DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	04/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and review of menus, the facility failed to provide 9 residents with a 4 ounce portion of oatmeal or grits according to the menu. (Residents #18, 23, 45, 2, 47, 44, 48, 32 and 26) The findings include: An observation of the breakfast tray line occurred on 04/25/13 at 07:10 AM. The breakfast menu included cereal of choice, egg, bacon, toast, juice, milk, coffee or hot tea. Cold cereal, grits and oatmeal were all available on the breakfast tray line. Review of the menu revealed 1 serving of cereal was to be provided to residents for breakfast. From 07:34 AM until 07:50 AM, the kitchen supervisor was observed to plate grits for Residents #18, 45, 2, 47, 44, 32 and oatmeal for Residents #23, and 26 using a 4 ounce serving utensil that was not completely full. The kitchen supervisor was observed to plate approximately 3/4 of the serving utensil of grits and oatmeal into a small bowl instead of a full 4 ounce portion. The kitchen supervisor stated during the observation when asked how she determined how much oatmeal or grits to provide "I fill it to the	F 363	F363 No negative impact was caused for any of the sampled residents. The corrective action was immediate thinning of the grits and oatmeal so they no longer were sticking to the serving utensil and a full 4 ounce serving was provided. Corrected 4/25/13. After the corrective action that was taken on 4/25/13, no other residents had the potential of being affected by this deficient practice. The changes that will be made to ensure that this deficient practice does not reoccur are as follows: The Dietary Manager purchased new 4 ounce serving scoops and inserviced the dietary staff on the importance of proper serving sizes (5/14/13). The Dietary Manager will observe the breakfast line 3 times weekly for 3 months to ensure that staff is serving the proper portions and that the new serving utensils are effective.	5/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Stinesley (Updated)	Administrator	5/22/13

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.

DHSR NLHC Black Mountain RO
Received
MAY 24 2013
by: PAM

Original Signature Date: 5-17-13

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F 363	Continued From page 1 top of the bowl, but I don't want to overfill." On 04/25/13 at 08:20 AM the dietary manager was interviewed and stated that a serving of hot cereal should be a full 4 ounce portion. She further stated that she did not typically observe the breakfast meal and was not aware that a full 4 ounce portion of grits or oatmeal was not provided to residents. An interview with the consultant registered dietitian (RD) was conducted on 04/25/13 at 10:49 AM. During the interview the RD confirmed that residents should receive foods in portions according to the menu.	F 363	The facility will monitor the performance of this plan by having the Dietary Manager report her findings of the serving line audits to the facilities Quality Assurance Team monthly for 3 months. The corrective action was completed on 5/17/2013	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	F431 There was no negative impact for those residents who were found to have the Calcium Plus Vitamin D Tablets. The corrective action was immediate removal of this medication from the medication cart. The Physician was called and this medication was discontinued and replaced with Calcium 600mg capsules. Corrected 4/24/13. No other residents had the potential to be affected by this deficient practice.	5/17/13

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F 431	Continued From page 2 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the provider pharmacy failed to label the strength of Vitamin D present in Calcium plus Vitamin D tablets dispensed to several active residents checked in 100 hall and 200 hall medication carts. The findings include: Medication storage areas including medication storage rooms, medication carts were observed for medication labeling requirements. A review of the provider pharmacy dispensed products of Calcium 600 mg with Vitamin D stock medication did not reveal the strength of Vitamin D present in those products, on the labels of the provider pharmacy: On 4/24/2013 at 3:27 PM observation of the 100/200 hall medication carts revealed several containers of Calcium with Vitamin D tablets packed by the pharmacy in which the strength of	F 431	In order to ensure that the deficient practice does not reoccur, the facility will no longer accept orders for Vitamin D that does not have the proper labeling of the strength. Nursing staff was inserviced on taking orders with Vitamin D to ensure proper labeling of strength. 3rd shift nursing staff will double check all orders daily to ensure proper labeling as well. The facility will request that that the pharmacy staff is inserviced to clarify any orders that do not have the strength specified. To ensure this plan is effective, documentation used by the 3rd shift nursing staff to check all orders will be reviewed by the Director of Nursing 2 times a week for 3 months. The Consultant Pharmacist will monitor the medications on a monthly basis to ensure that all medications given have the strength specified. The Director of Nursing and the Pharmacy Consultant will report their findings to the Quality	

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F 431	Continued From page 3 Calcium was disclosed but not the strength of Vitamin D on the pharmacy dispensing label. An interview with the medication nurse (Nurse #1) on 4/24/13 at 3:28 PM revealed that all over the counter and prescription pharmaceuticals were sent by the pharmacy with appropriate label to all the residents. Nurse #1 stated that the physician order sheet and Medication Administration Records (MARs) were generated by the pharmacy and all physician orders were faxed to pharmacy for documentation. She was not aware why the strength of Vitamin D was not disclosed on the pharmacy labels in the Calcium plus D products and was not sure how many international units of Vitamin D the residents were receiving. An interview with the consultant pharmacist on 4/24/13 at 3:35 PM revealed that all medications sent from the pharmacy should have the correct strength of medications and if there was any concern with the medication strength in the physician orders they would obtain clarification from the physician. In case of Calcium with Vitamin D tablets labeling, the interview revealed that the pharmacy had several strength of Calcium 600 mg plus Vitamin D and the strength should have been disclosed on the label. If the physician order was not specific to the strength of Vitamin D, a clarification should have been obtained from the physician. The pharmacist stated that it was a professional practice to indicate the strength of medication on repacked products on the labels. An interview with the Director of Nursing (DON) on 4/25/13 at 9:35 AM revealed that all stock	F 431	Assurance Team monthly for 3 months. The corrective action was completed on 5/17/2013.	

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F 431	Continued From page 4 medications were supplied by the provider pharmacy and was not aware why they were not accurately labeled with the correct Vitamin D content.	F 431		