STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services completed an Annual survey on 10/08/18 and a telephone exit on 10/09/18.	C 000		
C 170	10A NCAC 13G .0503 (e) Medication Administration Competency Evaluati 10A NCAC 13G .0503 Medication Administrationn Competency Evalutaion (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. Copies of this form and instructions for its use may be obtained at no cost by contacting the Adult Care Licensure Section, Division of Facility Services, 2708 Mail Service Center, Raleigh, NC 27699-2708. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 3 sampled staff (Staff C) had a completed Medication Administration Skills Validation form upon working at the facility. The findings are: Review of Staff C, relief Supervisor-in-Charge (SIC) personnel file on 10/08/18 revealed:	C 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 170	Continued From page 1 -Staff C began working as a relief SIC at this facility on 07/07/18. -There was no documentation Staff C had completed a Medication Administration Skills form for this facility. -There was a medication test passed on 06/15/12. Interview with a resident revealed Staff C, relief SIC had only worked in this house a few times and cooked meals and gave medications without any problems. Telephone interview the Administrator on 10/08/18 at 1:30pm revealed: -Staff C, relief SIC worked full time at another family care home and only worked as needed on this property. -Staff C had worked for her since 2003. -Staff C, relief SIC, did have Medication Administration Skills Validation form completed for the other facility. -She had not had a Medication Administration Skills Validation competed for this home for Staff C, relief SIC since there was one on file for the other facility. -She would have staff with the pharmacy come out this week to complete the Medication Administration Skills Validation for Staff C. Telephone interview with Staff C, relief SIC on 10/08/18 at 5:00pm revealed: -She started working some weekends at the family care homes in 07/18. -She had only worked at this facility "a couple of times." -She had administer medications for all residents. -One resident did require blood sugar readings and insulin injections and she completed those with no problems.	C 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 170	Continued From page 2 -She had been an SIC and Medication Aide since 2003 at the Administrators' other property's.	C 170		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 3 sampled staff (Staff C) had completed Licensed Health Professional Support (LHPS) competency validation prior to working in the facility. The findings are: Review of Staff C's, relief Supervisor-in-Charge (SIC) personnel file on 10/08/18 revealed: -Staff C began working as a relief Supervisor-in-Charge (SIC) at this facility on 07/07/18. -There was no documentation Staff C had completed a LHPS competency validation for this facility. Interview with a resident revealed Staff C had	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 171	Continued From page 3 only worked in this house a few times and cooked meals and gave medications without any problems. Telephone interview the Administrator on 10/08/18 at 1:30pm revealed: -Staff C worked full time at another family care home and only worked as needed on this property. -She had worked for her since 2003 at her other facilities. -She had not had a LHPS competency validation competed for this property for Staff C since there was one on file for the other facility. -She would have staff with the pharmacy come out this week to complete the LHPS competency validation for Staff C. Telephone interview with Staff C on 10/08/18 at 5:00pm revealed: -She started working some weekends at the family care homes in 07/18. -She had only worked at this facility "a couple of times." -The residents did not require any assistance with ambulation and were "mostly independent." -One resident did require blood sugar readings and she completed those with no problems. -She had been an SIC and Medication Aide since 2003 at the Administrators' other property's.	C 171		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 315	Continued From page 4	C 315		

resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure physician clarification for 1 of 3 sampled residents (Resident #1) related to sliding scale insulin (SSI).

The findings are:

Review of the current FL2 dated 09/05/18 for Resident #1 revealed:
-Diagnoses of acute cerebral vascular accident (CVA), hypertension, type 2 diabetes, aortic stenosis, hyperlipidemia, asthma and glaucoma.
-Medications included Humalog 100u/ml use as directed per sliding scale (used to control blood sugar), Lantus 100ml inject 48 units SubQ at bedtime (used to control blood sugar).
-No physician's order for SSI.

Review of the Resident Register for Resident #1 revealed she was admitted on 08/30/18.

Review of Resident #1's September and October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was no sliding scale on the eMAR for September or October.
-There was documentation staff checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 315	Continued From page 5 Resident #1's blood sugar twice daily at 8:00am and 5:00pm. -An entry for Humalog at 8:00am and again at 5:00pm documented Resident #1's blood sugar and the amount of Humalog given. -An entry for Lantus 48 units at 8:00pm. -There was documentation Lantus was administered at 8pm. Review of Resident #1's record revealed there was no documentation the physician had been notified regarding the SSI. Review of Resident #1's record revealed: -There were no clarification orders in the residents record for SSI. -There was no documentation in the progress notes where the physician had been contacted regarding the sliding scale. -A MAR from the previous facility had a sliding scale and Humalog 100 units, check fingerstick bloodsugar and inject subcutaneously per SSI before breakfast and supper: 0-200 = 0 units 201-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351-400 = 8 units 401-450 = 10 units >450 = Call MD A review of Resident#1's blood sugars on the September 2018 eMAR revealed: -A range from 105 to 319 for the 8am dose. -A range from 199 to 449 for the 8pm dose. A review of Resident#1's blood sugars on the October 2018 eMAR revealed: -A range from 199 to 347 for the 8am dose. -A range from 247 to 429 for the 8pm dose.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 315	Continued From page 6 Interview with Resident #1 on 10/08/18 at 10:00am and at 2:00pm revealed: -The Supervisor-in-charge (SIC) checked her blood sugar twice a day and would administer her insulin. -She was aware her blood sugars were running in the "300's" most of the time as the SIC told her when she checked her blood sugars. -She was not aware how much insulin was being administered nor was she aware of what her current sliding scale was. Interview with the SIC on 10/08/18 at 11:05am revealed: -She was not aware of what the actual SSI was for Resident #1. -The SSI was on the eMAR and the dose came up automatically in the eMAR for her to administer. -She was unable to print the SSI on the eMAR. -The SSI was put in the eMAR system by the facility pharmacy. Interview with the property manager on 10/08/18 at 12:55pm revealed: -When Resident #1 was admitted the Administrator sent the MAR from the previous facility dated 08/30/18 to the pharmacy as the medications were not on the FL2. -She had not had to contact the physician about Resident #1's blood sugars. -All physician contacts would be in the progress notes. Telephone interview with Resident #1's primary physician on 10/08/18 at 11:23am and 10/09/18 at 2:45pm revealed: -She had not seen Resident #1 since she had been admitted but had followed her at the	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 315	Continued From page 7	C 315		

previous facility.
-Resident #1 had an appointment scheduled for 10/26/18 but she did not keep it.
-She had not received any calls from the facility requesting clarification orders for Resident #1's SSI.
-The SSI was not the scale she had ordered for Resident #1.
-She was not aware another physician changed the SSI.
-She had received a request for a FL2 to be signed on 08/31/18 after the office had closed.
-She signed the FL2 on 09/05/18 but there was nothing about the SSI.
-"I prefer her on the SSI I had put her on."
-Since she was not notified she could not control her blood sugar levels and she would have issues related to high blood sugars (cardiovascular disease, kidney damage or kidney failure, damage to the blood vessels of the retina).
-"We could have changed her medication as needed if I known what her blood sugars were."
-She had agreed on 10/08/18 for Resident #1 to remain on the current SSI she was on until her next appointment on 11/02/18.

Review of a fax sent from the primary physician for Resident #1 on 10/08/18 at 2:00pm revealed:
-The SSI for Resident#1 that was not being used was:
Less than 70 initiate Hypoglycemia guidelines,
70- 139 = 0 units
140-180 = 3 units
181-240 = 4 units
241-300 = 6 units
301-350 = 8 units
351--400 = 10 units
Greater than 400 administer 12 units, notify provider and repeat blood sugar check in 30 minutes. Continue to repeat 10 units and blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 315	Continued From page 8 sugar checks every 30 minutes until blood glucose is less than 300mg/dl, then resume normal blood sugar check and insulin apart sliding scale. Telephone interview with the Administrator on 10/08/18 at 4:00pm revealed: -She had completed Resident #1's admission. -She had used an FL2 for Resident #1's admission but could not remember the date on it. -She could not provide a copy of the FL2 before 09/05/18. -She did not verify the SSI when she requested the new FL2 dated 09/05/18 from Resident #1's physician. -She called Resident #1's previous pharmacy on 08/30/18 to get a copy of Resident #1's eMAR. -Resident #1 had brought her medications from the previous facility with her when she was admitted. -She had forgotten to check the button in the facility eAR to get the SSI to print out. -She spoke with Resident #1's physician on 10/08/18 who agreed for her to remain on the present SSI scale the facility was using until her next appointment in November. Telephone interview with the facility pharmacy on 10/09/18 at 12:01pm revealed: -The original medication orders came to them from the eMAR printed on 08/30/18 from the previous facility. -There was a signed FL2 dated 06/04/18 that had "SSI as directed" on it. -"We went by the sliding scale on the MAR from 08/30/18 that was sent to us,from the other facility". -The facility received the medications on the evening of 08/30/18 at 8:35pm.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 330	Continued From page 9	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure that medications were discontinued as ordered by a licensed physician for 1 of 3 residents (Resident #3) for Lithium and Melatonin. The findings are: Review of Resident #3's current FL2 dated 08/30/18 revealed: -Diagnoses included major depressive disorder with agitation, bipolar with mixed features disorder, borderline personality disorder, mild neurocognitive disorder and adjustment disorder with anxiety features. -A physician's order for Lithium 150mg twice daily in the morning and at noon (used to treat manic episodes of bipolar disorder). -A physician's order for Lithium 300mg, 1 capsule at bedtime. -A physician's order for Melatonin 3mg, 2 tablets at bedtime for sleep. Review of Resident #3's record revealed: -A subsequent physician order dated 10/05/18 to	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 330	Continued From page 10	C 330		

discontinue Lithium 150mg.
-A subsequent physician order dated 10/05/18 to continue Lithium 300mg at bedtime for one week then discontinue.
-A subsequent physician order dated 10/05/18 to discontinue Melatonin 3mg.

Review of the October 2018 electronic Medication Administration Record (eMAR) on 10/08/18 revealed:
-An entry for Lithium 150mg, twice daily at 8:00am and 12:00pm, with a "DC'd" computer generated on the eMAR.
-An entry for Lithium 300mg at bedtime.
-An entry for Melatonin 3mg, 2 tablets at bedtime, with a "DC'd" computer generated on the eMAR.
-Lithium 150mg was documented as administered twice daily from 10/01/18 through 10/07/18 and once (8:00am dose) on 10/08/18.
-Melatonin 3mg was documented as being administered 10/01/18 through 10/07/18.

Based on documented administration on the October 2018 eMAR Lithium 150 mg was administered 6 times after receipt of the order to discontinue dated 10/05/18 and Melatonin was documented as being administered three times after receipt of the discontinue order dated 10/05/18.

Observation of the medications on hand on 10/08/18 at 10:50am revealed both the Lithium and Melatonin were on hand in the medications for Resident #3.

Interview with the Supervisor-in-Charge (SIC) on 10/08/18 at 11:00am revealed:
-She administered medications for this facility.
-She was not working on 10/04/18 and returned to the facility after 5:00pm on 10/05/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011379	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 6	235 COUNTRY TIME CIRCLE LEICESTER, NC 28748

(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) COMPLETE DATE
C 330	Continued From page 11 -She did not find the medication order dated 10/05/18 until sometime on 10/06/18. -The medication order was on the shelf and when she found the order she faxed to the pharmacy on 10/06/18. -Since the eMAR was not updated until 10/08/18 she failed to discontinue administration of both the Lithium 150mg and Melatonin 3mg. Telephone interview with the pharmacy technician from the dispensing pharmacy on 10/08/18 at 12:13pm revealed: -An order dated 10/05/18 to discontinue Lithium 150mg and Melatonin 3mg was faxed to their office on 10/06/18 after business hours. -The order was entered onto the eMAR on 10/08/18 to discontinue both medications. Telephone interview with staff at Resident #3's prescribing physician's office on 10/08/18 at 3:05pm revealed the Nurse Practitioner was not available for interview. Telephone interview with a pharmacists from the dispensing pharmacy on 10/09/18 at 2:25pm revealed the resident "more than likely" would not have any negative side-affects since the Lithium was being tapered by the prescribing physician. Based on observation, interview and record review it was determined Resident #3 was not interviewable.	C 330		