

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/08/2025
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN ADULT CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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 and a follow-up survey on 10/08/25.	C 000	In regards to 10A NCAC 13.G .0903(c) Licensed Health Professional Support	
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 3 sampled residents (#3) who had an LHPS task of fingerstick blood sugar (FSBS) checks.	C 254	The facility contacted the contracted nurse for the facility to obtain copies of the last LHPS's for the resident #3. The nurse stated that he did have copies of the LHPSs for December 2024, March 2025, June 2025 and September 2025. The nurse stated that he would bring those copies out to the facility. The copies were placed in Resident #3 chart on 10/11/2025, The facility will ensure that LHPS are completed quarterly on any resident that are required to have them and the LHPS are placed in the resident record. The facility will do an audit of resident records quarterly to ensure compliance.	10/9/2025 10/11/2025 and ongoing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

F00C11

TITLE

(X6) DATE

If continuation sheet 1 of 3

" Reviewed and Acknowledged " 12/10/2025 CPP