STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013006	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS LIVING CENTER	246 CABARRUS WEST CONCORD, NC 28025

(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
D 000	Initial Comments The Adult Care Licensure Section and Cabarrus County Department of Social Services conducted an annual survey on August 26, 2024 and August 27, 2024.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (#1) related to a medication to prevent blood clots. The findings are: Review of Resident #1's current FL2 dated 07/23/24 revealed diagnoses included Type 2 diabetes with chronic kidney disease, cerebral infarct (stroke) and atrial fibrillation (irregular heart rhythm). Review of Resident #1's skilled nursing facility's FL2 dated 06/28/24 revealed: -Diagnoses included left femur fracture (broken thigh bone), atrial flutter (irregular heart rhythm). -There was an order for apixaban (a medication to prevent blood clots) 2.5mg, one tablet twice daily.	D 276		

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Review of Resident #1's current FL2 dated 07/23/24 revealed there was an order for apixaban 5mg, one tablet twice daily.

Review of Resident #1's June 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for apixaban 5mg, one tablet twice daily at 8:00am and 8:00pm.
-Resident #1 was out of the facility from 05/25/24 to 06/28/24.
-Apixaban 5mg was documented as administered at 8:00am from 06/29/24 to 06/30/24 and at 8:00pm from 06/28/24 to 06/30/24.

Review of Resident #1's July 2024 eMAR revealed:
-There was an entry for apixaban 5mg, one tablet twice daily at 8:00am and 8:00pm.
-Apixaban 5mg was documented as administered at 8:00am and 8:00pm from 07/01/24 to 07/31/24.

Interview with a Pharmacist with the facility's contracted pharmacy on 08/27/24 at 1:59pm revealed:
-The facility faxed Resident #1's FL2 dated 06/28/24 to the pharmacy.
-Since Resident #1 was a readmission to the facility, a pharmacy technician or Pharmacist would have compared the readmission orders to what Resident #1 had received prior to her hospitalization.
-Resident #1 was on apixaban 5mg prior to her hospitalization and the order for apixaban 2.5mg twice daily on the FL2 dated 06/28/24 was overlooked by pharmacy staff.

Interview with the RCC on 08/27/24 at 10:02am revealed:
-When Resident #1 returned from the skilled

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D 276	Continued From page 2 nursing facility the FL2 was faxed to the pharmacy. -The pharmacy was responsible for entering medication orders into the eMAR system. -She, the MA Supervisor and the Administrator were responsible for ensuring the orders in the eMAR system matched the orders on Resident #1's FL2. -The orders were reviewed by only one staff member and there was no system in place for a second staff member to review the orders for accuracy. Interview with Resident #1's PCP on 08/27/24 at 10:58am revealed: -It was the facility's responsibility to ensure the contracted pharmacy entered medication orders correctly into the eMAR system. -She was unsure why apixaban 2.5mg twice daily was ordered for Resident #1 when she had been on apixaban 5mg twice daily prior to her hospitalization. -If Resident #1 received a higher than prescribed dose of apixaban there was a risk of bleeding. Interview with the Administrator on 08/27/24 at 2:29pm revealed: -The pharmacy was responsible for entering orders from residents' FL2s into the eMAR system. -The RCC and the MA Supervisor were responsible for reviewing the orders the pharmacy entered for accuracy.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes:	D 296		

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D 296	Continued From page 3 (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there were matching therapeutic diet menus for residents who had physician ordered therapeutic diets for ground/chopped texture. The findings are: Observation of the kitchen on 08/26/24 at 11:15am revealed: -A list of resident's therapeutic diets was posted for staff reference. -Therapeutic diets on the diet list included no added salt (NAS), ground/chopped meats, and CCHO diets. -The posted week at a glance menu was for regular, no added salt (NAS) and consistent carbohydrate diet (CCHO). -There were no therapeutic diet menus being referenced for meal preparation for ground/chopped meats. Interview with the Dietary Manager (DM) on 08/26/24 at 11:25am revealed: -She had worked at the facility for 14 years. -She knew what residents were on therapeutic diets but did not have any therapeutic diet menus to reference for residents on ground/chopped textured diets.	D 296		

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-She only had the week at a glance menu which was for regular, NAS, and CCHO.
-The facility changed menu companies about six months ago.
-She knew how to prepare the food for residents on ground/chopped textured diets as the former menu company had the individual diet menus and was familiar with how to prepare all diets.
-She could not recall the date, but did inform the Administrator that she needed to have the individualized diet menus from the new menu company for reference.
-The Administrator told her she would check with the facility owner.

Interview with the cook on 08/26/24 at 12:40pm revealed:
-She knew who was on the therapeutic diet list by referencing the list posted in the kitchen.
-She had training on the diets and how to prepare them.

Interview with the Resident Care Coordinator (RCC) on 08/27/24 at 11:30am revealed:
-She was responsible for making sure all therapeutic diets were communicated to the DM.
-She was not aware until yesterday 08/26/24 there were no therapeutic menus available for food service guidance for chopped/ground textured diets

Interview with the Administrator on 08/26/24 at 4:13pm revealed:
-They did not have any therapeutic menus except for the week at a glance menu which was for NAS, and CCHO.
-She did recall the DM coming to her asking about the therapeutic menus and thought she had followed up with the owner.
-The owner would be responsible for making sure

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D 296	Continued From page 5 the menus are available for food service guidance. Interview with the Owner on 08/27/24 at 2:02pm revealed: -He was responsible for ensuring the therapeutic menus were available for food service guidance. -The current menu company had only provided the menus that were posted for regular, NAS, and CCHO diets. A second interview with the Administrator on 08/27/24 at 2:08pm revealed: -It was her expectation that the owner would ensure all menus were available for food service guidance. -She would also make sure the kitchen staff had the therapeutic diets they need for guidance. Attempted telephone interview on 08/27/24 at 10:08am with the contracted menu companies' dietician was unsuccessful.	D 296		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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 interviews and record reviews, the facility failed to ensure medications were	D 358		

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administered as prescribed for 1 of 3 sampled residents (Resident #1) related to a medication used to control elevated blood sugar.

The findings are:

Review of Resident #1's current FL2 dated 07/23/24 revealed diagnoses included Type 2 diabetes with chronic kidney disease, cerebral infarct (stroke) and atrial fibrillation (irregular heart rhythm).

Review of Resident #1's skilled nursing facility FL2 dated 06/28/24 revealed:
-There was an order for humalog (a rapid acting insulin used to lower elevated blood sugar levels), inject 3 units before meals.
-There was an order for humalog, inject per sliding scale: FSBS: 200-249=2 units, 250-299=4 units, 300-349=6 units, 350-399=8 units, and greater than 400 to contact the Primary Care Provider (PCP).

Review of Resident #1's PCP order dated 07/09/24 revealed:
-There was an order to discontinue humalog 3 units before meals.
-There was an order to continue humalog sliding scale insulin three times daily.

Review of Resident #1's current FL2 dated 07/23/24 revealed there was an order for humalog before meals and at bedtime, inject per sliding scale: FSBS: 200-249=2 units, 250-299=4 units, 300-349=6 units, 350-399=8 units, and greater than 400 to contact the Primary Care Provider (PCP).

Review of Resident #1's July 2024 electronic Medication Administration Record (eMAR)

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D 358	Continued From page 7 revealed: -There was an entry for humalog, inject per sliding scale before meals and at bedtime at 7:30am, 11:30am, 4:30pm and 8:00pm. -On 07/12/24 at 7:30am, the resident's FSBS was 124 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/13/24 at 7:30am, the resident's FSBS was 137 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/13/24 at 11:30am, the resident's FSBS was 152 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/14/24 at 7:30am, the resident's FSBS was 170 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/14/24 at 11:30am, the resident's FSBS was 187 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/17/24 at 7:30am, the resident's FSBS was 108 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/17/24 at 4:30pm, the resident's FSBS was 180 and Resident #1 received 2 units when the order stated she should have received 0 units. -On 07/18/24 at 7:30am, the resident's FSBS was 100 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/18/24 at 11:30am, the resident's FSBS was 173 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/22/24 at 4:30pm, the resident's FSBS was 196 and Resident #1 received 3 units when the order stated she should have received 0 units. -On 07/26/24 at 11:30am, the resident's FSBS was 192 and Resident #1 received 2 units when the order stated she should have received 0	D 358		

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D 358	Continued From page 8 units. Interview with a medication aide (MA) on 08/27/24 at 10:39am revealed: -She began working at the facility in March 2024 and was trained by the Resident Care Coordinator (RCC) on how to administer sliding scale insulin. -She was trained to administer medications according to the orders on the eMAR. -Resident #1 was ordered humalog 3 units, along with sliding scale insulin, before meals but the 3 units were discontinued. -She was unsure when Resident #1's humalog 3 units before meals was discontinued. -She thought she may not have been aware Resident #1's humalog 3 units before meals was discontinued, and had administered the medication to Resident #1. Interview with the RCC on 08/27/24 at 10:02am revealed: -The MA was responsible for administering residents' medications according to the orders in the eMAR system. -The MA responsible for the medication errors started administering medications in May 2024 at the facility. -She and a Registered Nurse (RN) from the pharmacy trained the MA on medication administration, including the administration of Resident #1's insulin. -She was responsible for performing eMAR audits to ensure resident medications were administered as ordered. -She tried to complete the eMAR audits quarterly, but she had gotten behind and her last audit was completed around January 2024. Interview with Resident #1' PCP on 08/27/24 at	D 358		

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D 358	Continued From page 9 10:58am revealed: -She had discontinued Resident #1's humalog 3 units before meals because she felt the resident's FSBS were "fragile". -If Resident #1 received too much insulin it could cause low blood sugar levels, agitation, aggressive behaviors and coma. -She expected the MA to administer medications according to the medication orders. Interview with the Administrator on 08/27/24 at 2:29pm revealed: -She expected the MAs to administer medications according to the orders in the eMAR system. -The RCC was responsible for performing eMAR audits monthly, but she was behind.	D 358		