PRINTED: 04/14/2011 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULT	IPLE CONSTRUCTION IG	(X3) DATE S COMPL	
	345425		B. WING _		03/3	31/2011
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIF 49 FAIR HAVEN DRIVE 30STIC, NC 28018		114011
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 281 SS=E	483.20(k)(3)(i) SER PROFESSIONAL S	VICES PROVIDED MEET STANDARDS	F 281	F281	, <u>, , , , , , , , , , , , , , , , , , </u>	
	The services provided or arranged by the facility must meet professional standards of quality.			No negative impact was any of the sampled resid those documents that w	ents. For	
	by: Based on observation medical record review medication orders for	ons, staff interviews and ews, the facility failed to clarify or six of ten sampled at 2, 3, 6, 7, 9, and 10)		be affected, the correction of with clarifications writte 3/31/2011.	the orders n. Completed	
	The findings are:  1. Resident #6 was admitted 5/2/08 with diagnoses including syncope, normal pressure hydrocephalus, and dementia. The annual Minimum Data Set dated 3/10/11 revealed severe cognitive impairment, dependence on staff for activities of daily living, and oxygen therapy.			The DON met with the p review those residents' o		
i				had the potential to be a the same practice. All ch reviewed and any discre immediately corrected a clarifications written. Co	narts were pancies were nd	
	Resident #6 was ob- medications, which inhaler, from Licens	Pass on 3/30/11 at 8:55 a.m., served as she received her included a Pro Air HFA ed Nurse (LN) #1. The eive medication from a second		3/31/2011.  To ensure the deficient protection of reoccur, the facility of the shift nurse to review admission or clarification	will have the any new,	
	a Physician's Teleph the following: "Albute [chlorofluorocarbon] [per] inhalation two p Further record revies Physician's Telepho	ent's medical record revealed none Order dated 3/6/11 for erol [bronchodilator] CFC free 90 mcg [micrograms]/ ouffs qid [four times daily]." w revealed a 3/11/11 ne Order to discontinue the		accuracy. The nurse will process from recording of telephone orders to the order to the MAR. Speciwill be placed on review	review the on the physician's fic attention ing that the	
	Albuterol CFC free inhaler order.  Review of the resident's March 2011 Medication			transcription is for the ri with the correct drug an	-	(X6) DATE

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 grape 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.

Original Signature Date: 4-22-11

MAY 1 9 2011

OUNTERS FOR MEDICARE & MEDICARD SERVICES			<del>.</del>	ONID NO.	OMP 140. 0930-0391		
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345425		(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE		
			B. WING	<b>3</b>	03/3	1/2011	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
FAIR HA	VEN HOME INC			149 FAIR HAVEN DRIVE BOSTIC, NC 28018			
	0.0000000000000000000000000000000000000	THE RESIDENCE OF THE PERSON OF			200000000000000000000000000000000000000	T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACT)  CROSS-REFERENCED TO T  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281	Continued From pa	ge 1	F 28	correct time of administra	ation by the		
	Administration Rec			right route. All licensed r			
		haler order with the Albuterol ted as well as "Pro Air HFA		has been inserviced on th	e 5 rights of		
	(hydrofluoroalkane,	a CFC free inhaler] 90 mcg		medication administration	n and order		
	inhaler take 2 puffs po [by mouth] 4x [times] /day." Continued review of the MAR revealed both medications were initialed as administered from			transcription. Inservices have been			
				completed by the DON ef	completed by the DON effective		
	3/6/11-3/11/11.		•	3/31/2011. A monitoring	tool has		
	During an interview on 3/30/11 at 9:40 a.m., LN #1 was asked about the two inhaler medications listed on the MAR. The nurse said it took her until 3/11 to realize they were the same medication. She stated she reported it to the Nursing			· •	been developed for the nurse to		
				document that she has ch	ecked the		
				new orders and will document			
				discrepancies were found			
	Supervisor and the	Nursing Supervisor		orders are received by the			
		e inhaler order. LN #1 was ason why she initialed both		nurse, they will be report			
	medications as adn	ninistered but she stated only		oncoming nurse and chec			
	one inhaler had bee	en in use.		accuracy. If any nurse fin			
	Interview with the N	ursing Supervisor on 3/30/11		discrepancies, clarification			
	at 10:05 a.m. revea	led a second -shift nurse, who		be written immediately a			
		ring the survey, had added the lation on the MAR after the		be notified. In addition to			
	pharmacy sent the	resident's medications		checks by LPN, the Pharm			
		ht she needed to write it that		continue to review charts	•		
	way. The Nursing S	Supervisor stated the nurse tinued the other inhaler order		accuracy. Results will be			
	at that time.			on monthly Consultant Ph		1	
	Talanhana intensias	u on 2/20/11 at 10/20 a m with		Report. If the pharmacist			
		v on 3/30/11 at 10:20 a.m. with facility's pharmacy service		discrepancies the medica			
	revealed only one in	nhaler, the Pro Air HFA, had		review form will be comp	· ·		
	been sent for the re	esident.		pharmacist and addresse	<del>-</del>		
	During an interview	on 3/30/11 at 3:30 p.m., the		The monthly reviews will			
	Director of Nursing	(DON) stated medication		monitoring of the 5 rights			
!		ritten correctly, and if there are		Patient, Right Drug, Right	Dose, Right		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		345425					
NAME OF PROVIDER OR SUPPLIER  FAIR HAVEN HOME INC				1	REET ADDRESS, CITY, STATE, ZIP CODE 49 FAIR HAVEN DRIVE BOSTIC, NC 28018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	clarify the orders. T should only sign for the resident.  2. Resident #7 was diagnoses including dizziness. The adm dated 3/25/11 revea cognitively intact an activities of daily living Review of the Physical 3/17/11-3/31/11 revea handwritten order: (micrograms] IM (interior fine March 2011 March	he DON confirmed nurses medications administered to admitted 3/17/11 with cardiac dysrhythmias and ission Minimum Data Set aled the resident was dindependent with mosting.  Ician's Orders for ealed the following Cyanocobalamin 1110 mcg tramuscular] monthly. Review Medication Administration led the same order for 10 mcg IM monthly was form, but there were no cating the medication was  on 3/31/11 at 11:10 a.m., the confirmed she wrote the order Orders sheet and the MAR, is should have been for 1000 incg as written. She said the received the medication monthly and he was admitted ald not receive it until the onth. The Nursing Supervisor only comes in a 1000mcg was busy and just wrote 1110 justion, the dose would have	F 2		Time and Right Route). If the charmacist finds discrepancies, larification orders will be writted mmediately and DON will be not not on order to monitor the perform of this correction, daily monitor tools and Consultant Pharmacis Reports will be presented in the Quality Assurance Meeting monthe Quality Assurance Team will review the monitoring tools for discrepancies and take correctivations as needed.  Plan of Correction will be completely 5/1/2011.	otified. nance ing t e nthly. II	
	3 Resident #10 was	s readmitted 10/2/10 with					1

Event ID: UF7E11

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345425	B. WING		03/31/2011		
NAME OF PROVIDER OR SUPPLIER FAIR HAVEN HOME INC				14	EET ADDRESS, CITY, STATE, ZIP CODE 19 FAIR HAVEN DRIVE OSTIC, NC 28018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETION DATE	
F 281	altered mental statu- quarterly Minimum moderately impaired on staff for activities Review of the residerevealed a Physicia 11/16/10 for Cipro [ mouth every other of Review of the Nove Administration Reco was correctly transo Review of the Dece revealed the followin Take 1 tablet every December 2010 and revealed the followin tablet every other do the medication was December 2010 und During an interview Director of Nursing should specify the re- inconsistencies with clarify the orders. 4. Resident #3 was diagnoses including with Hemodialysis at The most recent Mi- indicated no impair dependence on staff Review of the mont March 2011 revealer restrictions. Review	j urinary tract infection [UTI], is, and acute bronchitis. The Data Set dated 12/30/10 d cognition and dependence of daily living.  ent's closed medical record in Telephone Order dated antibiotic] 500 milligrams by day for chronic/recurrent UTI. in the 2010 Medication ord (MAR) revealed the order cribed.  mber 2010 Physician's Orders ing order: "Cipro 500 mg tablet other day." Review of the d January 2011 MARs ing: "Cipro 500 mg Take 1 ay." Initialed entries indicated administered during	F 2	281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345425		B. WING	·	03/31/2011		
	PROVIDER OR SUPPLIER		149	ET ADDRESS, CITY, STATE, ZIP CODE 9 FAIR HAVEN DRIVE DSTIC, NC 28018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 281	potassium and fluid documentation reversithe dialysis provider resident's appointminstructed the nurse potassium and fluid the physician's order On 3/30/11 at 1:45 with the Medical Dirphysician) and the fluid physician stated the Nursing Supervisor and stated the order done for the resider On 3/30/11 at 3:30 Director of Nursing order should not harphysician's order. The staff member provided in the physician's order. The physician is ordered in the physician is not provided in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the physician in the physician is not physician in the phys	intake. Review of nursing saled nursing staff contacted of 3/2/11 to cancel the ent. The dialysis staff member to monitor the resident's intake, and the nurse wrote er.  p.m., the order was reviewed ector (the resident's Nursing Supervisor. The order was "vague." The agreed the order was vague, or didn't specify what should be et.  p.m., interview with the (DON) revealed the 3/2/11 we been written as a the DON stated the dialysis ling instruction to the facility erse, and nurses don't take curses. The DON stated orders with the physician when there admitted 8/18/08 with Dementia and a 2/22/11 fein Thrombosis. The most ta Set dated 1/20/11 indicated of cognition and dependence	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345425		B. WING _		03/3	03/31/2011	
	NAME OF PROVIDER OR SUPPLIER FAIR HAVEN HOME INC			REET ADDRESS, CITY, STATE, ZIP CODE 49 FAIR HAVEN DRIVE BOSTIC, NC 28018			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	dated 3/25/11 direct Cournadin dose at 8 On 3/30/11 at 11:05 were reviewed with Nursing Supervisor order on 3/25/11 to and the order was v Supervisor stated the Cournadin 6 mg dainot transcribed to the Record (MAR).  6. Resident #2 was diagnoses including Contractures, and P Minimum Data Set of impairment of cognistaff assistance for Supervisor of the resident was provided by a general Review of the Physical revealed an order for 22 hours each day, orders revealed the Crestor 40 mg table Actos 15 mg tablet to Ativan 0.5 mg Taked day as needed for a Senokot Stablet Tadaily Norflex 100 mg Taked daily Certagen Liquid Givenilla Certagen Certagen Liquid Givenilla Certagen Liquid Givenilla Certagen Liquid Certagen Liqu	ted staff to keep the 5.5 mg, per day.  5 a.m., the Coumadin orders the Nursing Supervisor. The stated she had written the continue Coumadin 5.5 mg, written incorrectly. The Nursing he resident was receiving ly, and the errant order was he Medication Administration  admitted 2/5/10 with Cerebrovascular Accident, reg Tube. The most recent dated 1/6/11 indicated severe tion and total dependence on all daily care.  esident revealed all intake astric tube.  cian's Orders for March 2011 or tube feeding to be provided Review of the medication following:  t by mouth at bedtime by mouth before breakfast et (1) tablet by mouth twice a	F 281				

TEMENT OF DEFICIENCIES PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345425	B. Wil	NG_		03/3	1/2011
NAME OF PROVIDER OR SUPPLIER FAIR HAVEN HOME INC				49 FAIR HAVEN DRIVE	<u> </u>	1/2011
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
On 3/30/11 at 3:30 stated the resident in tube, and the medic administration via g stated medication of correct route for administration via g stated medication of correct route for administration via g stated medication of correct route for administration of correct route for administration to larger than accordant of the clinical record in the clinical record information to identification to identification screen and progress notes.  This REQUIREMENT by:  Based on medical reinterviews, the facility transcribe physiciant sampled residents reorders. (Resident #60)	co.m., the Director of Nursing received all medications via ation orders should direct tube (gastric tube). The DON orders should reflect the ministration, and if there are orders, the nurses should retrievely the ministration of the ce with accepted professional ices that are complete; ted; readily accessible; and nized.  The plan of care and the results of any ming conducted by the State;  This not met as evidenced record reviews and staff to accurately sorders for one of ten eviewed for medication.			any of the sampled residents. Fe those documents that were four be affected, the corrective action immediate correction of the ord with clarifications written. Community 3/31/2011.  The DON met with the pharmace review those residents' charts that the potential to be affected the same practice. All charts we reviewed and any discrepancies immediately corrected and	or nd to n was lers pleted ist to hat by ere were	
			İ			
	PROVIDER OR SUPPLIER  VEN HOME INC  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From par On 3/30/11 at 3:30 stated the resident r tube, and the medic administration via g stated medication o correct route for adr inconsistencies with clarify the orders. 483.75(I)(1) RES RECORDS-COMPL LE  The facility must ma resident in accordant standards and pract accurately documen systematically organ  The clinical record in information to identify resident's assessme services provided; the preadmission screen and progress notes.  This REQUIREMEN by: Based on medical re interviews, the facility transcribe physician' sampled residents re orders. (Resident #6  The findings are:	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 On 3/30/11 at 3:30 p.m., the Director of Nursing stated the resident received all medications via tube, and the medication orders should direct administration via g-tube (gastric tube). The DON stated medication orders should reflect the correct route for administration, and if there are inconsistencies with orders, the nurses should clarify the orders. 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to accurately transcribe physician's orders for one of ten sampled residents reviewed for medication orders. (Resident #6)	PROVIDER OR SUPPLIER  VEN HOME INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  On 3/30/11 at 3:30 p.m., the Director of Nursing stated the resident received all medications via tube, and the medication orders should direct administration via g-tube (gastric tube). 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(Resident #6)  The findings are:  Resident #6 was admitted 5/2/08 with diagnoses	PROVIDER OR SUPPLIER  WEN HOME INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Conlinued From page 6  On 3/30/11 at 3:30 p.m., the Director of Nursing stated the resident received all medications via tube, and the medication orders should direct administration via g-tube (gastric tube). The DON stated medication orders should reflect the correct route for administration, and if there are inconsistencies with orders, the nurses should clarify the orders.  483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  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The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:  Based on medical record reviews and staff interviews, the facility failed to accurately transcribe physician's orders for one of ten sampled residents reviewed for medication orders. Resident #6)  The findings are:  Resident #6 was admitted 5/2/08 with diagnoses	SUMMARY STATEMENT OF DEFICIENCES  CACHETICAL TOPIC OF A SUMMARY STATEMENT OF DEFICIENCES  CONTINUED  FOR PROVIDERS PLAN OF CORRECTION  PROVIDER SUMMARY STATEMENT OF DEFICIENCES  PROVIDERS PLAN OF CORRECTION  PROVIDER PROVIDERS PLAN OF CORRECTION  PROVIDER PROVIDERS  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS  PROVIDERS  SUMMARY STATEMENT OF DEFICIENCES  PROVIDERS  PROVIDERS  SUMMARY STATEMENT OF DEFICIENCES  PROVIDERS  PROVIDER  PROVIDER  PROVIDER  PROVIDERS  SUMMARY STATEMENT OF CORRECTION  PROVIDER  PROVIDE

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CENTEROT ON MEDIONICE & MEDIONID CENTICES					OIVID 190, 0938-0391			
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345425	B. WII	√G _	<del></del>	03/3	I/2011	
NAME OF F	ROVIDER OR SUPPLIER		<del>-                                    </del>	STE	REET ADDRESS, CITY, STATE, ZIP CODE		- , V   1	
FAIR HA	VEN HOME INC		j	1	49 FAIR HAVEN DRIVE			
				E	BOSTIC, NC 28018			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JI.D BE	(X5) COMPLETION DATE	
F 514	Continued From page	ge 7	F (	514	To ensure the deficient practice	does		
i		dementia. The annual			not reoccur, the facility will have			
		dated 3/10/11 revealed severe			3 <sup>rd</sup> shift nurse to review any new			
		nt, dependence on staff for			•			
į	activities of daily livi	of daily living, and oxygen therapy.			admission or clarification orders			
		ent's medical record revealed			accuracy. The nurse will review	tne		
		none Order dated 3/6/11 for			process from recording on the			
		erol [bronchodilator] CFC   free 90 mcg [micrograms]/			telephone orders to the physicia			
į		puffs gid [four times daily]."			order to the MAR. Specific atter	ition		
	Further record revie	w revealed 3/11/11			will be placed on reviewing that	the		
		ne Order to discontinue the			transcription is for the right patie	ent,		
	Albuterol CFC tree t	ol CFC free inhaler order.			with the correct drug and dose,	the		
į	Review of the reside	ent's March 2011 Medication			correct time of administration b			
	Administration Reco				right route. All licensed nursing			
		naler order with the Albuterol ed as well as "Pro Air HFA			has been inserviced on the 5 rigi			
		a CFC free inhaler] 90 mcg			medication administration and o			
	inhaler take 2 puffs	po [by mouth] 4x [times] view of the MAR revealed both nitialed as administered from			transcription. Inservices have be			
					completed by the DON effective			
!	3/6/11-3/11/11.				3/31/2011. A monitoring tool ha			
 					* ·			
		about the two inhalers on			been developed for the nurse to			
Ì		, LN #1 said it took her until were the same. She stated			document that she has checked			
		r charge nurse and the			new orders and will document if	-		
		ntinued the one inhaler order.			discrepancies were found. If an			
		give a reason why she			orders are received by the 3 <sup>rd</sup> sh	ift		
		ations as administered but she			nurse, they will be reported to t	he		
	stated only one inha	HEI HAU DEEN BI USE.			oncoming nurse and checked for	r		
	Interview with the No	ursing Supervisor on 3/30/11			accuracy. If any nurse finds			
	at 10:05 a.m. reveal	ed a second -shift nurse, who			discrepancies, clarification order	į		
		ing the survey, had added the lition on the MAR after the			be written immediately and DOI			
		esident's medications			be notified. In addition to the d			
		at she needed to write it that			The notified. If addition to the di	uny	l	

Facility ID: 923166

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	IG		
· · · · · ·	345425		B. WII	1G _		03/3	31/2011
	PROVIDER OR SUPPLIER		i	1	REET ADDRESS, CITY, STATE, ZIP CODE 49 FAIR HAVEN DRIVE BOSTIC, NC 28018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	way. The nursing sushould have discontat that time.  During an interview Director of Nursing orders should be wrinconsistencies with clarify the orders. The	ge 8 upervisor stated the nurse tinued the other inhaler order on 3/30/11 at 3:30 p.m., the (DON) stated medication itten correctly, and if there are orders, the nurses should ne DON confirmed nurses medications administered to	F		checks by LPN, the Pharmacist we continue to review charts month accuracy. Results will be docume on monthly Consultant Pharmacist finds discrepancies the medication or review form will be completed by pharmacist and addressed by DC The monthly reviews will include monitoring of the 5 rights (Right Patient, Right Drug, Right Dose, I Time and Right Route). If the pharmacist finds discrepancies, clarification orders will be writte immediately and DON will be not in order to monitor the performation of this correction, daily monitorie tools and Consultant Pharmacist Reports will be presented in the Quality Assurance Meeting mont The Quality Assurance Team will review the monitoring tools for discrepancies and take corrective actions as needed.  Plan of Correction will be completely 5/1/2011.	aly for ent ist der y ON. Right n tified. ance ng	