

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Athene Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 13995 Clayton Road Town and Country, MO 63017	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>44950</p> <p>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors, when staff failed to administer one resident's diabetes medications for several days (Resident #2). The sample was 5. The census was 131.</p> <p>The Administrator was notified on 8/2/24, of the past non-compliance which began on 7/21/24. The facility began an investigation, audited resident medications, reviewed all new admissions orders, interviewed staff and residents, had a meeting with the pharmacy, and in-serviced staff on following physician orders, the protocols when a medication is not available, and verifying medications for new admissions. The deficiency was corrected on 7/31/24.</p> <p>Review of the facility's Medical Provider Order Policy, revised 4/7/22, showed:</p> <ul style="list-style-type: none"> -This facility shall use uniform guidelines for the ordering and following of medical provider orders; -Policy Explanation and Compliance Guidelines: <ul style="list-style-type: none"> -Medications and/or Treatments should be administered only upon the signed order of a person lawfully authorized to prescribe. -Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the medical provider, on the next visit to the facility. -Elements of the Medication and/or Treatment Order: <ul style="list-style-type: none"> -Date and time the order is written. -Resident's full name. -Name of medication and/or treatment -Dosage-strength of medication is included. -Time or frequency of administration. <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
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -Route of administration. -Type/Formulation (if applicable). -Hour of administration (if applicable). -Diagnosis or indication for use. -PRN (as needed) orders should also specify the condition, for which they are being administered, (e.g., as needed for sleep). -Documentation of Medication and/or Treatment Orders: -Each medication and/or treatment order should be documented with the date, time, and signature of the person receiving the order. -If using electronic medication records, input the medication and/or treatment order according to the electronic health record (EHR) instructions and facility policy. -Call, fax, or electronically transmit the medication and/or treatment order to the provider pharmacy. -Validate newly prescribed medications and/or treatment is in the electronic Medication Administration Record (MAR)/Treatment Administration Record (TAR). -When a new order changes the dosage of a previously prescribed medication, discontinue the order as per the electronic software instructions and retype the new order. -Validate the new order is in the electronic MAR/TAR. -Notify resident's sponsor/family of new medication order. -Following of Medication and/or Treatment Orders: -Medical provider Orders should be reviewed prior to administration of medication and/or treatment to validate the orders contains all required elements. -Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order. <p>Review of the facility's Medication Administration Policy, revised 9/1/22, showed:</p> <ul style="list-style-type: none"> -Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. -Policy Explanation and Compliance Guidelines: <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Keep medication cart clean, organized, and stocked with adequate supplies.</p> <p>-Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.</p> <p>-Review MAR to identify medication to be administered.</p> <p>-Administer medication as ordered in accordance with manufacturer specifications.</p> <p>-Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.</p> <p>Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/15/24, showed:</p> <p>-Cognitively intact;</p> <p>-Diagnoses include diabetes, heart failure, acid reflux, thyroid disorder, asthma, anxiety, and depression.</p> <p>Review of the resident's electronic Physician Order Sheet (ePOS), showed:</p> <p>-An order dated 6/11/24-7/17/24, for Farxiga (A medication used to treat type 2 diabetes, it can also be used to treat heart failure and chronic kidney disease) Oral Tablet 10 milligram (mg). Give one tablet by mouth one time a day related to type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>-An order dated 6/12/24, for Trulicity (A medication used to treat type 2 diabetes) 0.75 mg/0.5 milliliter (ml) Solution pen-injector. Inject 0.5 ml subcutaneously one time a day every Saturday related to type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>Review of the resident's June 2024 MAR/TAR, showed:</p> <p>-Farxiga Oral Tablet 10 mg. Give 1 tablet by mouth one time a day. Marked (9) Other/See progress notes on the following dates: 6/11 through 6/16, 6/18, 6/20, 6/22, and 6/23/24;</p> <p>-Trulicity 0.75 mg/0.5 ml Solution pen-injector. Inject 0.5 ml subcutaneously one time a day every Saturday. Marked (9) Other/See progress notes on the following dates: 6/15, 6/22, and 6/29/24.</p> <p>Review of the resident's July 2024 MAR/TAR showed:</p> <p>-Farxiga Oral Tablet 10 mg. Give 1 tablet by mouth one time a day. Marked (9) Other/See progress notes on the following dates: 7/5/24;</p> <p>-Trulicity 0.75 mg/0.5 ml Solution pen-injector. Inject 0.5 ml subcutaneously one time a day every Saturday. Marked (9) Other/See progress notes on the following dates: 7/6, 7/13, and 7/20/24.</p> <p>Review of the progress notes showed:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-6/14/24 12:54 P.M., Spoke with pharmacy regarding resident's order for Farxiga, not administered on shift, cost paper sent via fax and forwarded to management for further evaluation. Physician made aware resident states he/she is not able to consume Metformin the alternative recommendation.</p> <p>-No other progress note related to the Farxiga not being administered.</p> <p>-No progress note related to the Trulicity not being administered.</p> <p>During an interview on 8/1/24 at 12: 15 P.M., the Director of Nursing (DON) said she knows the facility messed up with the resident's Trulicity medication. The resident never got the medication. The DON said the resident was not diabetic though and was on it for weight loss not diabetes. She showed an email from the pharmacy dated 6/10/24. The DON said those emails come with an attachment to be sent back to the pharmacy with approval for the medication. The DON said the Assistant Director of Nursing (ADON) sent the approval but on 6/23/24, they got a second attempt email from the pharmacy. The DON replied for the pharmacy to dispense the medication on 6/25/24. The nurses were marking as unavailable and notified the doctor but were not informing the pharmacy or the DON. The nurse should have put the medication on hold until it was received and followed up on it with the doctor. The DON said she signed off on it so she thought it was here at the facility. She would expect them to notify her. The DON said she immediately started in-services. She also did individual education with all nurses involved. She set up a pharmacy meeting yesterday with the pharmacy liaison and pharmacy to prevent this from happening in the future.</p> <p>During an interview on 8/2/24 at 4:15 P.M., the DON said the nurse that does the admission would be responsible for verifying orders with the physician. She talked to the admission nurse for the resident and the nurse said he/she verified all the admission orders with the physician. The physician also said the nurse called and verified the orders. The physician said he/she asked for a home medication list from the family but they never brought the list. The ADON is responsible to audit the admissions. The Farxiga is one of the medications she found during her medication audit that the pharmacy had approval for but did not deliver to the facility. The DON said that is why she had the meeting. They did not deliver after the medication was approved and then after they did deliver they were not dispensing correctly. The pharmacy was only sending out 3 day doses instead of the full card, that is why some doses were missed but some were given in June. She would have expected staff to let her know immediately the medication was not there. They should call the pharmacy and then notify the physician. The physician would give orders to hold that medication and/or give order for an alternative medication until the other one arrives. If it does not arrive when the pharmacy states or is not covered, then notify the DON so she can follow up with the pharmacy.</p> <p>MO00239472</p>		