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 _____	05/18/2017

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 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair chipped and splintered bedroom and/or bathroom doors, which had the potential to cause splinters or skin tears, in 8 of 19 resident rooms (#'s 105, 201, 202, 204, 209, 211, 213 and 215). The findings included: A. Observations on 05/15/17 at 2:12 PM revealed the bedroom door to room 105 was chipped and splintered on the side edge of the door. Subsequent observation on 05/18/17 at 2:50 PM remained unchanged. B. Observations on 05/15/17 at 2:56 PM revealed the bedroom door to room 201 was chipped and splintered on the side edge of the door. Subsequent observation on 05/18/17 at 2:50 PM remained unchanged. C. Observations on 05/15/17 at 2:49 PM revealed the bedroom door to room 202 was chipped and splintered on the side edge of the door. Subsequent observation on 05/18/17 at 2:50 PM remained unchanged. D. Observations on 05/15/17 at 10:51 AM revealed the bedroom door to room 204 was chipped and splintered on the side edge of the door. Subsequent observations on 05/16/17 at 8:32 AM and 05/18/17 at 2:50 PM remained	F 253	QAPI was already in place with identified need for resident room repairs and general overall care. Facility round made to identify splintered doors. (Completed on: 5/17/17) Facility round made to identify splintered doors with immediate plan developed to repair identified doors. Plan as follows: 1. Identified doors were sanded. 2. Areas were filled with wood putty and sanded again. 3. Areas were re-varnished. Samples obtained of door guard to prevent further damage to edges of doors. Managers will identify splintered doors on daily rounds, and report abnormal findings to Daily QA Meeting x 4 weeks. Audit findings will be reported to QA x 3 months.	6/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 1	F 253		

unchanged.

E. Observations on 05/16/17 at 8:46 AM revealed the bedroom and bathroom doors in room 209 were chipped and splintered on the side edges of the doors. The wood was chipped and splintered near the bathroom door handle. Subsequent observation on 05/18/17 at 2:50 PM remained unchanged.

F. Observations on 05/15/17 at 1:55 PM revealed the bedroom door to room 211 was chipped and splintered on the side edges of the door. Subsequent observations on 05/16/17 at 9:53 AM and 05/18/17 2:50 PM remained unchanged.

G. Observations on 05/15/17 at 1:56 PM revealed the bedroom and bathroom doors in room 213 were chipped and splintered on the side edges of the doors. Subsequent observations on 05/16/17 at 8:45 AM and 05/18/17 at 2:50 PM remained unchanged.

H. Observations on 05/15/17 at 3:47 PM revealed the bedroom door to room 215 was chipped and splintered on the side edges of the door. Subsequent observation on 05/18/17 at 2:50 PM remained unchanged.

Interview and tour with the Maintenance Director on 05/18/17 at 2:45 PM revealed, the staff were in-serviced upon hire how to identify maintenance issues, how to complete a maintenance requisition and where to put the requisitions for the Maintenance Director to collect them. The Maintenance Director stated he checked the skilled nursing desk, the Social Worker's office and a box outside of his office more than once a day for the repair requisitions. He explained that

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	345425	A. BUILDING _____ B. WING _____	05/18/2017

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 253	Continued From page 2 he was currently in the process of sanding and refinishing the handrails in the hallways as well as repairing, restaining and repainting the doors to the resident rooms of which he had already started on the Rest Home side of the facility and would continue with the nursing home side after he finished. The Maintenance Director added that he did not have a scheduled plan but that he worked on the doors when he could. After pointing out the concerned resident bedroom and bathroom doors to the Maintenance Director, he agreed the damaged doors were a hazard for the residents and stated he would continue with the damaged doors identified. Interview with the Administrator on 05/18/17 at 3:34 PM revealed, the Management Team identified environmental concerns by rounds made throughout the facility and a Quality Assurance Performance Improvement (QAPI) plan was developed. The Administrator stated a project of sanding and refinishing the handrails in the hallways began in March and the kitchen would undergo a renovation with the replacement of the heating and air system. Informed the Administrator of the concern of the condition of the resident bedroom and bathroom doors being a potential hazard because of the chipped and splintered areas. The Administrator stated that Maintenance would start on the resident rooms next.	F 253		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		6/5/17

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 281	Continued From page 3 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow physician orders by obtaining an ordered laboratory test for 1 of 5 residents sampled for medication review (Resident #2). The findings included: Resident #2 was admitted to the facility on 10/09/14. Her diagnoses included diabetes and anemia. Medical record review revealed during the monthly pharmacist review of medications dated 01/31/17, the pharmacist noted that the diabetic medication Metformin was increased on 01/30/17 from 500 milligrams (mg) twice a day to 1000 mg twice a day. The note stated that the laboratory test for A1C was completed on 11/29/16 and was measured 7.0 %, which was high. The recommendation at this time was to repeat the A1C in 3 months due 02/28/17. The pharmacist review dated 02/28/17 noted that on 02/06/17 the A1C was still high at 6.0 %c. The pharmacist recommended a repeat A1C in 3 months due 05/06/17. A handwritten note next to this recommendation noted that an order was written on 03/24/17. Review of physician telephone orders revealed an order was written on 03/24/17 "Per Pharmacy Recommendations A1C Due 5/6/17. This was signed by the physician on 03/27/17.	F 281	Nurse Practitioner assessed current need for A1c to be drawn. Nurse Practitioner discontinued current order, related to A1c being drawn less than 30 days prior to order being written. A1c to be drawn in June 2017. Completion Date: June 30th, 2017 100% audit of all lab orders within the last 90 days will be completed. Procedures for documentation of labs have been updated to include: 1.Nurse documents lab in lab book once order received. 2.Once lab is drawn, nurse who draws lab will highlight the order in the lab book. 3.Once lab result is received, nurse will initial in the lab book to document received results. (this step has been added to procedure) 4.Abnormal labs will be called to physician. 5.Lab results will be placed in physician□s folder for review. All nursing staff educated on new procedure. Completed:5/18/17 DON will monitor labs by utilization of Lab Audit Tool, to review 100% of labs twice weekly x 60 days. Lab Audit Tool will be presented once weekly in Daily QA Meeting for review.	

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 281	Continued From page 4 Review of the medical record revealed no evidence that an A1C was drawn on 05/06/17. Review of laboratory tests revealed that on 05/08/17 CBC (complete blood count) with Differential/Platelets was drawn as the only ordered lab. Interview with Nurse #1 on 05/17/17 at 3:42 PM stated there was a lab book which logged all ordered pending laboratory tests. Review of this book revealed both the CBC and the A1C scheduled for 05/06/17. Nurse #2 stated on 05/17/17 at 3:50 PM during interview that the A1C was typically drawn every 3 months and she just wrote an order for it for next month as the last A1C was drawn on 03/06/17. She looked and stated she could not find where the laboratory test was completed for May. Review of the 03/06/17 A1C revealed the reading was still high at 6.0 %. The Director of Nursing (DON) was interviewed on 05/18/17 at 12:04 PM. She stated that once a pharmacy recommendation was obtain, a telephone order was written and the date and lab was written in the lab book. The night before the lab draws, the nurse wrote a lab requisition, based on the lab book entries. which accompanied the lab draw. She further stated there was no copy of the requisition maintained by the facility. The DON then stated there was no system for follow up to ensure the laboratory tests were completed as ordered. She could not say if the facility missed requisitioning the A1C or the lab missed it.	F 281	These tools will be reviewed in Monthly QA Meeting x 3 months to ensure proper procedure is being followed. Completed Date: August 1st, 2017	
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES	F 309		5/18/17

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F 309 SS=D	Continued From page 5 FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff	F 309	QAPI was initiated 5/17/17 which	

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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 309	Continued From page 6 interviews the facility failed to document the assessment of a resident before and after dialysis for 1 of 1 resident reviewed for dialysis (Resident #24). The findings included: Resident #24 was admitted to the facility on 02/01/17 with diagnoses of chronic kidney disease stage 5, diabetes and heart failure. Review of the quarterly Minimum Data Set (MDS) dated 05/02/17 revealed Resident #24 was cognitively intact and required dialysis. Review of the care plan dated 05/17/17 revealed Resident #24 required dialysis 3 times weekly related to end stage renal disease. The goal was for Resident #24 to be free of complications related to hemodialysis throughout the review. The interventions included: transport to dialysis as needed, coordinate care with dialysis center pertaining to resident needs, assess resident pre and post dialysis, weigh resident per facility protocol, review medications per pharmacy guidelines and policy, keep port/access clean and dry, bandage if needed, monitor vital signs, and assess port for patency. Review of the nurse's notes from 05/01/17 through present, the 05/2017 Medication Administration Record (MAR) and the 05/2017 Treatment Administration Record (TAR) revealed no documentation of assessment of Resident #24 pre or post dialysis, no communication between the dialysis center and the facility and no documentation of assessment of Resident #24's dialysis port for patency.	F 309	identified incomplete documentation, which included vital signs, nurses notes, and dialysis communication forms. Resident was assessed by nurse upon return to facility, which included vital signs, access site, orientation, and respiratory status. Resident was placed on acute board x 30 days for assessment prior to and after dialysis. There are no other residents with potential to be affected. Dialysis Communication form will be reviewed by the nurse upon return to facility, for every dialysis treatment. To include: 1. Receipt of form. 2. Completion of form. 3. Documentation of assessment of resident to include: Vital signs, access site, respiratory status and orientation. Nurse will assess resident prior to dialysis which includes: Access site, orientation, medications, vitals, and overall well being. This will be documented on the Dialysis Communication Form. DON will monitor compliance by reviewing the Dialysis Communication Form Checklist after each dialysis treatment in Daily QA x 4 weeks. After completion of 4 week review, DON will monitor daily Dialysis Communication Form Checklist weekly and report to Daily QA Meeting to ensure compliance. Results of review will be presented to QA monthly x 3 months.	

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F 309	Continued From page 7 An interview conducted on 05/17/17 at 4:00 PM with Nurse #1 revealed she did not check Resident #24's dialysis port for patency, she stated she assessed the area and put a numbing cream on it before sending him out to dialysis. She further stated she didn't document a resident assessment in the medical record pre and post dialysis for Resident #24. An interview conducted on 05/18/17 at 10:04 AM with Nurse #3 revealed she assessed Resident #24's dialysis port for patency but had never documented it in the medical record, MAR or TAR. An interview conducted on 05/18/17 at 10:07 AM with the Director of Nursing (DON) revealed it was her expectation for the nurses to assess the resident pre and post dialysis and document the assessment in the nurse's notes. She stated Resident #24's dialysis port should be assessed every shift and documented on the Medication Administration Record. She further stated there should be a communication form sent with Resident #24 to each dialysis appointment and received back with Resident #24 when he returned from dialysis for communication of orders from the dialysis center and kept in the medical record.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		6/7/17

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F 323	Continued From page 8 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain securely fastened side rails to the bed and in a manner to alleviate any gaps between the mattress and the side rail for 1 of 3 residents sampled for side rail use (Resident #13). The findings included: Resident #13 was admitted to the facility most recently on 12/11/07. Her diagnoses included cerebral vascular accident and bilateral hemiparesis. The annual Minimum Data Set (MDS) dated 11/22/16 coded her with unclear speech, usually understanding and being understood, and having severely impaired cognition. She was coded as	F 323	Resident side rails were assessed immediately and adjusted for proper positioning. 100% audit of side rail placement and proper fit. (Completed on :6/1/17) Staff to be educated to assess for any improper fitting side rails and to report any abnormalities immediately to the nurse. Nurse will then assess and notify maintenance with any immediate actions needed related to any inability to adjust/repair/reposition side rails. (Completed on: 6/7/17) Side rail check by department manager	

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	345425	A. BUILDING _____ B. WING _____	05/18/2017

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 323	Continued From page 9 requiring extensive assistance with bed mobility and transfers and being nonambulatory. Review of the Re-evaluation for side rail use dated 11/30/16 revealed the rationale for side rail use as half side rails were used for bed mobility and repositioning. Resident #13 was able to hold self over while care was being given. The quarterly MDS dated 02/16/17 coded her again with severely impaired cognition and requiring extensive assistance with bed mobility, total assistance with transfers and requiring set up and limited assistance with eating. The Re-evaluation for side rail use dated 03/01/17 described the rationale for side rail use as half rails for bed mobility and repositioning. She was able to hold self over while care was being given. The care plan dated 03/01/17 addressed the problem that she required extensive assistance to total care with activities of daily living skills related to left sided hemiparesis and decreased range of motion secondary to a past cerebral vascular accident. One of the interventions listed was the use of half side rails to aid with assistance of activities of daily living skills during changing or repositioning. The intervention noted she was able to hold self over with use of side rails. Review of the monthly computerized physician orders for May 2017 revealed "Safety Device Needed: side rails to aide with bed mobility, able to hold self over during care or repositioning." There was no start date for this device. Resident #13 was observed during the initial tour,	F 323	during daily rounds and report finding to Daily QA. Results will be reported in Daily QA Meeting and then reported to QA x 3 months.	

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 323	Continued From page 10	F 323		

which began at 9:05 AM on 05/15/17, in bed with the right half side rail in the upright position that was loose and not securely fastened to the bed. The left side of the bed was against the wall. The side rails remained loose when observed on 05/15/17 at 11:03 AM with 4 to 5 inches of play noted towards and away from the mattress.

Resident #13 remained in bed with the right top half rail upright, with inches of play and a gap between the mattress and the side rail large enough to fit a fist in during observations on 05/16/17 at 3:15 PM and on 05/17/17 at 8:53 AM.

On 05/17/17 at 10:26 AM, Nurse Aide (NA) #1 checked Resident #13 for wetness and turned and repositioned her in bed. After care was given, NA #1 was asked if the resident was capable of using the side rail. NA #1 stated yes if you cued her to do so. At this point, NA #1 used the knob located at the base of the side rail to tighten the loose side rail. Nothing was done about the gap between the side rail and mattress.

During the following observations, the side rail was observed with inches of play towards and away from the mattress and the fist size gap between the side rail and mattress as follows:
*05/17/17 at 12:52 PM;
*05/17/17 at 2:43 PM; and
*05/17/17 at 3:56 PM.

The resident remained in bed with the right top half rail loose and with a fist size gap between the mattress and side rail during observations on 05/18/17 at 9:43 AM, at 9:43 AM, at 10:22 AM, and at 10:51 AM. On 05/18/17 at 10:51 AM, NA #2 was observed repositioning Resident #13. Although NA #2 cued Resident #13 to hold the

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 323	Continued From page 11 rail, she did not. NA #2 was observed leaning against the rail several times rendering care and the side rail moved easily towards the bed. NA #2 made no attempt to tighten the side rail or fill the gap between the mattress and side rail. On 05/18/17 at 11:50 AM, the resident was in bed with the top half side rail upright. Although the side rail appeared tighter with less movement, the fist size gap remained. On 05/18/17 at 2:11 PM the Maintenance Director stated he kept no documentation of routine preventative maintenance checks. He stated that he relied on staff to fill out a work order for items needing maintenance's attention. He further stated he did not routinely check side rails for tightness or fit. He stated he has had no recent requests to check any resident's side rail. The Maintenance Director and Director of Nursing accompanied the surveyor to Resident #13's room, where she was positioned in bed. At this time, the side rail was noted to be loose with several inches of play. The Maintenance Director then moved the side rail closer to the head of the bed and tightened. The DON stated that she expected staff to report loose side rails or accident hazards. She further stated the facility had been working on reducing the use of side rails, however, Resident #13 used her side rail for repositioning when turning.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		6/9/17

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	345425	A. BUILDING _____ B. WING _____	05/18/2017

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 371	Continued From page 12 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the kitchen ceilings free from hanging dust over the steam table and free from hanging dust and peeling paint over the dish machine. The findings included: Observations on 05/17/17 at 8:56 AM revealed the popcorn ceiling above the dish machine was spotted with rust colored spots. The metal pipe running along the ceiling over the dish machine had paint which was peeling away, leaving hanging peels of loose paint above the clean end of the dish machine. The Dietary Manger stated at this time that they were expecting a new air	F 371	Ceiling cleaned by dietary manager to remove hanging dust. Previously scheduled ceiling repair to include: 1. Removal of all duct work from old AC unit. 2. Ceiling to be repaired after removal. 3. All wall and ceiling surfaces to be cleaned by professional contract service. 5. Ceiling to be repainted. Ceiling to be cleaned monthly and as needed per established schedule. Schedule to be reviewed by dietary manager monthly to ensure cleanliness of surfaces.	

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	345425	A. BUILDING _____ B. WING _____	05/18/2017

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 371	Continued From page 13 conditioning unit next week which would replace the peeling pipe. Observations of the popcorn ceiling above the steam table on 05/17/17 at 11:35 AM, on which food items were placed and plates of food were being prepared, was hanging dust. The Dietary Manger stated at this time that she had tried to use a duster to remove and even sticky tape but could not remove the hanging dust. Observations were made on 05/18/17 at 2:40 PM with the Administrator, Maintenance Director and Dietary Manager of the ceilings in the kitchen. Hanging dust was observed over the steam table and dish machine which were observed to move with the air circulation. The pipe over the dish machine had peeling paint hanging from it. The Dietary Manager stated that in April the Administrator pointed out the dust on the ceilings and asked her to clean it. She stated that she tried to use a duster and sticky tape which were unsuccessful. She then spoke to the Maintenance Director about how to remove the dust. At that time they developed a plan to replace the air conditioning unit which would remove the pipes and the plumbing lines running along the ceiling. Once this was completed, the ceiling would be easier to paint. The Administrator stated she was aware of this plan and was in agreement. The Maintenance Director stated that he ordered the new air conditioning unit two weeks ago for the kitchen and that company was due out next week. He stated they had not hired a painting company to come in yet to paint the ceiling, which was in their plans. The Dietary Manger stated it had been a couple of years since the ceiling was painted.	F 371	Dietary Manager to report weekly to Daily QA Meetings x 4 weeks. Then report to QA x 3 months.	

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F 372	Continued From page 14	F 372		
F 372 SS=E	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the dumpster area free of debris. The findings included: Observations on 05/15/17 at 9:00 AM upon driving to facility revealed debris was noticed on the ground around the 3 dumpsters. During the kitchen tour on 05/15/17 at 9:25 AM with the Dietary Manager, observations revealed 3 disposable gloves, 5 plastic cup lids, 7 straws, salt packets, and papers and plastic wrap debris on the ground around the dumpsters. The Dietary Manager stated at this time that the dumpsters were emptied on Saturday and positioned differently in the space. She stated the debris was probably under where the other dumpsters were before they were moved. A follow up interview with the Dietary Manager on 05/18/17 at 2:34 PM revealed that she passed the dumpsters on the way into the facility and should have noticed the debris on the ground. She stated the dumpsters were emptied Saturday night. The Administrator who was present during this interview stated that the dumpsters were used daily and it was everyone's responsibility to keep the dumpster area clean and free of debris.	F 372	Debris was removed from the dumpster area. No residents were affected. Housekeeping and dietary staff have been educated on removing any debris from dumpster area during daily trash removal from facility, which occurs 3 x daily per department. Daily Dumpster Area Monitoring tool implemented for both Dietary and Housekeeping Departments. Tool to be reviewed by department managers once weekly x 4 weeks and then monthly x 3. Results will be reported in QA monthly x 3 months.	6/6/17
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		6/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 15	F 431		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in

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F 431	Continued From page 16 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) 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 observation, record review and staff interviews the facility failed to properly store a medication per the manufacture's recommendation for a medication found in 1 of 1 medication cart. The findings included: Resident #23 was admitted to the facility on 11/15/16 with diagnoses that included osteoporosis (without acute fracture) which is a disease in which increased bone weakness increases the risk of a broken bone. On 02/03/17 Resident #23 was prescribed Miacalcin Nasal Spray (generic name Calcitonin Salmon) 200 international units (IU), spray one spray intranasal alternating nostrils daily for the treatment of her disease. Observed on 05/17/17 at 2:50 PM an opened box of Calcitonin Salmon Nasal Spray dated 05/05/17 (which indicated the date the bottle was opened) that was lying in the top drawer of the medication	F 431	Medication was removed from cart, discarded and replaced. Medication placed in basket for upright storage per manufacturer's guidelines. No other residents affected per 100% audit completed by DON. (Completed 5/17/17) Staff educated by DON on proper storage of Micalcin and need for it to maintain upright positioning. (Completed by: 6/5/17) Pharmacist will continue monthly medication cart audits to ensure proper storage. Pharmacist educated pharmacy staff related to proper medication storage and labeling medications that require special storage with bold auxiliary labels. (Completed 6/2/17)	

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FAIR HAVEN HOME INC	149 FAIR HAVEN DRIVE BOSTIC, NC 28018

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F 431	Continued From page 17 cart. The instructions read for Resident #23 to spray one spray intranasal alternating nostrils daily. Also included on the label were directions to discard 35 days after opening and to refer to insert for more information which the insert was not in the box. Interview with Nurse #1 on 05/17/17 at 2:50 PM revealed, she was not aware the Calcitonin Salmon Nasal Spray had specific storage instructions to be positioned in an upright position after it was opened. Nurse #1 stated she had never been told that nor had there ever been a sticker on the medication from the Pharmacy with that specific instruction for the medication. Nurse #1 also reported she had given that nasal spray to Resident #23 at 9:00 AM that morning. Interview with the Director of Nursing (DON) on 05/17/17 at 2:55 PM revealed she was unaware the Calcitonin Salmon Nasal Spray had specific storage instructions to be positioned in an upright position after it was opened. The DON added she had not received instructions from the Pharmacist of special instructions of storage for the medication. During a telephone interview with the Pharmacist on 05/17/17 at 4:21 PM he stated the Calcitonin Salmon Nasal Spray should be stored in an upright position after it was opened. He further stated the medication should have come from the Pharmacy labeled with those instructions and if the bottle was not labeled then he should have instructed the facility to do it.	F 431	Medication to be labeled. Audit to be completed daily x 30 days by Med nurse. DON to review audit weekly and report once weekly in Daily QA meeting times four weeks. Results of audit will be reported in QA and followed on an ongoing basis.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		6/5/17

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F 514	Continued From page 18 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to assess a resident's dialysis port for patency for 1 of 1 resident reviewed for dialysis (Resident #24).	F 514	QAPI initiated 5/17/17, which identified need for assessment of fistula every shift. On 5/17/17 after dialysis treatment, nurse	

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F 514	Continued From page 19 The findings included: Resident #24 was admitted to the facility on 02/01/17 with diagnoses of chronic kidney disease stage 5, diabetes and heart failure. Review of the quarterly Minimum Data Set (MDS) dated 05/02/17 revealed Resident #24 was cognitively intact and required dialysis. Review of the care plan dated 05/17/17 revealed Resident #24 required dialysis 3 times weekly related to end stage renal disease. The goal was for Resident #24 to be free of complications related to hemodialysis throughout the review. The interventions included: transport to dialysis as needed, coordinate care with dialysis center pertaining to resident needs, assess resident pre and post dialysis, weigh resident per facility protocol, review medications per pharmacy guidelines and policy, keep port/access clean and dry, bandage if needed, monitor vital signs, and assess port for patency. Review of the nurse's notes from 05/01/17 through present, the 05/2017 Medication Administration Record (MAR), and the 05/2017 Treatment Administration Record (TAR) revealed no indication of Resident #24's Arteriovenous Fistula (AVF) being assessed by checking for the thrill, a constant vibration feeling over the fistula, and bruit, an audible sound heard with a stethoscope, associated with blood flow over the fistula. An interview conducted on 05/17/17 at 9:00 AM with Resident #24 revealed the nurses put cream on his arm before he went to dialysis but they had	F 514	assessed fistula. Assessment included: bruit, thrill, vital signs, respiratory status, and orientation of resident. No other residents have potential to be affected. Assessment of fistula site added to MAR for nurse documentation. 100% education of nursing staff related to documentation of assessment. DON to monitor compliance by reviewing Dialysis Communication Form Checklist weekly and report to Daily QA once weekly x 4 weeks. Report results of compliance to QA committee x 3 months.	

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F 514	Continued From page 20	F 514		

never listened to his fistula with a stethoscope. He stated he just started dialysis in May and he had been 5 times.

An interview conducted on 05/17/17 at 4:00 PM with Nurse #1 revealed she did not check Resident #24's AVF for a thrill or bruit, she stated she assessed the area and put a numbing cream on it before sending him out to dialysis.

An interview conducted on 05/17/17 at 4:22 PM with the Nursing Supervisor of the Dialysis Center where Resident #24 received dialysis revealed it was very important for the facility staff to assess Resident #24's AVF by checking for a thrill and bruit at least daily. She stated if the AVF wasn't patent it should be reported to the Dialysis Center immediately and surgery could possibly be required to repair the AVF.

An interview conducted on 05/17/17 at 9:30 AM with the facility Nurse Practitioner revealed it was her expectation for staff to assess a thrill and bruit on dialysis residents with an AVF. She stated she was not aware it wasn't being done for Resident #24.

An interview conducted on 05/18/17 at 10:04 AM with Nurse #3 revealed she assessed Resident #24's AVF for a thrill and bruit but had never documented it in the medical record, MAR or TAR.

An interview conducted on 05/18/17 at 10:07 AM with the Director of Nursing (DON) revealed it was her expectation for the nurses to check for a thrill and bruit on Resident #24 every shift and document on the MAR to make sure the AVF was intact and functioning properly.

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