STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011377	A. BUILDING: _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN VIEW ASSISTED LIVING # 4	233 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 conducted an annual survey on 09/26/19.	C 000		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were not pre-charted prior to administration and to observe the resident actually taking the medication for 1 of 3 sampled residents (#1) related to medications for thyroid disease and reflux. The findings are: Observation during the initial tour on 09/26/19 from 8:37am to 9:20am revealed: -There was a clear medication cup on a table in Resident #1's room. -There was one dark yellow capsule and one tan tablet inside the medication cup. -There were no residents or staff in the room. Review of Resident #1's current FL2 dated	C 341		

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C 341	Continued From page 1 08/12/19 revealed: -Diagnoses included hypothyroidism and gastric esophageal reflux disease. -Medication orders included levothyroxine (treats thyroid disease) 75mcg daily, and omeprazole (treats reflux) 40mg twice daily. Review of Resident #1's 09/01/19 - 09/26/19 electronic Medication Administration Record (eMAR) revealed: -There was an entry for levothyroxine 75mcg daily with an administration time of 7:00am. -There was documentation that the levothyroxine 75mcg had been administered at 7:00am on 09/26/19. -There was an entry for omeprazole 40mg twice daily with administration times of 7:00am and 4:00pm. -There was documentation that the omeprazole 40mg had been administered at 7:00am on 09/26/19. Review of Resident #1's medications on hand on 09/26/19 at 12:09pm revealed: -There was a bubble pack labeled 1 of 2 and omeprazole 40mg take 1 capsule twice daily. -There were 60 capsule were dispensed on 09/13/19 with 22 tablets remaining. -The capsules in the bubble pack matched the capsule in the medication cup. -There was a bubble pack labeled levothyroxine 75mcg take 1 tablet daily. -There were 30 tablets were dispensed on 08/12/19 with 8 tablets remaining. -The tablets in the bubble pack matched the tablet in the medication cup. Interview with the Medication Aide (MA) on 09/26/19 at 8:42am revealed: -She had given the resident her medications,	C 341		

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C 341	Continued From page 2 levothyroxine and omeprazole, at 7:00am. -She "usually" watches the resident take her medications but the Resident had been in a hurry to go outside. -She had handed the medications to the resident, was interrupted, and left the room before the Resident took them. -She had not observed residents taking their medication in the past and the Administrator had spoken to her about it. -She knew she should watch the residents take their medications and document on the eMAR after they had been administered. Interview with Resident #1 on 09/26/19 at 9:07am revealed: -The medications in the cup were the resident's levothyroxine and omeprazole. -The MA did not always observe the resident take her medications. -The MA would sometimes leave the medications in the room and "walk away". Interview with the Administrator on 09/26/19 at 12:19pm revealed: -The MAs were trained to observe the residents taking their medications and document on the eMAR afterward. -She did not know why the MA had not observed the resident take the medications.	C 341		