STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345425	A. BUILDING _____ B. WING _____	03/31/2011

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

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F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews, the facility failed to clarify medication orders for six of ten sampled residents. (Residents # 2, 3, 6, 7, 9, and 10) 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. During Medication Pass on 3/30/11 at 8:55 a.m., Resident #6 was observed as she received her medications, which included a Pro Air HFA inhaler, from Licensed Nurse (LN) #1. The resident did not receive medication from a second inhaler. Review of the resident's medical record revealed a Physician's Telephone Order dated 3/6/11 for the following: "Albuterol [bronchodilator] CFC [chlorofluorocarbon] free 90 mcg [micrograms]/ [per] inhalation two puffs qid [four times daily]." Further record review revealed a 3/11/11 Physician's Telephone Order to discontinue the Albuterol CFC free inhaler order. Review of the resident's March 2011 Medication	F 281	F281 No negative impact was caused for any of the sampled residents. For those documents that were found to be affected, the corrective action was immediate correction of the orders with clarifications written. Completed 3/31/2011. The DON met with the pharmacist to review those residents' charts that had the potential to be affected by the same practice. All charts were reviewed and any discrepancies were immediately corrected and clarifications written. Completed 3/31/2011. To ensure the deficient practice does not reoccur, the facility will have the 3rd shift nurse to review any new, admission or clarification orders for accuracy. The nurse will review the process from recording on the telephone orders to the physician's order to the MAR. Specific attention will be placed on reviewing that the transcription is for the right patient, with the correct drug and dose, the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Suzanne S. Hensley — TITLE: ✓ Administrator ✓ — (X6) DATE: 5/19/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original Signature Date: 4-22-11

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BY:

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F 281	Continued From page 1 Administration Record (MAR) revealed duplication of the inhaler order with the Albuterol CFC free inhaler listed as well as "Pro Air HFA [hydrofluoroalkane, a CFC free inhaler] 90 mcg inhaler take 2 puffs po [by mouth] 4x [times] /day." Continued review of the MAR revealed both medications were initialed as administered from 3/6/11-3/11/11. 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 Supervisor and the Nursing Supervisor discontinued the one inhaler order. LN #1 was unable to give a reason why she initialed both medications as administered but she stated only one inhaler had been in use. Interview with the Nursing Supervisor on 3/30/11 at 10:05 a.m. revealed a second -shift nurse, who was unavailable during the survey, had added the Pro Air HFA medication on the MAR after the pharmacy sent the resident's medications because she thought she needed to write it that way The Nursing Supervisor stated the nurse should have discontinued the other inhaler order at that time. Telephone interview on 3/30/11 at 10:20 a.m. with a pharmacist at the facility's pharmacy service revealed only one inhaler, the Pro Air HFA, had been sent for the resident. During an interview on 3/30/11 at 3:30 p.m., the Director of Nursing (DON) stated medication orders should be written correctly, and if there are inconsistencies with orders, the nurses should	F 281	correct time of administration by the right route. All licensed nursing staff has been inserviced on the 5 rights of medication administration and order transcription. Inservices have been completed by the DON effective 3/31/2011. A monitoring tool has been developed for the nurse to document that she has checked the new orders and will document if any discrepancies were found. If any orders are received by the 3rd shift nurse, they will be reported to the oncoming nurse and checked for accuracy. If any nurse finds discrepancies, clarification orders will be written immediately and DON will be notified. In addition to the daily checks by LPN, the Pharmacist will continue to review charts monthly for accuracy. Results will be document on monthly Consultant Pharmacist Report. If the pharmacist finds discrepancies the medication order review form will be completed by pharmacist and addressed by DON. The monthly reviews will include monitoring of the 5 rights (Right Patient, Right Drug, Right Dose, Right	

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F 281	Continued From page 2 clarify the orders. The DON confirmed nurses should only sign for medications administered to the resident. 2. Resident #7 was admitted 3/17/11 with diagnoses including cardiac dysrhythmias and dizziness. The admission Minimum Data Set dated 3/25/11 revealed the resident was cognitively intact and independent with most activities of daily living. Review of the Physician's Orders for 3/17/11-3/31/11 revealed the following handwritten order: Cyanocobalamin 1110 mcg [micrograms] IM [intramuscular] monthly. Review of the March 2011 Medication Administration [MAR] record revealed the same order for Cyanocobalamin 1110 mcg IM monthly was handwritten on the form, but there were no initialed entries indicating the medication was given. During an interview on 3/31/11 at 11:10 a.m., the Nursing Supervisor confirmed she wrote the order on the Physician's Orders sheet and the MAR, and stated the order should have been for 1000 mcg and not 1110 mcg as written. She said the resident had not yet received the medication because it is given monthly and he was admitted mid-month and would not receive it until the beginning of next month. The Nursing Supervisor said the medication only comes in a 1000mcg dose and stated, "I was busy and just wrote 1110 but if there was a question, the dose would have been clarified." 3. Resident #10 was readmitted 10/2/10 with	F 281	Time and Right Route). If the pharmacist finds discrepancies, clarification orders will be written immediately and DON will be notified. In order to monitor the performance of this correction, daily monitoring tools and Consultant Pharmacist Reports will be presented in the Quality Assurance Meeting monthly. The Quality Assurance Team will review the monitoring tools for discrepancies and take corrective actions as needed. Plan of Correction will be completed by 5/1/2011.	

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F 281	Continued From page 3 diagnoses including urinary tract infection [UTI], altered mental status, and acute bronchitis. The quarterly Minimum Data Set dated 12/30/10 moderately impaired cognition and dependence on staff for activities of daily living. Review of the resident's closed medical record revealed a Physician's Telephone Order dated 11/16/10 for Cipro [antibiotic] 500 milligrams by mouth every other day for chronic/recurrent UTI. Review of the November 2010 Medication Administration Record (MAR) revealed the order was correctly transcribed. Review of the December 2010 Physician's Orders revealed the following order: "Cipro 500 mg tablet Take 1 tablet every other day." Review of the December 2010 and January 2011 MARs revealed the following: "Cipro 500 mg Take 1 tablet every other day." Initialed entries indicated the medication was administered during December 2010 until January 12, 2011. During an interview on 3/30/11 at 3:30 p.m., the Director of Nursing stated medication orders should specify the route, and if there are inconsistencies with orders, the nurses should clarify the orders. 4. Resident #3 was admitted 4/3/02 with diagnoses including End-Stage Renal Disease with Hemodialysis and Congestive Heart Failure. The most recent Minimum Data Set dated 1/6/11 indicated no impairment of cognition and dependence on staff assistance for daily care. Review of the monthly Physician's Orders for March 2011 revealed no order for fluid or dietary restrictions. Review of the written physician orders revealed an order written 3/2/11 to monitor	F 281		

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F 281	Continued From page 4 potassium and fluid intake. Review of nursing documentation revealed nursing staff contacted the dialysis provider 3/2/11 to cancel the resident's appointment. The dialysis staff member instructed the nurse to monitor the resident's potassium and fluid intake, and the nurse wrote the physician's order. On 3/30/11 at 1:45 p.m., the order was reviewed with the Medical Director (the resident's physician) and the Nursing Supervisor. The physician stated the order was "vague." The Nursing Supervisor agreed the order was vague, and stated the order didn't specify what should be done for the resident. On 3/30/11 at 3:30 p.m., interview with the Director of Nursing (DON) revealed the 3/2/11 order should not have been written as a physician's order. The DON stated the dialysis staff member providing instruction to the facility nurse was also a nurse, and nurses don't take orders from other nurses. The DON stated orders should be clarified with the physician when there are inconsistencies. 5. Resident #9 was admitted 8/18/08 with diagnoses including Dementia and a 2/22/11 diagnosis of Deep Vein Thrombosis. The most recent Minimum Data Set dated 1/20/11 indicated severe impairment of cognition and dependence on staff assistance for daily care. Review of the monthly Physician's Orders for March 2011 revealed an order for Coumadin 5.5 mg per day. Review of the written physician orders revealed an order written 3/18/11 to increase Coumadin (blood thinner) to 6 mg. (milligrams) per day. A written physician's order	F 281		

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F 281	Continued From page 5 dated 3/25/11 directed staff to keep the Coumadin dose at 5.5 mg. per day. On 3/30/11 at 11:05 a.m., the Coumadin orders were reviewed with the Nursing Supervisor. The Nursing Supervisor stated she had written the order on 3/25/11 to continue Coumadin 5.5 mg, and the order was written incorrectly. The Nursing Supervisor stated the resident was receiving Coumadin 6 mg daily, and the errant order was not transcribed to the Medication Administration Record (MAR). 6. Resident #2 was admitted 2/5/10 with diagnoses including Cerebrovascular Accident, Contractures, and Peg Tube. The most recent Minimum Data Set dated 1/6/11 indicated severe impairment of cognition and total dependence on staff assistance for all daily care. Observation of the resident revealed all intake was provided by a gastric tube. Review of the Physician's Orders for March 2011 revealed an order for tube feeding to be provided 22 hours each day. Review of the medication orders revealed the following: Crestor 40 mg tablet by mouth at bedtime Actos 15 mg tablet by mouth before breakfast Ativan 0.5 mg Take (1) tablet by mouth twice a day as needed for anxiety Senokot S tablet Take 1 tablet by mouth twice daily Norflex 100 mg Take 1 tablet by mouth twice daily Certagen Liquid Give 5 cc by mouth daily Zinc Sulfate 220 mg Take one capsule by mouth every day	F 281		

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F 281	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.	F 281		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 including syncope, normal pressure	F 514	F514 No negative impact was caused for any of the sampled residents. For those documents that were found to be affected, the corrective action was immediate correction of the orders with clarifications written. Completed 3/31/2011. The DON met with the pharmacist to review those residents' charts that had the potential to be affected by the same practice. All charts were reviewed and any discrepancies were immediately corrected and clarifications written. Completed 3/31/2011.	

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F 514	Continued From page 7 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. Review of the resident's medical record revealed a Physician's Telephone Order dated 3/6/11 for the following: "Albuterol [bronchodilator] CFC [chlorofluorocarbon] free 90 mcg [micrograms]/ [per] inhalation two puffs qid [four times daily]." Further record review revealed 3/11/11 Physician's Telephone Order to discontinue the Albuterol CFC free inhaler order. Review of the resident's March 2011 Medication Administration Record (MAR) revealed duplication of the inhaler order with the Albuterol CFC free inhaler listed as well as "Pro Air HFA [hydrofluoroalkane, a CFC free inhaler] 90 mcg inhaler take 2 puffs po [by mouth] 4x [times] /day." Continued review of the MAR revealed both medications were initialed as administered from 3/6/11-3/11/11. During an interview about the two inhalers on 3/30/11 at 9:40 a.m., LN #1 said it took her until 3/11 to realize they were the same. She stated she reported it to her charge nurse and the charge nurse discontinued the one inhaler order. LN #1 was unable to give a reason why she initialed both medications as administered but she stated only one inhaler had been in use. Interview with the Nursing Supervisor on 3/30/11 at 10:05 a.m. revealed a second -shift nurse, who was unavailable during the survey, had added the Pro Air HFA medication on the MAR after the pharmacy sent the resident's medications because she thought she needed to write it that	F 514	To ensure the deficient practice does not reoccur, the facility will have the 3rd shift nurse to review any new, admission or clarification orders for accuracy. The nurse will review the process from recording on the telephone orders to the physician's order to the MAR. Specific attention will be placed on reviewing that the transcription is for the right patient, with the correct drug and dose, the correct time of administration by the right route. All licensed nursing staff has been inserviced on the 5 rights of medication administration and order transcription. Inservices have been completed by the DON effective 3/31/2011. A monitoring tool has been developed for the nurse to document that she has checked the new orders and will document if any discrepancies were found. If any orders are received by the 3rd shift nurse, they will be reported to the oncoming nurse and checked for accuracy. If any nurse finds discrepancies, clarification orders will be written immediately and DON will be notified. In addition to the daily	

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F 514	Continued From page 8 way. The nursing supervisor stated the nurse should have discontinued the other inhaler order at that time. During an interview on 3/30/11 at 3:30 p.m., the Director of Nursing (DON) stated medication orders should be written correctly, and if there are inconsistencies with orders, the nurses should clarify the orders. The DON confirmed nurses should only sign for medications administered to the resident.	F 514	checks by LPN, the Pharmacist will continue to review charts monthly for accuracy. Results will be document on monthly Consultant Pharmacist Report. If the pharmacist finds discrepancies the medication order review form will be completed by pharmacist and addressed by DON. The monthly reviews will include monitoring of the 5 rights (Right Patient, Right Drug, Right Dose, Right Time and Right Route). If the pharmacist finds discrepancies, clarification orders will be written immediately and DON will be notified. In order to monitor the performance of this correction, daily monitoring tools and Consultant Pharmacist Reports will be presented in the Quality Assurance Meeting monthly. The Quality Assurance Team will review the monitoring tools for discrepancies and take corrective actions as needed. Plan of Correction will be completed by 5/1/2011.	