/22 at 1:00pm; 5 residents exited in 3 minutes and 30 seconds. -A fire rehearsal form was conducted on 01/24/23 at 2:00pm; 5 residents exited in 2 minutes and 10 seconds.	C 022	The facility will re-assess and re-evaluate the ambulatory status of all residents. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents are found incapable of the ability to ambulate and exit the facility independently, the administrator will notify OHSR and the facility will follow directives, Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules.	7/14/23 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 4 -A fire rehearsal form was conducted on 02/28/23 at 3:00pm; 5 residents exited in 2 minutes and 15 seconds. -There were no other fire rehearsal forms available to be reviewed. Observation of the facility on 07/11/23 between 8:00am-9:00am revealed: -There were 6 male residents residing in the facility. -One resident was preparing to leave the facility for a day program. -There was an electric wheelchair parked at the end of the hallway. Interview with the medication aide (MA) on 07/11/23 at 4:10pm revealed: -She did monthly fire drills. -She did not recall when she had last done a fire drill. -She did not know why the last fire rehearsal form completed was dated 02/28/23; she would locate the more recent fire rehearsal forms. -She had done fire drills on different shifts, including third shift. Interview with the facility's Owner/Administrator on 07/11/23 at 4:24pm revealed: -Fire drills were performed monthly, sometimes twice a day. -Residents received no assistance from the staff to exit the facility. 1. Review of Resident #3's current FL-2 dated 09/09/22 revealed: -Diagnoses included history of cerebrovascular disease, diabetes, hypertension, and edema. -The resident was ambulatory. -The resident required assistance with bathing and dressing.	C 022	All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulating will not be admitted. The facility will insure that all staff adheres to disaster plan and drill procedures. Residents will continue to participate in drills no less than once a month. The administrator will conduct random audits of fire rehearsed log to insure adherence to facility policy. Policy Interpretation and Implementation I. Fire drills are required at least quarterly on each shift. 2, The purpose of the drill is to familiarize all personnel with emergency procedures and to practice the skills needed to ensure the safety of all. 3. The drills are to focus on specific- tasks not routinely performed but critical to the safe management and evacuation of residents, visitors and staff in the event of a real fire. 4.Drills are- serious and not to be taken lightly. Professionalism is expected, and required. 5.Both residents and staff should be included in drill exercises. All facility employees on the premises at the time of a fire drill are required to participate and expected to follow all instructions issued. 6T he emphasis of a drill is to place an emphasis on orderly and safe evacuation procedures rather than on the. duration of an evacuation. 7.Visitors on the premises during a fire drill are required to evacuate the premises. Visitors must follow all instructions issued by staff members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 5 -The resident was incontinent of the bladder. -There was no documentation regarding the resident's orientation. Review of Resident #3's Resident Register revealed an admission date of 09/06/22. Review of Resident #3's assessment and care plan dated 09/25/22 revealed: -The resident had limited ability and was ambulatory with an aid or device; the device needed was a walker and wheelchair for long distances. -The resident had limited strength in his upper right extremities -The resident was sometimes disoriented. -The resident required extensive assistance from staff with bathing. -The resident required limited assistance from staff with toileting, dressing, and grooming/personal hygiene. -The resident required supervision with ambulation. -There was no documentation for the level of assistance needed for transferring. Observation of the facility on 07/11/23 at various times between 8:00am-4:00pm revealed: -Resident #3 was seated in a lift chair. -Resident #3 ate both his breakfast and his lunch sitting in the lift chair. Observation of the facility on 07/11/23 between 2:48pm-2:52pm revealed: -Resident #3 was seated in his lift chair with both legs elevated. -The fire alarm was sounded by the MA. -A loud audible alarm sound was heard through out the facility. -Resident #3 remained seated.	C 022	8.All procedures are expected to be carried out "'live" and not "simulated". 9.A post drill critique, staff discussion/debrief shall be conducted. The results of which will be documented on a standardized Fire Drill Report which shall include the following: o Date and Time of the drill o On which shift the drill was conducted o Staff Members present • Time for evacuation 10. **Residents must exit the facility independently. No physical assistance or verbal prompts may be used to aid the resident's evacuation. Any resident unable to perform the evacuation process due to physical or mental defect will be discharged.** **T**he administrator also provided for additional staff to be assist resident 3 should he need one on one assistance until he was transferred. This additional staffer was available 24 hours a day and was resided on the grounds of the facility. **Resident #3 was transferred from the facility on July 31, 2023.** Resident #2 family was contacted about the resident not responding to the fire alarm. The administrator ask the family to bring Resident 2 hearing aides. **As a result of resident 2 wearing his hearing aides he was then able to exit the facility for each fire drill that has occurred at least 3 times a week since 7/14/23.**	7/31/23 7/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 6 Interview with Resident #3 on 07/11/23 at 2:52pm revealed: -He knew the audible alarm was a fire alarm. -He needed assistance to get out of his chair and into his wheelchair to exit the facility. Interview with the MA on 07/11/23 at 4:01pm revealed: -Resident #3 could stand up but needed assistance to transfer into his wheelchair. -Resident #3 had transferred from the bed to the wheelchair and then into the lift chair in the living room since he moved in "about a year ago." -When she did the last fire drill, Resident #3 did not participate because she would have had to transfer him into his wheelchair. -The Administrator was aware that Resident #3 had needed assistance with transfers since January 2023. Telephone interview with Resident #3's family member on 07/11/23 at 10:41am revealed: -Resident #3 had only been at the facility for a few months. -He did not recall the exact move-in date. -Resident #3 had been having trouble with his ankle. -The Administrator told him last week that if Resident #3's ankle did not clear up he would have to move out of the facility. -The Administrator also gave him a written notice, but he was not sure of the date. -He started looking at other facilities because he knew he could not wait until the last minute to find one if the ankle did not clear up. -He had found a couple of options but was still looking. Second telephone interview with Resident #3's	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 7	C 022		

family member on 07/11/23 at 11:09am revealed the discharge notice was given to him on 06/28/23.

Interview with the facility's Owner/Administrator on 07/11/23 at 10:07am revealed:
-She gave Resident #3's family a discharge notice "about two weeks ago."
-She did not recall the exact date.

Second interview with the facility's Owner/Administrator on 07/11/23 at 11:35am revealed:
-She gave Resident #3's family the notification of discharge on 06/28/23.
-She did not make a copy of the discharge notification.
-Resident #3 started declining "about a month ago."
-She thought that it was just in his head, but when she knew it was not, she told Resident #3's family member the resident needed another level of care.
-She had not talked to Resident #3's family but felt they were looking for other facilities.

Third interview with the facility's Owner/Administrator on 07/11/23 at 4:24pm revealed:
-She knew Resident #3 could not exit the facility without assistance, which was why she had given him and his family a 14-day discharge notice.
-Up until one month ago, Resident #3 would be up in his electric wheelchair from the time he got out of bed until he went back to bed.
-Resident #3 was independent once he was in his wheelchair.
-She did not know if Resident #3 required assistance getting in and out of his wheelchair, but he could get out of the door independently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 8	C 022		

once he was in his chair.
-Resident #3 quit using his electric wheelchair "about a month ago."
-She did not want Resident #3 to use the wheelchair inside the facility because the wheelchair was too big for the facility and the floor had to be repaired because the weight of the wheelchair had torn the floor up.

Review of Resident #3's discharge notice provided by the Administrator on 07/12/23 at 11:25am revealed Resident #3 had been given a 30-day notice on 06/28/23.

Telephone interview with a nurse at Resident #2's primary care provider (PCP) office on 07/12/23 at 3:17pm revealed Resident #3 had not been seen in their office since 09/27/22 and she would not know if he could exit the facility without assistance or not.

2. Review of Resident #2's FL-2 dated 07/07/22 revealed:
-Diagnoses included dementia, neuropathy, hyperlipidemia, hypertension, and chronic kidney disease.
-The resident was constantly disoriented.
-Resident #2 was ambulatory, incontinent of the bladder, and required assistance with bathing, dressing, and feeding.
-Resident #2 wore hearing aids.

Review of Resident #2's Resident Register revealed the Resident Register was from the previous facility; a new Resident Register had not been completed.

Review of Resident #2's care plan dated 08/08/22 revealed:
-The resident was sometimes disoriented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 9	C 022		

forgetful, and needed reminders.
-The resident required extensive assistance with bathing, dressing, and grooming
-The resident required supervision when walking down steps or outside.

Observation of the facility on 07/11/23 between 2:48pm-2:52pm revealed:
-Resident #2 was sitting on the couch.
-A loud audible alarm sound was heard through out the facility.
-Resident #2 watched two other residents walk out the front door of the facility.
-Resident #2 did not move to exit the facility.

Interview with Resident #2 on 07/11/23 at 2:51pm while the fire alarm was sounding revealed:
-He did not hear any alarm.
-He was hard of hearing.

Interview with the MA on 07/11/23 at 4:01pm revealed:
-She had not performed a fire drill since Resident #2 had moved into the facility.
-She was not sure if Resident #2 would be able to hear a fire alarm.
-Resident #2 seemed like he may have some memory issues, but she was just getting to know him, so she could not say for sure.
-Sometimes she would tell Resident #2 something like to come to the dining room table and he would start to do it and then he would just stop and stand there.

Interview with the facility's Owner/Administrator on 07/11/23 at 4:24pm revealed:
-Resident #2 had only been at the facility for one week.
-Resident #2 participated in fire drills at the other facility he resided in before moving to this facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 10 on 07/04/23. -She thought the fire alarm was louder in the other facility. -Resident #2 also had hearing aids at the other facility but had lost them. -If Resident #2 heard the fire alarm he would have known to exit the facility. -She would contact Resident #2's family to get replacement hearing aids. -Even if Resident #2 had hearing aids he would take them out at night and would not be able to hear an alarm. Telephone interview with a nurse at Resident #2's primary care provider (PCP) office on 07/12/23 at 3:56pm revealed: -Resident #2 had a diagnosis of dementia. -Resident #2 had not been evaluated in their office in almost a year and therefore she could not speak to his memory loss. Attempted telephone interviews with Resident #2's family members on 07/12/23 at 12:18pm and 3:35pm were unsuccessful. _____ The facility failed to ensure the building was equipped and maintained in accordance with the facility's license capacity to allow 2 of 6 residents living in the facility who had physical limitations and utilized a wheelchair (#3) and a resident was hard of hearing and had cognitive deficits (#2) to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/11/23 for this violation.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 022	Continued From page 11 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 26, 2023.	C 022		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's FL-2 dated 07/07/22 revealed diagnoses included neuropathy, hyperlipidemia, dementia, hypertension, and chronic kidney disease. Review of Resident #2's Resident Register revealed the Resident Register was for the previous facility; a new Resident Register had not been completed.	C 202	**In regards to 10A NCAC 13G.0702(a) Tuberculosis Test and Medical Examination subsection (a)** The residents record was reviewed to find his other TB skin test. Resident was in a sister facility before moving to his current one. Resident #2's TB test were located from his previous provider and placed in the resident record. The first was given on 4/21/17 and read as a negative result on 4/23/17. The second step was administered on 5/15/17 and read as negative on 5/18/17. The facility will follow the NC Department of Health Service Regulation procedure for the admission of a resident and the documentation needed at admission for TB Testing. As well as the facility policy which state: Each resident must obtain Two-step Tuberculin Skin (TST)Test that is recorded on the FL-2 or other health care record prior to admission. Two step testing documentation will be verified prior to admission if entering from another adult care home, hospital or nursing care facilities. Two step testing is required for residents in adult care homes prior to admission. . If the individual has had a documented TST within the last 12 months that TST can be counted as the first step in 2 step testing. However, in order for the two step to be complete	**7/14/23** **7/14/23 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 202	Continued From page 12 Review of Resident #2's immunization and tuberculosis (TB) skin testing record revealed: -There was documentation of a TB skin test applied on 07/09/19 with a negative reading on 07/11/19. -There was no other documented TB skin tests or results available for review. Interview with the Administrator on 07/12/23 at 1:25pm revealed: -The Administrator's Assistant was responsible for the required documents for the residents such as the TB skin test. -The Administrator's Assistant was not available and she would be taking over the responsibilities for the resident records. -She was not aware Resident #2 only had one TB skin test documented. -She knew Resident #2 had two TB skin tests at the sister facility. -She would locate the second TB skin test and send it to the surveyor. Attempted interview with Resident #2 on 07/11/23 at 10:00am was unsuccessful. As of survey exit, no TB tests were for provided for Resident #2.	C 202	a resident must provide a documented negative TST within the preceding 12 months and should receive a single TST prior to admission and use this result as the second part of the two-step test. If a resident can provide a documented positive TST should have a Record of Tuberculosis Screening completed using the most recent chest x-ray report prior to admission The administrator will verify that the Two step TB testing is current upon each future admission and that it is kept in the resident's record.	
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for	C 242	**In regards to 10A NCAC 13G.0901(a0 Personal Care and Supervision** The administrator conducted a review of all residents nail. She then informed staff of which residents required nail cutting. She also reminded staff of their responsibility in fulfilling personal care for residents and proper documentation of fulfillment.	7/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 13 themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 4 of 4 sampled residents (#1, #2, #3, #4) related to fingernails that needed to be trimmed (#1, #3, and #4) and toenails that needed to be trimmed (#1, #2, #3, and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 03/07/23 revealed: -Diagnoses included schizophrenia, major depressive disorder, and hypertension. -The resident required assistance with bathing. Review of Resident #1's care plan dated 03/07/23 revealed Resident #1 required extensive assistance with bathing and grooming and limited assistance with dressing. Review of Resident #1's personal care record for May 2023, June 2023, and July 2023 for 07/01/23-07/11/23 revealed: -Skin, hair, and foot care were to be provided daily. -There was documentation Resident #1 received assistance with skin care daily. -There was no documentation that nail care had been performed. Observation of Resident #1 on 07/11/23 at 8:26am revealed: -All his fingernails extended one-half to three-fourths of an inch beyond his fingertips. -The second, third, fourth, and fifth toenails on the left foot extended one-fourth of an inch beyond the end of the toe and were thick and	C 242	Staff was instructed to perform nail care on all residents. Staff cut finger nails on 1, 2, 3 and 4. Staff cut toe nails on residents 1 and 2 and 4. and 4. However #4 had to schedule a podiatrist appointment for one of his toe nails. Resident #3 had a podiatrist visit scheduled for 7/31/23. Another resident not listed had a podiatrist visit scheduled for 8/8/23. Additionally staff were informed of the importance of completing all personal care task in a timely manor. The administrator will monitor all personal care task to insure that residents are receiving all needed tasks as outline in their care plans, fl-2 and doctors orders. The administrator or designee will evaluate compliance of staff at least twice a month to insure completion of task and proper documentation of personal care task. All staff have completed the 80 hour personal care training and the Diabetes 101 training. They received an in-service from the facility nurse to review proper documentation and performace of personal care tasks.	7/16/23 7/15/ 23 and ongoing 7/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 14	C 242		

jagged.
-All the toenails on the right foot were thick and jagged; two of the toenails extended one-fourth of an inch beyond the end of the toes.

Interview with Resident #1 on 07/11/23 at 8:26am revealed:
-He needed nail clippers.
-He did not like his fingernails or toenails to be "this long."
-He had not asked anyone to cut his nails, and no one had asked.

Interview with the medication aide (MA) on 07/11/23 at 4:01pm revealed:
-She had noticed Resident #1's fingernails needed to be cut a couple of days ago.
-She told the resident she would get to them before she left the facility on Thursday, 07/13/23.
-She thought she cut Resident #1's fingernails "about a month ago."
-She just had not had time to cut his fingernails yet.
-She helped Resident #1 with his shower but had not noticed his toenails needed to be trimmed.

Refer to the interview with the MA on 07/11/23 at 4:01pm.

Refer to the interview with the Administrator on 07/11/23 at 4:24pm.

2. Review of Resident #4's current FL-2 dated 03/10/22 revealed:
-Diagnosis included schizophrenia, panic disorder, hyperlipidemia, seizure disorder, and unspecified intellectual disabilities.
-The resident required assistance with bathing and dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 15 Review of Resident #4's care plan dated 03/04/23 revealed Resident #4 required extensive assistance with bathing and grooming/personal hygiene and limited assistance with dressing. Review of Resident #4's personal care record for 07/01/23-07/11/23 revealed: -Skin, hair, and foot care were to be provided daily. -There was documentation Resident #4 received assistance with skin care daily. -There was no documentation that nail care had been performed. Observation of Resident #4 on 07/11/23 at 9:48am revealed: -All his fingernails extended one-fourth to three-fourths of an inch beyond his fingertips. -All his toenails extended one-fourth of an inch past the end of his toes and multiple toenails had sharp edges. Interview with Resident #4 on 07/11/23 at 9:48am revealed: -Staff assisted him with bathing. -He did not like his fingernails and toenails long. -He had to ask staff to cut his fingernails and toenails for him. -He had not asked staff to cut his fingernails and toenails for him. Interview with the medication aide (MA) on 07/11/23 at 4:01pm revealed she assisted Resident #4 with his bathing, but she had not noticed his fingernails and toenails needed to be cut. Refer to the interview with the MA on 07/11/23 at 4:01pm.	C 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 16 Refer to the interview with the Administrator on 07/11/23 at 4:24pm. 3. Review of Resident #2's FL-2 dated 07/07/22 revealed: -Diagnoses included neuropathy, hyperlipidemia, dementia, hypertension, and chronic kidney disease. -Resident #2 required assistance with bathing, feeding, and dressing. Review of Resident #2's care plan dated 08/08/22 revealed Resident #2 required extensive assistance with bathing, dressing, and grooming/personal hygiene. Review of Resident #2's personal care record for 07/01/23-07/11/23 revealed: -Skin, hair, and foot care were to be provided daily. -There was documentation Resident #2 received assistance with skin care on 07/01/23-07/02/23, and 07/04/23-07/10/23, there was no documentation for 07/03/23. -There was no documentation that nail care had been performed. Observation of Resident #2's toenails on 07/11/23 at 10:00am revealed: -The first toe on his right foot had a toenail that extended one-fourth of an inch past the end of his toe and half of the nail had been broken off leaving the toenail sharp and jagged. -The other toenails on the right foot were uneven and jagged. -The fifth toe on his left foot extended beyond the end of the toe and was jagged. Interview with Resident #2 on 07/11/23 at 9:59am revealed:	C 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 17	C 242		

-He thought he had been at the facility for 3-4 months.
-He thought he had one toenail that needed to be cut.

Interview with the medication aide (MA) on 07/11/23 at 4:17pm revealed Resident #2 had been at the facility "about a week" and she had not noticed his toenails.

Refer to the interview with the MA on 07/11/23 at 4:01pm.

Refer to the interview with the Administrator on 07/11/23 at 4:24pm.

4. Review of Resident #3's current FL-2 dated 09/09/22 revealed:
-Diagnoses included a history of cerebrovascular disease, diabetes, hypertension, and edema.
-The resident required assistance with bathing and dressing.

Review of Resident #3's assessment and care plan dated 09/25/22 revealed:
-The resident had limited strength in his upper right extremities
-The resident required extensive assistance from staff with bathing.
-Staff would provide nail care.

Review of Resident #3's after visit summary dated 09/27/22 revealed:
-Resident #3 had been seen by his primary care provider (PCP).
-There was documentation that Resident #3 had an appointment with a podiatrist on 09/30/22 at 11:30am.

Observation of Resident #3's fingernails and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 18	C 242		

toenails on 07/11/23 at 6:15pm revealed:
-Resident #3's fingernails on his left hand extended past the end of each finger one-fourth an inch.
-Resident #3's fingernails on his right hand extended past the end of each finger three-eighths to one-half inch.
-Resident #3's feet were dry and crusty.
-The first toenail on his left foot was thick and jagged.
-The second and third toenails had grown over the end of the toes and had curled underneath the toe; the third toenail had began to curl over the end of the toe.
-The first toenail on his right foot was thick and jagged.
-The second toenail had grown over the end of the toe and curled underneath the toe.

Review of recommendations for foot care from the American Diabetes Association (ADA) revealed:
-Diabetics should wash their feet well every day.
-They should dry their feet carefully and apply a gentle moisturizer.
-Toenails should be kept trimmed because long or thick nails could press on neighboring toes and cause open sores.
-Be sure to trim toenails straight across and use an emery board to file down any sharp edges.

Interview with Resident #3 on 07/11/23 at 6:08pm revealed:
-He did not like his fingernails long and they needed to be cut.
-He needed his toenails cut too.
-He did not recall who last cut his nails or when his nails had been cut.

Interview with the medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 19 07/11/23 at 6:09pm revealed: -She had noticed Resident #3's fingernails and toenails needed to be cut but she could not do them because he was diabetic and needed to see a podiatrist. -She did not know if an appointment had been made for Resident #3 to see a podiatrist. -The Administrator was responsible for making appointments. Interview with the Administrator on 07/11/23 at 4:29pm revealed: -The MAs were responsible for cutting the resident's fingernails and toenails unless the resident was diabetic and diabetic residents went to a podiatrist for foot care. -The MA could cut the residents' fingernails. -She would have expected the MA to tell her when a resident needed to be seen by a podiatrist. -She was concerned the residents' needs were not getting met by the MA. -She had told another [named] MA to cut Resident #3's fingernails last week. Telephone interview with a nurse at Resident #2's primary care provider (PCP) office on 07/12/23 at 3:17pm revealed Resident #3 had not been seen in their office since 09/27/22 and she could not answer any questions related to podiatry needs. Attempted telephone interview with Resident #3's podiatrist on 07/12/23 at 8:19am and 10:28am was unsuccessful. Attempted telephone interview with the [named] MA on 07/12/23 at 3:16pm was unsuccessful. Refer to the interview with the MA on 07/11/23 at 4:01pm.	C 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 242	Continued From page 20 Refer to the interview with the Administrator on 07/11/23 at 4:24pm. _____ Interview with the MA on 07/11/23 at 4:01pm revealed: -She assisted all residents in and out of the bathtub and washed their back and their feet. -She was responsible for cutting the residents' fingernails and toenails unless the resident was diabetic. -She had not had time to cut the resident's fingernails because she had been very busy trying to do everything that needed to be done in the facility and assisting at the sister facility next door when needed. Interview with the Administrator on 07/11/23 at 4:24pm revealed: -Staff were responsible for cutting the residents' fingernails and toenails. -If a resident was diabetic, the resident would need to be seen by a podiatrist. -She had a meeting less than a month ago with all staff and told them to assist every resident with their shower, assess their skin, wash the residents' feet and ankles, and make sure their nails were trimmed. -She was concerned the residents' needs were not getting met by the MA. -These needs would not be missed if the staff were doing what they were supposed to be doing.	C 242		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from	C 249	**In regards to 10 NCAC 13 G. 09902 (C)(3) (4) Health Care** The administrator met with staff and instructed them to complete and document all health care actions. She also reminded staff of the proper	7/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 249	Continued From page 21 a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure orders were implemented and documented for 1 of 3 sampled residents (#3) related to the application and removal of compression stockings. The findings are: Review of Resident #3's current FL-2 dated 09/09/22 revealed: -Diagnoses included history of cerebrovascular disease, diabetes, hypertension, and edema. -The resident required assistance with bathing and dressing. Review of Resident #3's assessment and care plan dated 09/25/22 revealed: -The resident had limited strength in his upper right extremities -The resident required extensive assistance from staff with bathing. -The resident required limited assistance from staff with toileting, dressing, and grooming/personal hygiene. Review of Resident #3's physician's order dated 10/11/22 revealed an order for compression stockings daily. Review of Resident #3's Licensed Health Professional Support (LHPS) assessment form dated 04/22/23 revealed:	C 249	methods to remove and apply ted hose. The administrator reviewed the order for the ted hose with the staff and how to document completion of the task. Additionally the administrator will verify that all physician orders are completely followed through and documented in the health service record of each client. The administrator will review all physician orders upon the return of each resident from the physician or evaluation of a resident by another health care provider. The administrator will document her review and insure that proper treatment is giving from the time of the visit or evaluation to its completion and thereafter. Additionally, the administrator will insure that any resident orders are gone over with staff from the addition of the order and that staff sign to state that they understand and can provide the service to the resident. The administrator will insure that SICs properly document the administration of an order or a medication in the resident's record, whether it be on the MAR or in the Health Service Section of the resident's record. An in-service review with staff covering medical documentation and to review and validate staff competency in performance of LHPS task. Each staff continued to demonstrate the ability to complete specified lhps tasks and competency evaluation.	7/16/23 and ongoing 7/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 249	Continued From page 22 -Resident #3 required assistance with applying and removing compression stockings. -Resident #3 complained about his legs hurting and feeling weak. -There was increased edema noted in both ankles and legs, with edema more prominent in his right foot and ankle. -Staff demonstrated proper techniques for applying and removing Resident #3's compression stockings. Review of Resident #3's May 2023, June 2023, and July 2023 for 07/01/23-07/11/23 medication administration record (MAR) revealed there was no entry for compression stockings daily. Observation of Resident #3 on 07/11/23 at various times between 8:00am-3:00pm revealed: -At various times between 8:00am-3:00pm, Resident #3 was sitting in a chair with his legs elevated and he was not wearing compression stockings. -At various times between 8:00am-3:00pm, Resident #3 had on soft black socks that were creased in multiple places. -At 2:56pm, when Resident #3's socks were pulled down, his legs were indented in multiple places where the socks were creased. -At 2:58pm, the medication aide (MA) was applying Resident #3's compression stockings over the top of his soft black socks. -At 2:59, when the socks were removed the resident had indentions on his legs where the socks were creased. Interview with the MA on 07/11/23 at 2:58pm and 4:01pm revealed: -She did not know she should not apply compression hose over the socks that were creased.	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 249	Continued From page 23 -She usually applied Resident #3's compression stockings in the mornings when she assisted him with dressing. -She "just forgot" to apply Resident #3's compression stockings today, 07/11/23. -She did not document when the compression stockings were applied or removed. Interview with Resident #3 on 07/11/23 at 6:08pm revealed he did not wear compression stockings every day, maybe twice a week. Interview with the Administrator on 07/12/23 at 1:10pm revealed: -The MA was responsible for making sure Resident #3's compression stockings were applied every day. -Staff had never documented when they applied compression stockings. -Every day that she saw Resident #3 he was wearing compression stockings. -"It was not too many days she could remember him not having them on." -She expected the MA to apply the compression stockings every day as ordered and to let her know if the resident did not wear them, such as a refusal. Attempted telephone interviews with the provider who wrote the order for the compression stockings on 07/12/23 at 8:22am and 10:20am was unsuccessful. Attempted telephone interview with the facility's contracted LHPS nurse on 07/12/23 at 10:27am was unsuccessful.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330	In Regards to 10 NCAC 13 G. 1004 (a) Medication Administrationo	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 24 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents related to a hypertensive medication, a blood thinner, and a pain medication (#2). The findings are: Review of Resident #2's current FL-2 dated 07/07/22 revealed diagnoses included neuropathy, hyperlipidemia, dementia, hypertension, and chronic kidney disease. Interview with the medication aide (MA) on 07/11/23 at 12:50pm Resident #2 moved into the facility the afternoon of 07/03/23. a. Review of Resident #2's FL-2 dated 07/07/22 revealed an order for Amlodipine (used to treat high blood pressure) 10mg daily. Review of Resident #2's medication administration record for 07/03/23-07/11/23 revealed: -There was an entry for Amlodipine 10mg with a scheduled administration time of 8:00am. -There was no documentation Amlodipine 10mg had been administered from 07/03/23-07/11/23;	C 330	On 7/13/23 the administrator contacted the facility pharmacy to inquire on the status of medications for resident #2. The pharmacy informed the administrator that they have not received response from the provider concerning the refills. The administrator contacted the provider directly. The provider then refilled all of Resident 2 medication. They also informed the administrator that no refill request had been received from the pharmacy. In fact the facility pharmacy was contacting the wrong provider's office for Resident 2. The medication was delivered to the facility to include Amlodipine ,Aspirin , Pregabalin. The administrator will conduct random monthly audits to insure that Medication aides review all MARs and medication to insure accuracy with all physician orders. Additionally, the facility will insure that all physician orders are faxed to the pharmacy upon any visit that residents with their physician to insure accuracy and clarification. All orders will then be placed in the resident record. The facility will insure that all staff completes annual continuing education requirement for medication aides. The facility will also audit medication records in between pharmaceutical reviews to insure compliance. Staff will familiarize and adhere to the facility's policy for medication orders. An in-service training on medication documentation and administration for staff	7/13/23 7/15/23 7/15/23 and ongoing 7/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 25 there were no exceptions documented. Observation of Resident #2's medications on hand on 07/11/23 at 5:53pm revealed there was no Amlodipine available to be administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/12/23 at 9:00am revealed: -Resident #2 had received medications from this pharmacy when he resided at the sister facility. -Amlodipine 10mg was last filled on 02/27/23 for a 30-day supply. -The medication was cycled filled, but the 02/27/23 dispensing was the last refill available on the prescription. -The facility's primary care provider (PCP) was the primary contact for this medication. -There had been no refill requests from the current facility for this medication. -The pharmacy had requested refills from Resident #2's on 04/20/23, 05/30/23, 06/06/23, and 07/10/23; no response to the requests were received. -He had not received a discontinued order for Amlodipine 10mg daily. -He did not know what the staff's responsibility was for refills; he could only say what he was responsible for, which was to request refills. -If Resident #2 did not receive his Amlodipine medication as ordered, the resident may have an increase in his blood pressure. Observation of Resident #2's BP on 07/12/23 at 12:49pm revealed a BP of 186/59. Interview with the medication aide (MA) on 07/12/23 at 12:50pm revealed: -She had seen Amlodipine 10mg listed on Resident #2's MAR from the sister facility.	C 330	The designated staff person for medication administration will be responsible for checking medication supply routinely to ensure adequate amount for administration. A request for more medication will be made to the residential provider in an adequate amount of time to prevent running out of the medication. If there is no medication available, the designated staff person will contact the residential provider to bring the medication into SHACH. Staff will document administration of medications/treatments on the monthly medication sheet by: 1. Ensuring the person's name, allergies, prescriber's name, month, and year are on the monthly medication sheet. 2. Completing documentation on the monthly medication sheet in black ink. 3. Ensuring whiteout, erasing, or disfigurement, such as scratching out are not used at any time. Schedule II controlled substances, will be stored in a double locked storage area permitting access to the person served and staff authorized to administer medications. Staff will maintain a count of all controlled drugs in the facilty.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 26	C 330		

-She did not know if Amlodipine 10mg had been discontinued because the only thing she had seen for Resident #2 was his MAR and medications he brought with him.

Telephone interview with a nurse at the provider's office on 07/12/23 at 3:56pm who signed the FL-2 for Resident #2 revealed:
-Resident #2 was seen in their office on 07/07/22 to complete a FL-2.
-The medications listed on the FL-2 were the medications Resident #2 brought into the office with him on 07/07/22.
-She did not see any documentation related to requests for Resident #2's Amlodipine to be refilled.
-Resident #2 had a diagnosis of hypertension.
-If Resident #2 had not received his Amlodipine, it could be an issue with his BP due to his diagnosis of hypertension.
-They would have expected to have been contacted for a follow-up appointment to assess what Resident #2's current medication needs were.

b. Review of Resident #2's FL-2 dated 07/07/22 revealed an order for Aspirin (used as a blood thinner) 81mg daily.

Review of Resident #2's medication administration record for 07/03/23-07/11/23 revealed:
-There was an entry for Aspirin 81mg with a scheduled administration time of 8:00am.
-There was no documentation that Aspirin 81mg had been administered; there were no exceptions documented.

Observation of Resident #2's medications on hand on 07/11/23 at 5:53pm revealed there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 27	C 330		

no Aspirin available to be administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/12/23 at 9:00am revealed:
-Aspirin 81mg was last filled on 02/27/23 for a 30-day supply.
-The medication was cycled filled, but the 02/27/23 dispensing was the last refill available on the prescription.
-The facility's primary care provider (PCP) was the primary contact for this medication.
-There had been no refill requests from the current facility for this medication.
-The pharmacy had requested refills from Resident #2's on 04/20/23, 06/06/23, and 07/10/23; no response to the requests were received.
-He had not received a discontinued order for Aspirin 81mg daily.
-Aspirin was used as a blood thinner and if the medication was not received the resident would not receive the benefits of a blood thinner and could have increased the chance for a blood clot.

Interview with the medication aide (MA) on 07/12/23 at 12:50pm revealed:
-She had seen Aspirin 81mg listed on Resident #2's MAR from the sister facility.
-She did not know if Aspirin 81mg had been discontinued because the only thing she had seen for Resident #2 was his MAR and medications he brought with him.
-She had not called any other providers for refills for Resident #2's Aspirin.

Telephone interview with a nurse at the provider's office on 07/12/23 at 3:56pm who signed the FL-2 for Resident #2 revealed:
-She did not see any documentation related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 28	C 330		

requests for Resident #2's Aspirin to be refilled.
-If Resident #2 had not received his Aspirin, it could increase his risk of blood clots.

c. Review of Resident #2's FL-2 dsted 07/07/22 revealed an order for Pregabin (used to treat nerve pain) 50mg three times daily.

Review of Resident #2's medication administration record (MAR) for 07/03/23-07/11/23 revealed:
-There was an entry for Pregabalin 50mg take one tablet three times daily with a scheduled administration time of 8:00am, 1:00pm, and 8:00pm.
-There was no documentation that Pregabalin 50mg had been administered from 07/03/23-07/11/23; there were no exceptions documented.

Observation of Resident #2's medications on hand on 07/11/23 at 5:53pm revealed there was no Pregabin available to be administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/12/23 at 12:21pm revealed:
-The original prescription for Pregabalin was received on 11/08/22 from the facility's primary care provider (PCP).
-Pregabin 50mg was last filled on 05/02/23 for 90 tablets which was a 30-day supply.
-The dispensing on 05/02/23 was the last refill on that prescription.
-There had been no refill requests from the current facility for this medication.
-The pharmacy had requested refills from the PCP on 06/06/23 and 07/10/23; no response to the requests was received.
-He had not received a discontinued order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 29 Pregabalin daily. -Pregabalin was used to treat nerve pain and without the medication, the resident could experience an increase in pain. Interview with the medication aide (MA) on 07/12/23 at 12:50pm revealed: -She had seen Pregabin listed on Resident #2's MAR from the sister facility. -She did not know if Pregabin had been discontinued because the only thing she had seen for Resident #2 was his MAR and medications he brought with him. -Resident #2 had not complained of any pain to her. Telephone interview with a nurse at the provider's office on 07/12/23 at 3:56pm who signed the FL-2 for Resident #2 revealed: -She did not see any documentation related to requests for Resident #2's Pregabalin to be refilled. -Resident #2 had a diagnosis of polyneuropathy and without the Pregabin, the resident could have been in discomfort. _____ Interview with the medication aide (MA) on 07/12/23 at 12:50pm revealed: -She had called the PCP listed on Resident #2's MAR and the PCP told her she was not the resident's PCP and that she only did psychiatric medications. -When she called the pharmacy they had the facility's contracted PCP also listed as the provider for those medications. -She had not called any other providers for Resident #2. -She had not called the provider who signed Resident #2's FL-2 for medication refills.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 330	Continued From page 30 Telephone interview with a nurse at the provider's office on 07/12/23 at 3:56pm who signed the FL-2 for Resident #2 revealed: -Resident #2 was seen in their office on 07/07/22 to complete a FL-2. -The medications listed on the FL-2 were the medications Resident #2 brought into the office with him on 07/07/22. -They would have expected to have been contacted for a follow-up appointment to assess what Resident #2's current medication needs were. Interview with the Administrator on 07/12/23 at 1:25pm revealed: -She was not aware Resident #2 did not have his medications sent from the sister facility. -The MA would have been responsible for contacting the pharmacy to have the medications refilled and to let her know immediately so she could follow up as well. -Had she known the medication was not available to be administered she would have called the pharmacy and the PCP if needed. -The facility's PCP had been seeing Resident #2. -She was not aware the facility's PCP said she was only following Resident #2 for psychiatric medications. -If the facility's PCP did not want to refill the medications, she would have sent the resident back to his previous PCP. Attempted interview with Resident #2 on 07/11/23 at 10:00am was unsuccessful. Attempted telephone interviews with the facility's contracted PCP on 07/12/23 at 8:22am and 10:20am was unsuccessful.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 367	Continued From page 31	C 367		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 1 of 2 sampled residents (Resident #2) who had an order for a controlled substance medication used to treat insomnia. The findings are: Review of Resident #2's FL-2 dated 07/07/22 revealed diagnoses included dementia, neuropathy, hyperlipidemia, hypertension, and chronic kidney disease. Review of Resident #2's physician orders revealed there was no order for Zolpidem Tartrate (used to treat insomnia) 5mg take one tablet in the evening as needed if the resident awakens and was unable to sleep. Review of Resident #2's medication administration record (MAR) for 07/01/23-07/11/23 revealed: -There was an entry for Zolpidem Tartrate 5mg take one tablet in the evening as needed if the resident awakens and was unable to sleep. -The dates of 07/01/23-07/05/23 were marked out	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 367	Continued From page 32	C 367		

on the MAR for Zolpidem Tartrate.
-There was documentation Zolpidem Tartrate was administered on 07/06/23 and 07/10/23.
-There was no documentation Zolpidem Tartrate was administered on 07/07/23, 07/08/23, or 07/09/23.

Review of Resident #2's controlled substance count sheets (CSCS) revealed:
-There was an order for Zolpidem Tartrate 5mg take one tablet in the evening as needed if the resident awakens and was unable to sleep dispensed on 01/13/23 for 30 tablets.
-On 07/06/23, the name of the person administering the medication was documented; there was no time documented, the amount on hand was documented as 30, the amount given was 1 and the amount remaining was 29.
-The date, amount received, the amount given, and the amount remaining was pre-filled in from 07/07/23-07/09/23; no name of the person giving, or time was documented.
-On 07/09/23, the name of the person administering the medication was documented, but there was no time documented, the amount on hand was documented as 26, the amount given was 1, and the amount remaining was 25.

Observation of Resident #2's medication on hand on 07/11/23 at 5:53pm revealed:
-There was a punch card for Zolpidem Tartrate 5mg take one tablet in the evening as needed if the resident awakens and was unable to sleep was dispensed on 01/13/23 for 30 tablets.
-There were 25 tablets remaining in the punch card; 5 tablets had been punched from the card.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/12/23 at 9:00am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 367	Continued From page 33	C 367		

-Resident #2's original prescription for Zolpidem Tartrate 5mg take one tablet in the evening as needed if the resident awakens and was unable to sleep which was received on 12/08/22.
-Zolpidem Tartrate had been dispensed on 12/08/22 and 01/13/23 for 30 tablets each dispensing.
-CSCS were provided with each dispensing.
-The administration of controlled medication should be documented on the CSCS and the MAR each time the medication was administered.

Interview with the medication aide (MA) on 07/12/23 at 12:50pm revealed:
-She documented on the MAR and the CSCS when she administered a controlled substance.
-She was supposed to document on the back of the MAR when she administered a controlled substance for effectiveness.
-She did not know why she did not document on the back of the MAR for 07/06/23 and 07/10/23.
-She documented on the CSCS when she administered Resident #2's Zolpidem Tartrate.
-She did not know why she did not document a time when she administered the medication.
-She did not work on 07/07/23-07/09/23 and did not know why those dates had not been signed by a [named] MA.

Interview with the Administrator on 07/12/23 at 1:25pm revealed:
-When the MA administered a controlled medication, the MA should document on the CSCS and sign the MAR the medication had been administered.
-She was concerned the MAs were not documenting the administration of controlled medication on the MAR and CSCS as instructed.

Attempted interview with Resident #2 on 07/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079086	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN ADULT CARE HOME	165 GLENDALE DRIVE EDEN, NC 27288

(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) COMPLETE DATE
C 367	Continued From page 34 at 10:00am was unsuccessful. Attempted telephone interview with the [named] MA on 07/12/23 at 3:16pm was unsuccessful.	C 367		