PRINTED: 11/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345553	B. WING _	B. WING		C 10/15/2015	
	NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	1 107	13/2013	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157 SS=D	(INJURY/DECLINE/R A facility must immediconsult with the reside known, notify the resion an interested family accident involving the injury and has the pot intervention; a significaphysical, mental, or publications in health status in either life throllinical complications significantly (i.e., a new existing form of treatmonsequences, or to be treatment); or a decise the resident from the §483.12(a). The facility must also and, if known, the resor interested family must change in room or roospecified in §483.15(resident rights under regulations as specified this section. The facility must record the address and phore legal representative of the second review, the facility must record review, the facility in the facility in the facility in the second review, the facility in the facility	ately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in ential for requiring physician cant change in the resident's sychosocial status (i.e., a y, mental, or psychosocial eatening conditions or y; a need to alter treatment due to discontinue an ment due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative ember when there is a see)(2); or a change in Federal or State law or end in paragraph (b)(1) of the resident's residented family member.	F 1	F 157 This plan of correction will serve a facility is allegation of compliance	as the	11/12/15	

10/30/2015 **Electronically Signed**

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.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25				C	
		345553	345553 B. WING				/15/2015	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				140	1 71ST SCHOOL ROAD			
AUTUMN	CARE OF FAYETTEVII	LLE		FA	YETTEVILLE, NC 28314			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 157	Continued From pa	nge 1	F 1	157				
	administration for C	Cymbalta via Gastrostomy tube			requirements of 42 CFR, Part 483,			
	(G Tube) for 1 of 3	sampled residents observed			Subpart B for long term care facilities.			
	for medication adm	inistration via G Tube			Preparation and submission of this pla			
	(Resident #139). F	indings included:			correction is in response to DHHS 256			
				for the 10/15/2015 survey and does n				
		admitted on 8/19/2014 with			constitute an agreement or admission			
	diagnoses that included depression, for which				Autumn Care of Fayetteville of the tru			
	she was prescribed Cymbalta 60 mg daily via G				the facts alleged or the correctness of			
tube. She was not interviewable as per the Minimum Data Set dated 08/19/15.				conclusions stated on the statement of				
	Minimum Data Set	dated 08/19/15.			deficiencies. This plan of correction is			
	Manufactura guidal	lines recommend that			prepared and submitted because of the	ie		
	_	lines recommend that ne) "pellets accumulated in			requirements of 42 CFR, Part 483,			
		and G Tubes and few pellets			Subpart B throughout the time period stated in the statement of deficiencies	· In		
	passed through the	•			accordance with state and federal law			
		uloxetine (Cymbalta) pellets			however, submits this plan of correction			
		pes was shown not to be a			address the statement of deficiencies			
		d for delivery to patients."			to serve as it¿s allegation of complian			
		а тол остиготу но рашению.			with the pertinent requirements as of t			
	Nurse #1 was obse	erved to administer Cymbalta			dates stated in the plan of correction a			
		s via G Tube for Resident #139			as fully completed as of November 12			
		13/15. She was observed to			2015.			
	disassemble the Cy	ymbalta capsule, put the						
	granules into a med	dication administration cup,			For the Residents affected: Resident			
		mount of dry granules into the			#139 was seen by the physician on			
	•	hen poked her gloved finger			10-16-2015. The physician discontinu			
		t several times to push the			the Cymbalta. The physician also wro			
		ne bottom and then pushed 30			an order for the resident¿s G-Tube to			
		nto the same G Tube port by			replaced and an appointment has bee	n		
		n a plunger to force the			scheduled for 12/15/2015.			
		the tubing. Large amounts of			For the Residents with the potential to			
	_	clusters were seen adhered			affected: On 10/26/2015 all residents			
		length of the tubing of the G d as black to light brown. The			G-tubes were assessed by Director of			
		ble to be moved through the			Nursing and RN Supervisor to ensure other G-tubes did not have clusters	all		
		r 'milking' the tube.			adhered to the inside of the tubes.			
	labe by parpairing 0	i mining the tabe.			Physician was notified by RN supervis	sor		
	Nurse #1 was inter	viewed on 10/13/15 at 11:30			for other resident taking Cymbalta via			
		that she administers the			G-tube and orders were received to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345553 B. WING			C 10/15/2015		
NAME OF PE	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	13/2013
AUTUMN (CARE OF FAYETTEVILLI	E		1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE	(X5) COMPLETION DATE
F 157	are difficult to dissolve notified the physician administration of the control she stated "No, because at least getting some that her behaviors has revealed that the tubin palpable granules sin facility (July 2015). Some thought to inform the the tubing either. The Director of Nursing 10/14/15 at 1:45 PM. Not been notified of an issues with Cymbalta the same with the physician assigned to After seeing the G Turdisgusted. I have nevexpectation is that the having issues with mesoon as it happens." 483.25(g)(2) NG TRE RESTORE EATING Some seed on the comprese resident, the facility meson or with assistant tube unless the resident.	ules because the granules e. When asked if she has or any member of difficulties in administration, use I feel that the resident is of the medication. I feel we improved." She further ing has been discolored with ce she began working at the he indicated that she never physician of the condition of and was interviewed on She indicated that she had my medication administration and that she had confirmed visician and the physician take care of Resident #139. be, she stated "I am ver seen a tube like this. My e nurse notify the physician if edication administration as ATMENT/SERVICES - SKILLS hensive assessment of a	F 15	discontinue the medication. Measures Put in Place/System Chail In-services began by Staff Developm Nurse on 10/14/2015 until all nurses in-serviced on contacting the physic resident; s G-Tube condition has a change and notify the physician if the an issue with administering any medication to a resident. Monitoring: Director of Nursing or Designee will observe 5 G-tube medication passes per week for 4 weeks. Then G-tube medication passes monthly for 2 medication to a resident. Monitoring: Director of Nursing or Designee will observe 5 G-tube medication of 2 medication with administering medication via G-and if so physician is notified timely. A comprehensive review of the audit described above and the systems modifications we have made will be discussed and monitored through or quality assurance meeting at least quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modification or training are in order.	ment s were ian if a ere is 5 onths elty -tube ts ur be ations	11/12/15

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 10/15/2015	
		345553 B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	0/13/2013
ALITUMAL	CADE OF FAVETTEVILL	=		1401 71ST SCHOOL ROAD		
AUTUMN	CARE OF FAYETTEVILL	=		FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 322	F 322 Continued From page 3		F 32	22		
	(2) A resident who is gastrostomy tube rec treatment and service pneumonia, diarrhea, metabolic abnormaliti	fed by a naso-gastric or				
	by: Based on observation facility failed to 1) pust Gastrostomy tube (G medication administration observed for G Tube (Resident #118) and individual medication residents observed for via G Tube (Resident included: Resident #118 was a diagnoses that included hypertension, demen arthritis, and calcium The resident was pre medications to be additube inserted through	Tube) port prior to ation for 1 of 3 residents medication administration 2) flush water in between administration for 2 of 3 or medication administration #118 and #139). Findings dmitted on 1/3/13 with ed diabetes mellitus, tia, reflux, rheumatoid and vitamin D deficiency.		F322 This plan of correction will serve facility is allegation of compliant requirements of 42 CFR, Part is Subpart B for long term care far Preparation and submission of correction is in response to Defor the 10/15/2015 survey and constitute an agreement or add Autumn Care of Fayetteville of the facts alleged or the correct conclusions stated on the state deficiencies. This plan of corresponded and submitted because requirements of 42 CFR, Part is Subpart B throughout the time stated in the statement of deficiencies with state and federaccordance with state and federaccordance with state and federaccordance with state and federaccordance submits this plan of corrections.	nce with 483, acilities. f this plan of HHS 2567 does not mission of f the truth of tness of the ement of ection is use of the 483, period ciencies. In eral law,	
	the above named dia twice daily, Metformir Glipizide 5 mg twice of daily, Zantac 150 mg	gnoses: Coreg 12.5 mg		address the statement of defice to serve as it is allegation of committee the pertinent requirements dates stated in the plan of corresponding to the plan of cor	iencies and ompliance s as of the rection and	

		IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345553	B. WING		C 10/15/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/13/2013	
				1401 71ST SCHOOL ROAD		
AUTUMN	CARE OF FAYETTEVILL	E		FAYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 322	Continued From page	e 4	F 32	2		
	mg twice daily, Aspiri 2000 International Ur	n 81 mg daily, and Calcitriol nits daily.		2015.		
	Resident #139 was a diagnoses that includ depression, reflux, irochronic back pain. The following medicat G Tube for the name twice daily, Baclofen 60 mg daily, Cozaar mg every 4 hours as liquid 1100 mg daily. interviewable per the 08/19/15. 1) Medication adminiconducted on 10/13/was observed to remmedications for Residuards and/or stock be medications into 1 crushed all of the mecrush bag, and adminicolations and adminiconducted all of the mecrush bag, and adminiconducted and adminiconducted all of the mecrush bag, and adminiconducted and adminiconducted all of the mecrush bag, and adminiconducted and adminiconducted all of the mecrush bag, and adminiconducted and adminicondu	dmitted on 8/19/2014 with led hypertension, on deficiency anemia, and he resident was prescribed ions to be administered via d diagnoses: Coreg 6.25 mg 5 mg twice daily, Cymbalta 25 mg daily, Percocet 5/325 needed, and Ferrous Sulfate Resident #139 was not Minimum Data Set dated stration observation was 15 at 10:30 AM. Nurse #1		For the Residents affected: Resider was seen by the physician on 10-16 to ensure resident; s condition was For the Residents with the potential affected: In-services began on 10/1 by Staff Development Nurse until al nurses were in-serviced on the facil policy of medication administration. G-tube. This policy includes Flushin with 30cc of water or as ordered pri medication administration, and indic crushing medications in separate pouches, and flush tube with water each medication is administered. Measures Put in Place/System Cha All nurses annually and upon hire wobserved by the Staff Development Coordinator or designee performing medication administration via peg to per policy. Monitoring: Director of Nursing or S Development Nurse will observe 5 6 med passes per week for 4 weeks.	S-2015 stable. to be 4/2015 l ities via ng tube or to vidually after linge: vill be J ube ttaff G-tube	
	verification step to ch	to the medication important process is a leck for any obstruction in erceived by observation		5 G-tube med passes monthly for 2 months to ensure nurses are flushir G-Tube prior to administering medic and flushing G-tube between each medication that is administered. A comprehensive review of the aud	ng cation	
	AM. She acknowledg G Tube prior to admit She stated "I just mis	ewed on 10/13/14 at 11:30 ged that she did not flush the nistering the medications. ssed it."		described above and the systems modifications we have made will be discussed and monitored through o quality assurance meeting at least quarterly. Any further omissions regarding physician notification will	ur	
	10/14/15 at 1:45 PM.	_		addressed by the QA Committee to determine if further systems modific		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/15/2015			
		345553	B. WING					
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	10/13/2013			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 322	each time as per our 2) Nurse #1 was observed medication the punch cards and the medications into the medications toge administered the me Nurse #1 replicated I Resident #139. She medications individual flushes in between mensure that the full distribution the residents.	Iministering any medication policy." Served to remove all one for Resident #118 from for stock bottles, placed all of 1 crush bag, crushed all of 1 ther in the crush bags, and dication mixtures by G Tube. The procedure again for did not administer the ally with 30 milliliters of water medication administration to ose of the medication flows reaches the gastric area of	F 32	and/or training are in order.				
F 332 SS=D	AM. She could not provide a substance of the provided and	to what the facility policy is in between individual dministration. Ing was interviewed on PM. She stated "Our policy pine all medications together by G tube. The nurses are ter one medication at a time between (administrations). The nurses do as our policy of MEDICATION ERROR	F 33	2	11/12/15			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345553	B. WING				C 45/2045
NAME OF DE	ROVIDER OR SUPPLIER	04000		ет	FREET ADDRESS, CITY, STATE, ZIP CODE	10/	15/2015
NAME OF F	COVIDER OR SUFFLIER						
AUTUMN (CARE OF FAYETTEVIL	LE			101 71ST SCHOOL ROAD		
				FA	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 332	Continued From pag	ge 6	F 3	332			
	This REQUIREMEN by:	T is not met as evidenced					
	Based on observati	ons, medical record review,			F332		
	and staff interview, t	he facility failed to maintain a			This plan of correction will serve as the	,	
	medication administ	ration error rate below an			facility¿s allegation of compliance with		
	acceptable level of 5	5% for 26 opportunities			requirements of 42 CFR, Part 483,		
	•	on error rate 11.5%, Resident			Subpart B for long term care facilities.		
		rors of 26 medication			Preparation and submission of this plan		
	administration oppor	rtunities). Findings included:			correction is in response to DHHS 256 for the 10/15/2015 survey and does no		
	Medication administ	ration observation was			constitute an agreement or admission	of	
	conducted on 10/13	/15 at 10:30 AM.			Autumn Care of Fayetteville of the truth	າ of	
					the facts alleged or the correctness of	:he	
		admitted on 1/3/13 with			conclusions stated on the statement of		
	_	ded diabetes mellitus,			deficiencies. This plan of correction is		
	• •	ntia, reflux, rheumatoid			prepared and submitted because of the	;	
		n and vitamin D deficiency.			requirements of 42 CFR, Part 483,		
		escribed the following			Subpart B throughout the time period		
		dministered via gastrostomy			stated in the statement of deficiencies.	In	
		e inserted through the			accordance with state and federal law,		
		ers nutrition and medicine			however, submits this plan of correctio		
		ch) for the above named			address the statement of deficiencies a	-	
	•	2.5 mg twice daily, Metformin			to serve as it's allegation of compliance		
		Glipizide 5 mg twice daily,			with the pertinent requirements as of the		
	_	daily, Zantac 150 mg daily,			dates stated in the plan of correction at		
		r, Plaquenil 200 mg twice n 500 mg twice daily, Aspirin			as fully completed as of November 12, 2015.		
		lcitriol 2000 International			2013.		
	Units daily.	icitioi 2000 international			For the Residents affected: Nurse was		
	ornio dally.				provided one on one education by Staf		
	Resident #139 was	admitted on 8/19/2014 with			Development Nurse regarding policy o		
	diagnoses that inclu				g-tube medication administration with	-	
	•	on deficiency anemia, and			return demonstration on 10/19/2015	ſ	
		The resident was prescribed			For the Residents with the potential to	be	
		ations to be administered via			affected and measures put in	-	
	_	ed diagnoses: Coreg 6.25 mg			place/system change: In-services bega	ın	
		n 5 mg twice daily, Cymbalta			on 10/14/2015 by Staff Development	ĺ	
		25 mg daily, Percocet 5/325			nurse until all nurses were in-serviced		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345553	B. WING		1	C 10/15/2015	
	ROVIDER OR SUPPLIER CARE OF FAYETTEVILL	.E		STREET ADDRESS, CITY, STATE, ZIP CO 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		0/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 332	mg every 4 hours as liquid 1100 mg daily. interviewable per Mindated 8/19/15. 1). Nurse #1 was obsprescribed medication the punch cards and the medications into the medications toge administered the me Nurse #1 replicated Resident #139. Nurse #1 was intervi AM. She could not prescribe the me not say that medications pertaining about combining me administration. She do not say that medication be crushed together by G Tube." The Director of Nurs 10/14/2015 at 1:45 Fedoes not say to combining to be administered be instructed to administered binstructed to administered with water flushes in	needed, and Ferrous Sulfate Resident #139 was not nimun Data Set assessment served to remove all ons for Resident #118 from /or stock bottles, placed all of 1 crush bag, crushed all of their in the crush bag, and dication mixture by G Tube. the same procedure again for ewed on 10/13/15 at 11:30 provide an answer to to what the facility policy is	F 3:		cations g them ing or Staff erve 5 G-tube weeks. Then hly for 2 e crushing all ered via G-tube separately each the audits stems e will be rough our ut least sions cion will be hittee to		
	Cymbalta (chemical granules via G Tube observed to disasser put the granules into administration cup, a	o observed to administer name: duloxetine) 60 mg dry for Resident #139. She was mble the Cymbalta capsule, a separate medication and pour a small amount of G Tube medication port.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		345553	B. WING		C 10/15/2015
	ROVIDER OR SUPPLIER	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	10/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 332	Continued From pa	_	F 33	2	
	the G Tube medical granules towards the pushed 30 milliliters port. Large amount	I to poke her gloved finger into tion entrance port to push the se bottom of the port and then sof water into the medication its of granule clusters were entire length of the tubing black to light brown.			
	"Cymbalta 60 mg by information from Elic Cymbalta, stated "Acconducted to deterred a 60 mg duloxetine visually adhere to o (naso-gastric) Tubes apple juice or water which the pellets according to the state of the	er dated 4/27/15 stated by G Tube daily." However, Lilly, the manufacturer of A laboratory study was mine whether the pellets from (Cymbalta) capsule would by robstruct G Tubes of NG best when mixed with either Based on the results, in becumulated in both the NG by and few pellets passed administration of duloxetine ding tubes was shown not to ethod for delivery to patients."			
	AM. She stated "T get some of the Cyr doesn't dissolve in granules. I feel that have improved since Nurse #1 further state it this way. This is and the resident. T since I started work July (of 2015)." Note that Cymbadministered via G pharmacy or the phamedication adminis	riewed on 10/13/15 at 11:30 This is the only way that I can ambalta into the resident. It water so I administer it as dry t (Resident #139's) behaviors to I have been doing this." The water was I have been doing this. The water in the two the seen like this ing at the facility which was in was #1 indicated that she did walta could not be to I have been like this ing at the facility which was in was #1 indicated that she did walta could not be to I have been like this inguity which was in was in was in was in was walter in the facility which was in was walter in the facility was walter in the facili			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
345553		B. WING _	B. WING		C 10/15/2015	
	ROVIDER OR SUPPLIER	Ε		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		10/13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 332 F 333 SS=D	The Director of Nursin 10/14/2015 at 1:45 Pl she stated "I am disg nurse to have alerted difficulties of administ I would also expect pl orders and recommer administer medication 483.25(m)(2) RESIDE SIGNIFICANT MED ETHE The facility must ensurany significant medical	palpable clusters of hroughout the entire tube. Ing was interviewed on M. After seeing the tube, susted. I would expect the me or the physician of the ering Cymbalta by G Tube. harmacy to review our not the best way to ns." ENTS FREE OF ERRORS Irre that residents are free of ation errors.	F3			11/12/15
	by: Based on observation interview, the facility of repeated occurrence error by administering tube (G Tube) since of prescribed Cymbalta Findings included: Resident #139 was and diagnoses that include behaviors, for which is Cymbalta (chemical or daily via G Tube. She per Minium Data Set 8/19/15. Manufacture guideline	of a significant medication of Cymbalta by Gastrostomy July 2015 for 1 of 1 residents via G tube (Resident #139). Idmitted on 8/19/2014 with ed depression with she was prescribed lame: duloxetine) 60 mg e was not interviewable as assessment done on		F333 This plan of correction will serve facility is allegation of compliant requirements of 42 CFR, Part 4. Subpart B for long term care fact Preparation and submission of the correction is in response to DHF for the 10/15/2015 survey and constitute an agreement or adminimum Care of Fayetteville of the facts alleged or the correcting conclusions stated on the stater deficiencies. This plan of correct prepared and submitted because requirements of 42 CFR, Part 4. Subpart B throughout the time pastated in the statement of deficiencies.	ce with 83, cilities. this plan of HS 2567 does not nission of the truth of ness of the ment of ction is se of the 83, period	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 10/15/2015	
		345553 B. WING					
NAME OF D	ROVIDER OR SUPPLIER	0.000	 	STREET ADDRESS, CITY, STATE, ZIP CC		0/15/2015	
TVAIVIL OF T	NOVIDEN ON OUT FEEL				,DL		
AUTUMN	CARE OF FAYETTEVILL	E		1401 71ST SCHOOL ROAD			
				FAYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 333	Continued From page	e 10	F 33	33			
	through the tubes, (the duloxetine pellets through not to be a dedelivery to patients." Nurse #1 was also of	oserved to administer		accordance with state and for however, submits this plan of address the statement of de to serve as it is allegation of with the pertinent requirement dates stated in the plan of or as fully completed as of November 1981.	of correction to ficiencies and f compliance ints as of the orrection and		
	Cymbalta 60 mg dry granules via G Tube for Resident #139 at 10:30 AM on 10/13/15. She was observed to disassemble the Cymbalta capsule, put the granules into a medication administration cup, and pour a small amount of dry granules into the G tube medication port. She then poked her gloved finger into the G Tube port to push the granules towards the bottom and then pushed 30 milliliters of water into the G Tube medication port. Large amounts of granule clusters were seen adhered to the entire length of the tubing of the G tube and discolored from black to light brown.			For the resident found to be nurse observed during the nadministration was in-service rights of medication administ the importance of triple checto prevent any further medication by province to prevent any further medication was informedication error 10/14/2015 the medication error was no and did not place the reside	nedication ed on the tration and ck procedures eation error by desident med of the is and states t significant		
	AM. She indicated the adhering to the tubing granules. When que on the full dose of Cy resident with her met stated "I had not tho way that I can get so resident. It doesn't administer it as dry g #139's) behaviors heen doing this." None taught me to do think works best for nube has been like the facility which was #1 indicated that she	ewed on 10/13/15 at 11:30 at the granule clusters g did look like Cymbalta stioned about her thoughts mbalta not reaching the hod of administration, she ught about it. This is the only me of the Cymbalta into the dissolve in water so I ranules. I feel that (Resident ave improved since I have urse #1 further stated " No t this way. This is what I ne and the resident. The s since I started working at in July (of 2015). " Nurse did not know that Cymbalta pered via G Tube, had not		complications. To ensure other residents are in a similar manner, the nurse in-serviced by Staff Develop on 10/14/2015 until all nurse in-serviced on making sure as is given to a resident. To ensure on-going compliate pharmacy; squality assurant conducted unannounced means on 10/29/2015 to ensure proposed during survey observed during these audit found to be proficient during medication pass and was also the information gained during in-service.	sing staff was ment Nurse es were all medication ence, the ace nurse ed pass audits oper dosage is a orders. The ey was also s. She was the ole to verbalize		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURV COMPLETE	
		345553	B. WING _			C 10/15/2015
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CO 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	ODE	10/10/2010
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 333	difficulties in medicat not give consideration discolored tube with predication adhered to the she further indicated globules of black grassince she began work in July 2015. She also never brought this issiphysician, nor had the her that Cymbalta contube. The Director of Nursi 10/14/15 at 1:45 PM. not aware of any issuadministration of Cym After seeing the tube disgusted. I would evalented me or the phyadministering Cymbal expect pharmacy to recommend the best medications. " 483.60(c) DRUG REGIRREGULAR, ACT Control of the pharmacist. The pharmacist must the attending physicial in the size of the physicial in the size of the phyadministering cymbal expect pharmacy to recommend the best medications. " 483.60(c) DRUG REGIRREGULAR, ACT Control of the pharmacist must the attending physicial in the pharmacist must be provided in the pharmacist must be ph	cy or the physician of the ion administration, and did in to questioning the largely palpable clusters of throughout the entire tube. It that the tube has had large nules adhered to the tubing king at the facility which was so revealed that she had sue to the attention of the e pharmacy ever instructed uld not be administered by G on the service of the difficulties of the difficulties of the difficulties of the service of the difficulties of the service of the servic	F 3	Monitoring: Director of Nurse Development Nurse will observed passes per week for 4 5 G-tube med passes mont months to ensure that there notification of physician if an occurs with administering mr. G-tube. The results of these intended to ensure on-going will be discussed and monit our next quality assurance in next two quarters.	serve 5 G-tube weeks. Then hly for 2 is timely ny difficulty nedication via e audits g compliance cored through	11/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345553	B. WING			1	C
		343533	D. WING_			10/	15/2015
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE			14	TREET ADDRESS, CITY, STATE, ZIP CODE 401 71ST SCHOOL ROAD AYETTEVILLE, NC 28314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page	e 12	F4	428			
	by: Based on record revolusers dealing with in administration of Cyn (G Tube, a tube insert to provide nourishme 1 residents (Resident Resident #139 was a diagnoses that includ was prescribed the Cadministered via G Trinterviewable as per Minimum Data Set da Medication administratione on 10/13/15 at observed to administration on 10/13/15 at observed to	ated 8/19/15. ation observations were 10:30 AM. Nurse #1 was er Cymbalta (chemical mg dry granules via G Tube the was observed to abalta capsule, put the cation administration cup, count of dry granules into the ort at a time. She then ger into the G Tube port to push the granules if the port and then pushed into the medication port. anule clusters were seen length of the tubing and o light brown. cal record revealed a d 4/27/15 which stated G Tube daily." cilly, the manufacturer of			This plan of correction will serve as the facility is allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan correction is in response to DHHS 256 for the 10/15/2015 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. accordance with state and federal law, however, submits this plan of correction address the statement of deficiencies at to serve as it is allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction are as fully completed as of November 12, 2015. For the Residents affected: Resident # was seen by the physician on 10-16-20. The physician discontinued the Cymba For the Residents with the potential to affected and measures put in place/system change: The Consultant Pharmacist was in-serviced by Director Nursing on 10/15/2015 on the manufactures recommendation not to	n of 7 t to of n of he e nd 139 115. Ita.	

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391
STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		345553	B. WING			10/	15/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN	CARE OF FAYETTEVILL	F		14	401 71ST SCHOOL ROAD		
7.010	071112 01 17112112VIE2	_		F/	AYETTEVILLE, NC 28314		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page 13 conducted to determine whether the pellets from a 60 mg duloxetine (Cymbalta) capsule would visually adhere to or obstruct G Tubes or NG (naso-gastric) Tubes when mixed with either apple juice or water. Based on the results, in which the pellets accumulated in both the NG Tubes and G Tubes and few pellets passed through the tubes, administration of duloxetine pellets through feeding tubes was shown not to be a dependable method for delivery to patients."		F	428	administer Cymbalta via G-tube. The Director of Nursing notified physician of 10/16/2015 of one other resident in factors of the conduction of the conductin	cility	
					receiving Cymbalta by G-Tube and ord were received to discontinue the Cymbalta Monitoring: Director of Nursing or RN Supervisor will monitor all new medica orders for residents receiving medicati by G-Tube weekly ongoing to ensure a	tion ons any	
	AM. She stated "Thi get some of the Cymidoesn't dissolve in vigranules" Nurse # taught me to do it this	ewed on 10/13/15 at 11:30 is is the only way that I can balta into the resident. It vater so I administer it as dry #1 further stated "No one s way." Nurse #1 indicated that Cymbalta could not be			resident does not receive the Cymbalta via G-tube. A comprehensive review of the audits described above and the systems modifications we have made will be discussed and monitored through our quality assurance meeting at least	Ā	
	administered via G To recommendations an pharmacy of the diffic administration. She a	ube per manufacturer d had not informed the culties in medication also confirmed that the t, who reviews medications			quarterly. Any further omissions regarding physician notification will be addressed by the QA Committee to determine if further systems modificati and/or training are in order.		
	administered by G Tu The Pharmacist was 12:00 PM. He confirn Resident #139 was b	interviewed on 10/15/15 at ned that he was aware that eing administered Cymbalta					
	Cymbalta insolubility made a recommenda from such administra	ot brought up the issue of by G Tube and had not ever ition that the facility refrain tive practice. He provided					
	Pharmacist of Austral capsule content and enteral feeding tubes question regarding the information from Austral	Society of Health Systems lia that stated "Open disperse in apple juice for ." He did not respond to a e applicability of using tralia in the United States. formation from an abstract of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: ` ´		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345553		B. WING _	B. WING		C 10/15/2015		
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		0/13/2013	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	applesauce, apple juifor administration in provide specific in administration and strapplesauce and applesauce and it applesauce and it applesauce and it, nor did administer the granul not provide an answer awareness of the vast the internet dissuadir administration of Cynfrom reputable source including the Federal and the manufacture. The Director of Nursi 10/14/2015 at 1:45 Proposed and the stated "I am disguirse to have alerted difficulties of administ I would also expect proders and recommendation and state of the state	ting the dissolution of arious methods including ce, and chocolate pudding patients with swallowing med that this abstract did aformation about G Tube ated "If it is stable in a juice, I believe it would be an inistration." The not state to administer the sauce or apple juice to id the pharmacist ever d Nurse #1 attempt to a maplesauce. He did are to questions regarding his at information available on a gethe practice of G Tube an balta, including information as in the United States. Drug Administration (FDA) are, Eli Lilly. The grass interviewed on the me or the physician of the tering Cymbalta by G Tube. The harmacy to review our and the best way to as from reputable sources in the ERS/MEET.	F 4			11/12/15	
	A facility must mainta assurance committee	in a quality assessment and consisting of the director of hysician designated by the					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION UILDING		COMPLETED	
		345553	B. WING		1	C 0/15/2015	
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314		10/15/2015	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 520	Continued From page 15 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced		F 5.	20			
	by: Based on record re facility 's Quality As Committee (QA Cor implemented proced interventions that th 01/08/2015. This w which was originally recertification survey area of notifying the timely manner. The during the two feder pattern of the facility	views and staff interviews the sessment and Assurance nmittee) failed to maintain dures and monitor these e committee put into place on as for one recited deficiency cited on 12/11/2014 during a y, and again on the current y. The deficiency was in the physician of changes in a continued failure of the facility al surveys of record shows a or is inability to sustain an surance Program. Findings		F520 This plan of correction will serve facility is allegation of compliance requirements of 42 CFR, Part 48 Subpart B for long term care fact Preparation and submission of the correction is in response to DHH for the 10/15/2015 survey and do constitute an agreement or admit Autumn Care of Fayetteville of the facts alleged or the correcting conclusions stated on the statent deficiencies. This plan of correct prepared and submitted because requirements of 42 CFR, Part 48 Subpart B throughout the time prepared.	ne with 33, silities. In the plan of 18 2567 pees not 18 silities of the 18 silities of t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 520	and record review, the physician of the difficial administration for Cyr (G Tube, a tube inserforfacilitation of nutritial administration) for 1 cobserved for medicat Tube (Resident #139). The facility was recited to develop and impless monitor these interves physician is notified in relates in the current Cymbalta by G Tube. During an interview with 10/15/15 at 12:00 PM facility 's QA Commit Director of Nursing, the pharmacist, and 9 de Administrator indicated met on a quarterly bath 12/11/14, the Administ committee "focused committee" focused of the committee administration in the committee of the difficult of the physician of the committee of the difficult of the physician of the difficult of the physician of the physician of the difficult of the physician	ervations, staff interviews, e facility failed to notify the ulties in medication mbalta via Gastrostomy tube ted directly into the stomach on and medication of 3 sampled residents ion administration via G.). In the fact of the failed ment procedures and intions to ensure the in a timely manner as it is ituation to administrator on the indicated that the tee consisted of himself, the partment heads. The ed that the QA Committee is is. For the citation dated	F 52	stated in the statement of definaccordance with state and fed however, submits this plan of address the statement of defic to serve as it is allegation of cwith the pertinent requirement dates stated in the plan of corras fully completed as of Nover 2015. For the Residents affected and with the potential to be affected meeting consisting of Medical Pharmacist, Dietician, Director Administrator, both Unit Mana scheduled for 11/2/2015 to revisively findings. Measures put in place/system days a week the Director of Ni Administrator will conduct a mithe unit manager, MDS Coord Staff Development Coordinate meeting is intended to review from the previous days, critical and all orders written from previous ensure follow-up on any are identified concern. Monitoring: Director of Nursing Administrator will review their the weekly meeting to ensure that are currently being follows committee are followed up on basis. The QA committee will reviews quarterly to evaluate feffectiveness.	deral law, correction to ciencies and compliance is as of the rection and mber 12, d for those ad: A QA Director, r of Nursing, gers is view the a change: 5 ursing or leeting with linator, and for. This incidents all issues, evious days ea of g or lotes from any areas ed by the QA a weekly review these		