

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Saint Lucie		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37970</p> <p>Based on record review and interviews, the facility failed to protect the residents' rights to be free from neglect for newly admitted residents requiring dialysis treatments. The facility failed to ensure a newly admitted resident 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 facility failed to ensure resident rights to prevent neglect regarding care and services for dialysis communication for newly admitted residents, resulting in serious harm and possibly the death of the resident (Resident #1). Upon admission to the hospital emergency department, Resident #1 was discovered to have a critically high serum potassium level, which could lead to hear problems including arrhythmia, heart attack, and death.</p> <p>On 10/31/24, it was determined that the findings of the survey posed Immediate Jeopardy to the health and safety of the dialysis residents residing in the facility. The facility's Executive Director was informed of the Immediate Jeopardy on 10/31/24 at 5:15 PM. The facility had 8 inhouse dialysis residents.</p> <p>The Immediate Jeopardy began on 07/23/24 and removed on 08/19/24. The facility continued to implement corrective actions until they achieved substantial compliance for F600.</p> <p>During the survey, the facility provided a corrective action plan on November 01, 2024. The survey team verified the facility's corrective actions to correct the noncompliance for f600 and F698 on August 23, 2024, prior to the survey visit.</p> <p>F600 was determined to be past noncompliance.</p> <p>Cross reference to F698.</p> <p>The findings included:</p> <p>A review of the facility policy titled Abuse, Neglect, Exploitation & Misappropriation, document name N-1265, Effective 11/30/2014, revised date, 11/16/2022 stated in part:</p> <p>Definition - Neglect is the failure of the center, it's employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105257	If continuation sheet Page 1 of 13

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Policy - It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse.</p> <p>Employees of the center are charged with a continuing obligation to treat residents so that they are free from abuse, neglect, mistreatment, and/or misappropriation of property.</p> <p>A review of Resident #1's medical record revealed the resident was originally admitted to the facility on [DATE], transferred to the hospital on 07/07/24, and readmitted 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, myocardial infarction (heart attack), dependence on renal dialysis, congestive heart failure (a condition that happens when your heart cannot pump blood well enough to give your body a normal supply), and Type II diabetes. This resident was also dependent on gastrostomy tube feeding (a tube placed surgically through the stomach to provide nutrition).</p> <p>A review of the physician orders on admission included, but not limited to, Hemodialysis (a medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly) 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 (a thin flexible tube that is inserted into a large vein to provide access to the circulatory system) (right chest) for bleeding/symptoms of infection every shift dated 07/23/24. Vital signs post dialysis in the evening every Monday, Wednesday, Friday dated 07/23/24. Vital signs prior to dialysis one time a day every Monday, Wednesday, Friday, dated 07/23/24.</p> <p>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.</p> <p>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 [Monday, Wednesday, Friday] (onsite dialysis at the nursing home facility). The interventions 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 (bacteria in the blood), septic shock.</p> <p>A review of the Minimum Data Set (MDS) assessment dated [DATE], which was 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 had a urinary catheter and an ostomy. The Brief Interview Mental Status (BIMS) score was 00, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the nursing progress notes for Resident #1 revealed the resident was admitted on [DATE] and documented in part: the resident is oriented to person, swallowing problems are not noted and resident receives PEG (Percutaneous Endoscopic Gastrostomy) tube feedings. Bladder issues not noted, No urinary catheter. No ostomy noted. Dialysis status is hemodialysis [via] right upper chest [catheter], no bleeding noted.</p> <p>The nurse's note for 07/24/24 by Staff C, a Licensed Practical Nurse (LPN) documented in part: Dialysis status is hemodialysis [via] right upper chest [catheter] and dialysis site is dry and intact.</p> <p>There was not a nursing progress note for an assessment done on 07/26/24 by Staff D, a LPN and Resident #1's day shift nurse (7 AM to 7 PM).</p> <p>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.</p> <p>On entrance conference on 08/07/24 at approximately 9:10 AM the facility policy and procedure for dialysis services was requested. The facility Director of Nursing (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.</p> <p>On 08/07/23 at 11:30 AM an interview with Staff A, Admissions personnel, 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 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 surveyor review.</p> <p>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 the nursing home 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 was obtained to send the resident to the ED for dialysis. The resident had not had dialysis for 7 days.</p> <p>An interview with the facility 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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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 3 PM 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 PM 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.</p> <p>An interview with Staff C, a LPN, on 08/07/24 at 1:40 PM revealed Staff C was Resident #1's nurse on 7/24/24. 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.</p> <p>An interview with Staff E, a 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.</p> <p>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.</p> <p>An interview with Staff D, a 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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with Staff A, Admissions Personnel, 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.</p> <p>A review of the hospital records revealed Resident #1 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's serum potassium level was 7.6 Critically High (3.5-5.2mmol/L) and Blood Urea Nitrogen level was 155 High (6-22 mg/dl) on 07/29/24 in the ED. The resident also had a discharge 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 in the hospital on 07/31/24.</p> <p>*The facility submitted an acceptable Immediate Jeopardy Removal Plan on November 1, 2024 and the surveyor verified the following immediate actions were implemented:</p> <p>The facility submitted appropriate reporting through the AHCA portal on 08/17/24 and 08/22/24.</p> <p>On 08/18/24 staff education was initiated for all nursing personnel (RN, LPN, and CNA), therapy staff, dietary staff, housekeeping/laundry staff, and administrative and department heads.</p> <p>A Quality Assurance and Performance Improvement (QAPI) meeting was held on 08/19/24 with the Executive Director, Medical Director, Director of Clinical Services, Plant Operations, Registered Dietician, MDS Coordinator, Business Development Director, Business Office Manager, Activities Director, and Admissions Director to review the data, root cause analysis, and plan for improvement. Staff interviews were conducted with the staff involved with the event (Staff B, C, D, and E) on 10/31/24 and 11/1/24.</p> <p>On 08/17/24 the facility installed a communication box outside the dialysis room at the facility as an additional way to communicate with the nurses in the dialysis unit. Nursing and Admission staff were educated on the improved communication process. During survey on 11/1/24, interviews with the dialysis staff and nurses were conducted and they confirmed they are following the proper communication process.</p> <p>***The facility provided a corrective action plan on November 1, 2024 and the surveyor verified the following corrective actions:</p> <p>The plan for improvement consisted of education/training for all staff providing care to residents and the Executive Director will complete a random audit of 10% of all residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure no concerns related to abuse/neglect are identified. The findings will be reviewed monthly by the QAPI committee until substantial compliance is identified. All newly hired staff will receive education in orientation regarding abuse/neglect.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/20/24 a full house audit was completed on all residents to determine any concerns for abuse/neglect. No issues were identified.</p> <p>As of 08/23/24, 142 of 178 staff had completed the education. A certified letter was sent to those who did not attend advising that they could not work at the facility until the education was completed.</p> <p>The monthly QAPI meetings were held on 09/26/24 and 10/31/24 to discuss and review the corrective action plan.</p> <p>Education sign-in sheets were reviewed and verified with random staff interviews on 11/1/24.</p> <p>All audits were reviewed and have been completed as stated. There have been no further concerns regarding neglect for newly admitted dialysis residents or current dialysis residents receiving dialysis care.</p> <p>Random resident interviews were conducted over the course of the survey on 10/30/24, 10/31.24 and 11/1/24, and there were no allegations/complaints of abuse or neglect.</p> <p>On 10/31/24 at 9:45 AM during an interview with the Medical Director, he stated he does participate in QAPI meetings, and he was involved with the corrective action plan for this event. He further stated the implications for a resident who does not have needed dialysis treatment can lead to fluid overload causing dyspnea (shortness of breath) and cardiac issues such as heart failure. It can also cause increased potassium levels leading to cardiac concerns.</p> <p>An interview with the Executive Director on 10/31/24 at 12:30 PM revealed the facility has changed dialysis companies to do in-house dialysis. The new company started on 10/07/24. The admission process has changed with the new company. Everything is done electronically through email from the admission personnel at the facility directly to admission personnel at the dialysis company. Electronic confirmations are obtained to verify the communication is complete. A paper communication is given to the executive director as well as placed in the communication box outside the dialysis door for the dialysis nursing staff. The facility CNA staff are now responsible for transporting their residents to and from dialysis to avoid any confusion as to where the residents are. All residents have assigned chair times for dialysis, which was reviewed and verified during the survey. Audits are being done weekly now and have been in 100% compliance. During survey on November 1, 2024, the surveyor reviewed the neglect audits which were completed on 8/27/24, 9/3/24, 9/6/24, 9/10/24, 9/13/24, 9/17/24, 9/20/24, 9/27/24, 10/4/24, 10/11/24, 10/18/24, and 10/24/24.</p> <p>The nursing staff are aware of notifying the dialysis nurses if they have a resident that requires dialysis, and they are not on the list for that day. This was verified through staff interviews as well on November 1, 2024.</p> <p>On 10/31/24 12:55 PM the External Business Development/Interim Admission Coordinator (IAC) was interviewed. She stated the process was to email admissions at the new dialysis company with all clinical info they need for admission. If she doesn't hear back by the following morning, she reaches out to them again. She always gets confirmation of the admission. A bright colored form and one goes to dialysis, and one goes to the executive director. The box outside the dialysis door is used for every resident so nurses are aware of a new patient.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with the dialysis nurse, and RN on 10/30/24 at 10:59 AM verified the above process for dialysis admissions.</p> <p>The facility obtained substantial compliance with their corrective action plan on 08/23/24 with 100% of the staff either completing training or being notified of the training requirement before returning to their position in the facility and implementing ongoing audits to ensure compliance.</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37970</p> <p>Based on record review and interviews, the facility failed to ensure newly admitted residents received dialysis services in a timely manner causing one resident to be transferred to a higher level of care, affecting 1 of 3 residents reviewed for dialysis (Resident #1). The facility failed to ensure resident rights to prevent neglect regarding care and services for dialysis communication for newly admitted residents, resulting in serious harm and possibly the death of the resident (Resident #1). Upon admission to the hospital emergency department, Resident #1 was discovered to have a critically high serum potassium level, which could lead to heart problems including arrhythmia, heart attack, and death.</p> <p>On 10/31/24, it was determined that the findings of the survey posed Immediate Jeopardy to the health and safety of the dialysis residents residing in the facility. The facility's Executive Director was informed of the Immediate Jeopardy on 10/31/24 at 5:15 PM. The facility had 8 inhouse dialysis residents.</p> <p>The Immediate Jeopardy began on 07/23/24 and removed on 08/19/24. The facility continued to implement corrective actions until they achieved substantial compliance for F698. During the survey, the facility provided a corrective action plan on November 1, 2024. The survey team verified the facility's corrective actions to correct the noncompliance for F600 and F698 on August 23, 2024, prior to the survey visit.</p> <p>F698 was determined to be past noncompliance.</p> <p>Cross reference to F600.</p> <p>The findings included:</p> <p>A review of Resident #1's medical record revealed the resident was originally admitted to the facility on [DATE], transferred to the hospital on 07/07/24, and readmitted 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, myocardial infarction (heart attack), dependence on renal dialysis, congestive heart failure (a condition when your heart cannot pump blood well enough to give your body a normal supply), and Type II diabetes. This resident was also dependent on gastrostomy tube feeding (a tube placed surgically through the stomach to provide nutrition).</p> <p>A review of the physician orders on admission included, but not limited to, Hemodialysis (a medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly) 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 (a thin flexible tube that is inserted into a large vein to provide access to the circulatory system) (right chest) for bleeding/symptoms of infection every shift dated 07/23/24. Vital signs post dialysis in the evening every Monday, Wednesday, Friday dated 07/23/24. Vital signs prior to dialysis one time every Monday, Wednesday, Friday, dated 07/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 [Monday-Wednesday-Friday]. The interventions 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 (bacteria in the blood), septic shock.</p> <p>A review of the Minimum Data Set (MDS) assessment dated [DATE], which was 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 had a urinary catheter and an ostomy. The Brief Interview Mental Status (BIMS) score was 00, which indicated severe cognitive impairment.</p> <p>A review of the nursing progress notes for Resident #1 revealed the resident was admitted on [DATE] and documented in part: the resident is oriented to person, swallowing problems are not noted and resident receives PEG (Percutaneous Endoscopic Gastrostomy) tube feedings. Bladder issues not noted, No urinary catheter. No ostomy noted. Dialysis status is hemodialysis [via] right upper chest [catheter], no bleeding noted.</p> <p>The nurse's note for 07/24/24 by Staff C, a Licensed Practical Nurse (LPN) documented in part: Dialysis status is hemodialysis [via] right upper chest [catheter] and dialysis site is dry and intact.</p> <p>There was not a nursing progress note for an assessment done on 07/26/24 by Staff D, a LPN and Resident #1's day shift nurse (7AM to 7 PM).</p> <p>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.</p> <p>On entrance conference on 08/07/24 at approximately 9:10 AM the facility policy and procedure for dialysis services was requested. The facility Director of Nursing (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.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 08/07/23 at 11:30 AM, an interview with Staff A, Admissions Personnel, 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 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 surveyor review.</p> <p>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 the nursing home 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 was obtained to send the resident to the ED for dialysis. The resident had not had dialysis for 7 days.</p> <p>An interview with the facility 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.</p> <p>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 PM 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>An interview with Staff D, a 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.</p> <p>An interview with Staff A, Admissions Personnel, 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.</p> <p>A review of the hospital records revealed Resident #1 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's serum potassium level was 7.6 Critically High (3.5 -5.2 mmol/L) and Blood Urea Nitrogen level was 155 High (6-22 mg/dl) on 07/29/24 in the ED. The resident also had a discharge 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 in the hospital on 07/31/24.</p> <p>*The facility submitted an acceptable Immediate Jeopardy Removal Plan on November 1, 2024, and the surveyor verified the following immediate actions were implemented:</p> <p>The facility submitted appropriate reporting through the AHCA portal on 08/17/24 and 08/22/24.</p> <p>On 08/18/24 staff education was initiated for all nursing personnel (RN, LPN, and CNA), therapy staff, dietary staff, housekeeping/laundry staff, and administrative and department heads.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Quality Assurance and Performance Improvement (QAPI) meeting was held on 08/19/24 with the Executive Director, Medical Director, Director of Clinical Services, Plant Operations, Registered Dietician, MDS Coordinator, Business Development Director, Business Office Manager, Activities Director, and Admissions Director to review the data, root cause analysis, and plan for improvement. Staff interviews were conducted with the staff involved with the event (Staff B, C, D, and E) on 10/31/24 and 11/1/24.</p> <p>On 08/17/24 the facility installed a communication box outside the dialysis room at the facility as an additional way to communicate with the nurses in the dialysis unit. Nursing and Admission staff were educated on the improved communication process. During survey on 11/1/24, interviews with the dialysis staff and nurses were conducted and they confirmed they are following the proper communication process.</p> <p>***The facility provided a corrective action plan on November 1, 2024 and the surveyor verified the following corrective actions:</p> <p>The plan for improvement consisted of education/training for all staff providing care to residents and the Executive Director will complete a random audit of 10% of all residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure no concerns related to abuse/neglect are identified. The findings will be reviewed monthly by the QAPI committee until substantial compliance is identified. All newly hired staff will receive education in orientation regarding abuse/neglect.</p> <p>On 08/20/24 a full house audit was completed on all residents to determine any concerns for abuse/neglect. No issues were identified.</p> <p>As of 08/23/24, 142 of 178 staff had completed the education. A certified letter was sent to those who did not attend advising that they could not work at the facility until the education was completed.</p> <p>The monthly QAPI meetings were held on 09/26/24 and 10/31/24 to discuss and review the corrective action plan.</p> <p>Education sign-in sheets were reviewed and verified with random staff interviews on 11/1/24.</p> <p>All audits were reviewed and have been completed as stated. There have been no further concerns regarding neglect for newly admitted dialysis residents or current dialysis residents receiving dialysis care.</p> <p>Random resident interviews were conducted over the course of the survey on 10/30/24, 10/31.24 and 11/1/24, and there were no allegations/complaints of abuse or neglect.</p> <p>On 10/31/24 at 9:45 AM during an interview with the Medical Director, he stated he does participate in QAPI meetings, and he was involved with the corrective action plan for this event. He further stated the implications for a resident who does not have needed dialysis treatment can lead to fluid overload causing dyspnea (shortness of breath) and cardiac issues such as heart failure. It can also cause increased potassium levels leading to cardiac concerns.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with the Executive Director on 10/31/24 at 12:30 PM revealed the facility has changed dialysis companies to do in-house dialysis. The new company started on 10/07/24. The admission process has changed with the new company. Everything is done electronically through email from the admission personnel at the facility directly to admission personnel at the dialysis company. Electronic confirmations are obtained to verify the communication is complete. A paper communication is given to the executive director as well as placed in the communication box outside the dialysis door for the dialysis nursing staff. The facility CNA staff are now responsible for transporting their residents to and from dialysis to avoid any confusion as to where the residents are. All residents have assigned chair times for dialysis, which was reviewed and verified during the survey. Audits are being done weekly now and have been in 100% compliance. During survey on November 1, 2024, the surveyor reviewed the dialysis audits which were completed for the week of 8/27/24, 9/3/24, 9/10/24, and 9/17/24. The monthly audit for October was completed on 10/30/24, and reviewed by the surveyor.</p> <p>The nursing staff are aware of notifying the dialysis nurses if they have a resident that requires dialysis, and they are not on the list for that day. This was verified through staff interviews as well on November 1, 2024.</p> <p>On 10/31/24 12:55 PM the External Business Development/Interim Admission Coordinator (IAC) was interviewed. She stated the process was to email admissions at the new dialysis company with all clinical info they need for admission. If she doesn't hear back by the following morning, she reaches out to them again. She always gets confirmation of the admission. A bright colored form and one goes to dialysis, and one goes to the executive director. The box outside the dialysis door is used for every resident so nurses are aware of a new patient.</p> <p>An interview with the dialysis nurse, and RN on 10/30/24 at 10:59 AM verified the above process for dialysis admissions.</p> <p>The facility obtained substantial compliance with their corrective action plan on 08/23/24 with 100% of the staff either completing training or being notified of the training requirement before returning to their position in the facility and implementing ongoing audits to ensure compliance.</p>		