STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Saint Lucie	611 S 13th St Fort Pierce, FL 34950

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37970 Based on record review and interview, the facility failed to ensure newly admitted residents, dependent on dialysis, received dialysis services in a timely manner causing the resident to be transferred to a higher level of care affecting 1 of 3 residents reviewed for dialysis (Resident #1). The findings included: A review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic kidney disease, colostomy, pressure ulcer of the sacral region, contracture, aphasia following cerebral infarction, end stage renal disease, non-ST elevation myocardial infarction, dependence on renal dialysis, congestive heart failure, and type II diabetes. This resident was also dependent on gastrostomy tube feeding. A review of the physician orders on admission included, but not limited to, Hemodialysis at Aspire 611 South 13th Street, Monday, Wednesday, and Friday The date of this order was 07/23/24. Hemodialysis - Assess site Central Venous Catheter (right chest) bleeding/symptoms of infection every shift Dated 07/23/24. Vital signs post dialysis in the evening every Mon, Wed, Fri dated 07/23/24. Vital signs prior to dialysis on time every Mon, Wed, Fri, dated 07/23/24. A review of Resident #1's medication administration record (MAR) revealed documentation that Vital signs were done prior to dialysis on 07/24/24, 07/26/24, and 07/29/24. There is documentation of the hemodialysis access site in the right chest being assessed for bleeding and infection on every shift for every day the resident was in the facility, starting on 07/23/24 on the evening/night shift though 07/29/24 on the day shift. A review of Resident #1's care plans revealed a care plan dated 07/25/24 stating the resident needs dialysis related to end stage renal failure. Hemodialysis at MLK Renal Institute 611 S 13th St., Fort [NAME] FL 34950 M-W-F. The goals on the care plan are listed as: check and change dressing daily at access site and document. Encourage resident to go for the scheduled dialysis appointments. Resident received dialysis. Monitor labs and report to doctor as needed. Monitor/document/report as needed any signs or symptoms of infection to access site. Monitor/document/report as needed any signs or symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the Minimum Data Set (MDS) dated [DATE], which is the 5-day admission assessment, stated under section O - Special Treatment, Procedures, and Programs that Resident #1 received dialysis while he was a resident. Section H - Bladder and bowel documents the resident has a urinary catheter and an ostomy. Brief Interview Mental Status (BIMS) 00. A review of the nursing progress notes for Resident #1 revealed the resident was admitted on [DATE] and documents in part: the resident is oriented to person, swallowing problems are not noted and resident receives peg tube feedings. Bladder issues not noted, No urinary catheter. No ostomy noted. Dialysis status is hemodialysis right upper chest, no bleeding noted. The nurse's note for 07/24/24 by Staff C, a Licensed Practical Nurse (LPN) documents in part: Bowel has no ostomy noted. Dialysis status is hemodialysis right upper chest and dialysis site is dry and intact. There was not a nursing progress note for an assessment done on 07/26/24 by Staff D, an LPN and Resident #1's day shift nurse (7 AM - 7 PM). On 07/29/24 Staff D documented at 4:45 PM that Resident #1 was sent out to the ED (Emergency Department) to get dialyzed per physician order, due to the resident not receiving dialysis for 7 days. On entrance conference on 08/07/24 at approximately 9:10 AM the facility policy and procedure for dialysis services was requested. The facility DON stated they did not have a policy for dialysis services and did not have a policy for the process of new admissions requiring dialysis services. On 08/07/23 at 11:30 AM, an interview with Staff A, Admissions Personnel, it was revealed when a new admission comes, requiring dialysis, the dialysis provider is emailed the required information for that resident. Staff A stated she had sent Resident #1's information to the Director of Nursing (DON) with the dialysis provider on 06/25/24, which was prior to his first admission on 07/05/24. The resident did not receive dialysis due to being sent out to the hospital on 07/07/24. Staff A stated she received notification the dialysis provider did not have the documentation required for Resident #1 on 07/29/24, so it was sent to them again on 07/29/24. Staff A stated all of this is done by email and a copy of the emails were provided for review. On 08/07/24 at approximately 11:45 AM, a telephone interview with Dialysis Staff H (DON of the dialysis provider) revealed that Dialysis Staff H had not received any communication from this facility regarding dialysis for Resident #1 until it was requested on 07/29/24 after the dialysis nurse informed Dialysis Staff H that there was a resident in need of dialysis at the facility. When the resident was brought to the inhouse dialysis area by the dialysis nurse the resident was not feeling well and was not stable enough to have dialysis there. The resident's physician was contacted, and an order obtained to send the resident to the ED for dialysis. The resident had not had dialysis for 7 days. An interview with the facilty DON on 08/07/24 at 12:00 PM revealed the DON was aware of the resident not receiving dialysis since the admission on 07/23/24 and was awaiting on more information from Staff A, who was not in the facility at this time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with Staff B, a Certified Nursing Assistant (CNA) on 08/07/24 at 12:17 PM revealed Staff B was Resident #1's caregiver on the 7 AM until 3PM shift on 07/24/24. Staff B stated after cleaning him up she put a pad under him so he would be ready to go to dialysis when the dialysis nurse came to pick the resident up. Staff B stated she let the nurse know he was ready to go about 12:30 because no one had shown up yet to pick up the resident. Staff B left for lunch and upon returning at approximately 2:30 PM noticed the resident was still in his bed how she had left him. Staff B reminded the nurse that she had him ready for dialysis and stated the nurse was aware the resident was a dialysis patient. Staff B left at 3:00 PM when the shift was over and is unaware what happened after that. Staff B further stated she was Resident #1's CNA on Monday 07/29/24 and had cleaned the resident up that day so he was ready to go to dialysis. Staff B further stated the resident was not feeling well that day and the resident ended up being transferred to the hospital. An interview with Staff C, an LPN, on 08/07/24 at 1:40 PM revealed Staff C was Resident #1's nurse on 07/24/24. Staff C stated she did not remember what happened on 07/24/24 with this resident regarding dialysis. Staff C further stated she would know if a resident had dialysis if told in report from the previous shift or the dialysis nurse would come to pick them up. Staff C stated again she does not remember the day and that she was doing good to remember yesterday. An interview with Staff E, CNA, on 08/07/24 at 1:45 PM revealed she works on that hall on Fridays and every other Sunday. Staff E stated she was not informed Resident #1 needed to go to dialysis on 07/26/24. Usually the dialysis nurse comes to get the resident who needs to go to dialysis. Staff E reiterated she was not informed Resident #1 was supposed to go to dialysis that day. An interview with Dialysis Staff F, A Registered Nurse (RN), and Dialysis Staff G, a Certified Clinical Hemodialysis Technician (CCHT), on 08/07/24 at 2:15 PM revealed both staff are employed by the dialysis provider and do dialysis onsite at this facility. Dialysis Staff G stated the process for new patients is the facility admissions department will contact the DON of the dialysis provider, and the DON will pass it along to the dialysis staff to go assess the resident and get consent. Dialysis Staff G was at this facility while Resident #1 was in the facility and stated they were not informed of the need for dialysis until Monday, 07/29/24. On that day he was very unstable, so the decision was made to send the resident to the ED for dialysis. Prior to Monday 07/29/24, they were not informed of the resident being in the facility. Both Dialysis Staff F and G were aware of the new system for new dialysis patients. The facility will be putting new patient information in a box outside of their door and the email will still be going to the Dialysis DON. An interview with Staff D, an LPN, on 08/07/24 at 2:30 PM via telephone revealed she remembers being Resident #1's nurse on 07/29/24 but does not remember 07/26/24. Per staff assignment records it was verified Staff D was the resident's nurse on 07/26/24. Staff D stated typically the dialysis team will come and let them know who is going to dialysis and they will get them ready. Staff D further stated it is also on the resident's physician orders so the nurse should see it there as well. Staff D does recall seeing the order for dialysis on 07/29/24. Staff D is not aware of the process used for a new resident admitted who requires dialysis. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with Staff A via telephone on 08/07/24 at 4:05 PM revealed her co-worker, Staff I, admissions staff, had faxed the information on 07/23/24 to the Dialysis DON. Staff A is not able to provide documentation of the fax being sent and confirmation of receipt to the Dialysis DON. Staff A stated they could not email due to internet issues that day. Staff A was informed on 07/29/24 that the dialysis provider did not receive Resident #1's documentation or request for dialysis services and she refaxed it on 07/29/24. A review of the hospital records Resident #1 was transferred to revealed the resident arrived in the ED via Emergency Medical Services (EMS) on 07/29/24 at 5:16 PM. On arrival the resident was diagnosed with severe hyperkalemia (high level of potassium in the blood) and uremia (abnormally high levels of waste products in the blood to which the treatment is dialysis). The resident also had a diagnosis of sepsis, due to a large stage 3 decubitus (pressure injury) and chronic sacral (portion of the spine between the lower back and tailbone) osteomyelitis (bone infection). The resident was started on IV antibiotics and had a poor prognosis per the hospitalist notes and admitted to the hospital. The resident passed away on 07/31/24. The above findings revealed the facility neglected to communicate the need for dialysis for a newly admitted resident, Resident #1, to the dialysis provider. The lack of communication resulted in the resident failing to receive dialysis services for 7 days, which then resulted in an emergent transfer of the resident to the ED for emergent dialysis services. There was a physician's order in the resident's medical record, but it was not followed or addressed by the resident's nursing staff on Wednesday 07/24/24 and Friday 07/26/24. There was a care plan in place to provide dialysis to this resident and the care plan was not followed by the facility staff.