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

PRINTED: 05/07/2013 FORM APPROVED OMB NO. 0938-0391

| F 363 SS=E 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, | STATEMENT OF DEFICIENT AND PLAN OF CORRECTION | NCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 7.700 - 7707050 17.7000 | | ONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|--|--|---|-------------------------|-----|---|---|----------------------------|
| FAIR HAVEN HOME INC (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 363 SS=E 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, | | | 34 <mark>5</mark> 425 | B. WING_ | | ı | 04/ | 25/2013 |
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| 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 #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" 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 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. | Menus resident dietary a Board of Academ and be for the second of the se | must meet the ts in accordar allowances of of the National my of Sciences followed. EQUIREMENT on observation of menus, the ts with a 4 our cording to the 17, 44, 48, 32 and 18 dings include: ervation of the 15/13 at 07:10 dicereal of chanilk, coffee or late the 18 dings include: expervisor was the 18 dings include: bowl instead chen supervisor was observing ute bowl instead chen supervisor was the serving ute the serving uter th | e nutritional needs of ce with the recommended the Food and Nutrition Research Council, National s; be prepared in advance; is not met as evidenced in advance; is not met as evidenced in actility failed to provide 9 ince portion of oatmeal or menu. (Residents #18, 23, and 26) breakfast tray line occurred AM. The breakfast menu bice, egg, bacon, toast, not tea. Cold cereal, grits available on the breakfast in menu revealed 1 serving rovided to residents for 4 AM until 07:50 AM, the as observed to plate grits for 47, 44, 32 and oatmeal for 6 using a 4 ounce serving completely full. The kitchen wed to plate approximately insil of grits and oatmeal into of a full 4 ounce portion. The stated during the keed how she determined | F | 363 | No negative impact was caus any of the sampled residents corrective action was immed thinning of the grits and oath they no longer were sticking serving utensil and a full 4 outerving was provided. Correct 4/25/13. After the corrective action the taken on 4/25/13, no other residents had the potential of affected by this deficient practice. The changes that will be made ensure that this deficient practice action that the potential of affected by this deficient practice. The Dietary Manager purchated new 4 ounce serving scoops inserviced the dietary staff of importance of proper serving (5/14/13). The Dietary Manager purchated the dietary staff of importance of proper serving (5/14/13). The Dietary Manager purchated the breakfast line 3 weekly for 3 months to ensure staff is serving the proper potential that the new serving uterity. | The iate neal so to the ince cted nat was f being ctice. de to actice ws: sed and n the g sizes ger will times re that ortions | 5/17/13 |
| ABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE, TITLE (X6) DATE (X7) DATE (X7) DATE (X8) DATE | _ABORATORY DIRECTOR'S | 'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATURE | +-1) | | TITLE | dan | |

RAMINIDUCIOR Any deficiency statement ending with an asterisk (*) denotes a desciency which the institute 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 used, an approved plan of correction is requisite to continued program participation.

Event ID: Best 11

Facility ID: 923166

If continuation sheet Page 1 of 5

Original Signature Date:

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

| NAME OF PROVIDER OR SUPPLIER FAIR HAVEN HOME INC CAPID CAPACITY CAPACI | | | | | 3) DATE SURVEY COMPLETED | | |
|--|--------|--|---|--------|---|------------------------------------|------------|
| PAIR HAVEN HOME INC CAN ID SUMMARY STATEMENT OF DEPICIENCIES (LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS CONTINUED AND CONSECUTION SHOULD BE CHOSS-REFERENCE TO THE APPROPRIATE DEFICIENCY (LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS The facility will monitor the DEFICIENCY MUST BE PRECEDED BY FULL TAGS The facility will monitor the DEFICIENCY (LEACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 363 | | | 345425 | B. WNG | | 04/2 | 25/2013 |
| 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 431 48.360(b), (d), (e) DRUG RECORDS, SEEL 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 is smintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically resonated professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws the | N | | | 10 | 49 FAIR HAVEN DRIVE | | ř. |
| 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 431 483.60(b), (d), (e) DRUG RECORDS, LABEU/STORE DRUGS & BIOLOGICALS 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 The receive action was completed on 5/17/2013 F 431 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 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 potentia | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to to be affected by this deficient practice. | F 431 | on 04/25/13 at 08:20 was interviewed and cereal should be a ful further stated that she the breakfast meal an ounce portion of grits provided to residents. An interview with the dietitian (RD) was cor 10:49 AM. During the that residents should according to the menu 483.60(b), (d), (e) DR LABEL/STORE DRUCT The facility must emply a licensed pharmacist of records of receipt a controlled drugs in sur accurate reconciliation records are in order a controlled drugs is mare conciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. In accordance with Stafacility must store all docked compartments | AM the dietary manager stated that a serving of hot I 4 ounce portion. She edid not typically observe at was not aware that a full 4 or oatmeal was not consultant registered aducted on 04/25/13 at interview the RD confirmed receive foods in portions at. UG RECORDS, GS & BIOLOGICALS Ioy or obtain the services of a who establishes a system and disposition of all efficient detail to enable an an and determines that drug and that an account of all sintained and periodically used in the facility must be with currently accepted and include the and cautionary expiration date when | | performance of this plan by he the Dietary Manager report he findings of the serving line aud the facilities Quality Assurance. Team monthly for 3 months. The corrective action was completed on 5/17/2013 F431 There was no negative impact those residents who were four have the Calcium Plus Vitamire. Tablets. The corrective action immediate removal of this medication from the medication from the medication. The Physician was called this medication was discontinuand replaced with Calcium 60 capsules. Corrected 4/24/13. No other residents had the potto be affected by this deficient. | t for and to a was ion and ued Omg | 5/17/13 |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL [*] A. BUILDI | | | X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|------------------------------------|-----|---|---|----------------------------|
| | | 345425 | B. WNG | | | 04/ | 25/2013 |
| | ROVIDER OR SUPPLIER | | | 14 | EET ADDRESS, CITY, STATE, ZIP CODE 9 FAIR HAVEN DRIVE DSTIC, NC 28018 | | * |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) | E | (X5) COMPLETION DATE |
| F 431 | | eys. ide separately locked, | F | 431 | In order to ensure that the defi practice does not reoccur, the facility will no longer accept or for Vitamin D that does not have | ders | 5 A 20 |
| | controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t | Abuse Prevention and nd other drugs subject to he facility uses single unit | | | the proper labeling of the strer Nursing staff was inserviced on taking orders with Vitamin D to | ngth. | 2. g. V 22. G |
| | | tion systems in which the imal and a missing dose can | 17-00-000-18 | | ensure proper labeling of stren 3 rd shift nursing staff will doubl | ngth. le | 8 - SEC - |
| | by: Based on observation interviews the provide the strength of Vitami Vitamin D tablets dispresidents checked in | is not met as evidenced ns, record reviews and staff or pharmacy failed to label n D present in Calcium plus bensed to several active 100 hall and 200 hall | | | check all orders daily to ensure proper labeling as well. The fa will request that that the pharmstaff is inserviced to clarify any orders that do not have the str specified. | cility macy rength | |
| | storage rooms, medic for medication labeling the provider pharmacy Calcium 600 mg with did not reveal the stree those products, on the pharmacy: | reas including medication reation carts were observed grequirements. A review of y dispensed products of Vitamin D stock medication right of Vitamin D present in a labels of the provider | | | To ensure this plan is effective, documentation used by the 3 rd nursing staff to check all orders be reviewed by the Director of Nursing 2 times a week for 3 months. The Consultant Pharm will monitor the medications o monthly basis to ensure that a medications given have the strenger of Nursing 2 the Director of Nursing 2 the | shift s will macist on a ll | A 6 0 |
| 4 | 100/200 hall medication containers of Calcium | PM observation of the on carts revealed several with Vitamin D tablets acy in which the strength of | | | specified. The Director of Nurs and the Pharmacy Consultant v report their findings to the Qua | will | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | C. State of the Control of the Contr | PLE CONSTRUCTION G | | E SURVEY PLETED |
|--------------------------|---|---|--|---|--|--|
| | | 345425 | B. WNG _ | | 04 | /25/2013 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 149 FAIR HAVEN DRIVE BOSTIC, NC 28018 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE | (X5) COMPLETION DATE |
| F 431 | | d but not the strength of macy dispensing label. | F 4 | months. The corrective act completed on 5/17/2013. | | and the second s |
| | on 4/24/13 at 3:28 PM counter and prescripti sent by the pharmacy the residents. Nurse order sheet and Medi Records (MARs) were | | | | | ** ** # # ** ** ** ** ** ** ** ** ** ** |
| | pharmacy for docume why the strength of Vi on the pharmacy labe products and was not | ntation. She was not aware tamin D was not disclosed Is in the Calcium plus D | | | 88 8 1 530 1 - 1 ⁶ 53 | |
| | 4/24/13 at 3:35 PM resent from the pharmastrength of medication concern with the mediphysician orders they from the physician. In Vitamin D tablets labe that the pharmacy had Calcium 600 mg plus should have been disciphysician order was n Vitamin D, a clarificatio obtained from the phystated that it was a proindicate the strength of products on the labels | would obtain clarification case of Calcium with ling, the interview revealed I several strength of Vitamin D and the strength closed on the label. If the ot specific to the strength of on should have been sician. The pharmacist ofessional practice to f medication on repacked | | | | |
| | | Director of Nursing (DON) revealed that all stock | | | | - |

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

| OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMP | SURVEY LETED | | |
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| | 345425 | B. WING | | 04/ | 25/2013 | | |
| NAME OF PROVIDER OR SUPPLIER FAIR HAVEN HOME INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 149 FAIR HAVEN DRIVE BOSTIC, NC 28018 | | | | | |
| (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | | | (X5) COMPLETION DATE | | |
| Continued From page medications were sup pharmacy and was no | e 4 oplied by the provider of aware why they were not | | DEFICIENCY) | | | | |
| | | | | | | | |
| | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page medications were sup pharmacy and was not accurately labeled with | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | ROVIDER OR SUPPLIER ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 149 FAIR HAVEN DRIVE BOSTIC, NC 28018 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | A BUILDING | | |