STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265118	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Point Health and Rehabilitation	2840 West Clay St Saint Charles, MO 63301

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of five sampled residents, received necessary care and services in accordance with professional standards of pactice when staff failed to obtain laboratory tests and administer lactolose (a liquid medication used to treat liver failure by removing ammonia from the blood, a waste product normally processed in the liver and removed through the urine. Ammonia build up in the blood can be very dangerous and can be toxic to the brain) as ordered by the resident'sphysician. The resident, with known liver disease, became lethargic and dehydrated (loss of more fluid than taken in, the body does not have enough water and other fluids to carry out its normal functions) with an elevated blood level of ammonia, critially elevated levels of sodium and chloride (minerals required for normal body function) and elevated kidney function laboratory tests indicating severe dehydration and kidney failure. The resident was hospitalized as a result. The facility census was 61. Review of the facility policy, Medication Administration, dated 9/1/22, showed the following: -Medications are administered by licensed nurses, or other staff who were legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice; -Review the Medication Administration Record (MAR) to identify medication to be administered; -Remove the medication from the source; -Administer medication as ordered in accordance with manufacturer specificaions; -Observe the resident consumption of the medication; -Sign the MAR after administration; -Report and document any adverse side effects or refusals; -Correct any discrepancies and report to the nurse manager. Review of the facility policy Notification of Changes, dated 9/1/21, showed the following: -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there was a change requiring such notification; (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Circumstances requiring notification included accidents, significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status, and circumstances that required a need to alter treatment; -For residents incapable of making decisions, the representative would make any decisions that had to be made. 1. Review of Resident #1's Physician Order Sheet (POS), dated 2/15/23, showed the following: -Diagnoses of chronic kidney disease stage 3 (kidney failure), chronic viral hepatitis C (a viral infection that attacks the liver and leads to inflammation, spreads by contact with contaminated blood and can lead to serious liver damage), and cirrhosis of the liver (liver damage leading to scarring and liver failure); -Lactulose (liquid medication used to treat liver failure by removing ammonia from the blood) 10 grams (gm)/15 milliliters (ml) give 30 ml three times daily related to liver failure, cirrhosis of liver. Review of the resident's annual Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 2/16/24, showed the following: -Severely impaired cognition; -No hallucination or delusions; -Required substantial (staff assisting with more than half of the effort) with wheelchair mobility, toileting, personal hygiene. Review of the resident's POS dated 3/5/24 showed an order to obtain Complete Blood Cell Count (CBC, a laboratory blood test used for diagnostic purposes) and Comprehensive Metabolic Panel (CMP, a laboratory blood test use for diagnostic purposes that included electrolytes and liver function tests). Review of the resident's laboratory results dated [DATE] showed the following: -CMP specimen was hemolyzed (clotted blood in the tube rendering the specimen unusable); -Attempts to contact the nurse were unsuccessful, report sent to advise lab was unable to perform testing due to specimen hemolyzed. Please contact lab if redraw was needed stat (immediate) or make a new requisition for redraw on the next routine lab day. Review of the resident's care plan revised 3/13/24 showed the following: -Activities of Daily Living (ADLs) self-care deficit, his/her functional ability varied. Staff should encourage the resident to participate to the fullest extent possible, monitor/document and report any changes, any potential for improvement, reasons for self-care deficit, and declines in function; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Medications taken related to liver failure. Staff should monitor frequently for signs and symptoms of neurologic impairment. If neurologic compromise was noted, urgent treatment was necessary. Review of the resident's MAR dated 4/13/24 showed staff documented at 9:00 A.M. and 2:00 P.M. lactulose 30 ml not administered, see progress notes (nurses' notes). Review of the resident's nurses notes dated 4/13/24 showed no staff documentation regarding lactulose not administered at 9:00 A.M. and 2:00 P.M. and no documentation staff notified the resident's physician lactulose was not administered. Review of the resident's MAR showed staff documented the following: -On 4/14/24 at 2:00 P.M. lactulose 30 ml not administered, resident refused; -On 4/15/24 at 9:00 A.M. and 2:00 P.M. lactulose 30 ml not administered, resident refused; -On 4/17/24 at 9:00 P.M. lactulose 30 ml not administered, resident sleeping. Review of the resident's nurses notes showed no documentation staff notified the resident's physician lactulose was not administered on 4/14/24, 4/15/24 and 4/17/24. Review of the resident's vital signs record dated 4/20/24 at 9:08 A.M. showed staff documented the resident's blood pressure (measurement of how forcefully blood circulates against the walls of the blood vessels), was 175/126 mmHg (millimeters of mercury, a measurement of pressure, normal blood averages 120/80, indicates potential hypertensive, high blood pressure, crisis). Review of the resident's nurses notes showed no additional staff assessment of the resident's condition and no documentation staff notified the resident's physician of the resident's elevated blood pressure. Review of the resident's nurses note dated 4/21/24 showed Licensed Practical Nurse (LPN) A documented at 10:31 A.M. the resident was up in the wheelchair, was lethargic and his/her left arm was edematous (abnormally swollen with fluid). The resident was not responding to any stimuli, stared into space, pupils were fixed. Jerking motion noted while up in the wheelchair. LPN A called the physician. Blood pressure 135/110 (indicating high blood pressure), pulse 91 beats per minute (normal less than 80 at rest), respirations 18 breaths per minute, (normal range 10-18) temperature 97.5 degrees (normal 98.6 degrees). Review of the resident's vital signs record dated 4/21/24 at 11:42 A.M. showed staff documented the resident's blood pressure was 135/125 mmHg (indicating high blood pressure). Review of the resident's nurses notes dated 4/21/24 showed LPN A documented the following at 11:57 A.M. the physician's exchange (triage team) returned the telephone call and said they had no record of the resident. It was noted in the resident's medical record lactulose medication had not been given for four days. A dose was given at that time. The nurses note did not indicate the resident's physician was notified lactulose was not given for four days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's record showed no additional staff assessment of the resident and no documentation staff notified the resident's physician of the resident's condition. Review of the resident's MAR dated 4/22/24 showed staff documented at 2:00 P.M. lactulose 30 ml not administered, with no documentation indicating the reason why staff did not administer the resident's lactose. Review of the resident's vital signs record dated 4/24/24 showed staff documented the following: -At 8:47 A.M. blood pressure 177/100 mmHg (indicating high blood pressure); -At 9:43 P.M. blood pressure 100/73 mmHg. Review of the resident's nurses note dated 4/24/24 at 10:13 P.M., showed staff documented at 9:40 P.M. the resident had a hard time breathing, assessment revealed the resident used accessory muscles to breath (indicating respiratory distress), supplemental oxygen was applied at 2 liters (measurement of oxygen delivered through a tube inserted in the nose), blood pressure was 100/73, pulse 83, respirations 20. Resident was unresponsive to voice, touch, or pain. Staff called the physician, orders received to send the resident to the emergency department. Review of the resident's emergency room laboratory results dated [DATE] showed the following: -Sodium (mineral or electrolyte required in the blood for proper body function) level 169, critical level result (laboratory test with normal range 135-145, indicating dehydration or excessive lack of water. The most serious symptoms of dehydration are brain dysfunction, confusion, muscle twitching, seizures, coma and death); -Chloride (mineral or electrolyte required in the blood for proper body function) level 134, critical level (laboratory test with normal range 97-110, indicating dehydration or excessive lack of water); -Creatinine (laboratory blood test, normal 0.6 - 1.10) 2.66 high result (indicating kidney disease, not filtering waste from the blood effectively); -Blood Urea Nitrogen (BUN, laboratory blood test, normal 6 - 25) 80 high result (indicating kidney disease, could also indicate dehydration). Review of the resident's hospital laboratory results dated [DATE] showed ammonia level of 79 (normal less than 50, high ammonia blood levels are life threatening and can lead to confusion, disorientation, excessive sleepiness, change in consciousness, tremors, coma and death). During interview on 5/2/24 at 2:35 P.M. Certified Nurse Assistant (CNA) B said the resident could transfer with assistance, walk short distances and used a wheelchair for mobility. He/She was talkative and asked for water and sodas frequently. The resident went downhill, became sleepy and tired, drowsy and slept all the time. This went on for a week before staff sent the resident out to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/2/24 at 2:45 P.M. Certified Medication Technician (CMT) C said the resident refused the lactulose at times, staff had to mix the lactulose with coffee or something to hide the taste and then the resident would take the medication. The resident was more lethargic the few days before he/she was transferred to the hospital. The resident missed several doses of lactulose before transfer to the hospital. During an interview on 5/2/24 at 1:45 P.M. LPN A said the following: -The resident was usually friendly and outspoken; -On 4/21/24 the resident was lethargic with an unclear voice, elevated blood pressure and not feeling well or acting normal. It was noticed on 4/21/24 the resident's lactulose bottle was full and staff had not administered the medication as ordered. Several doses were missed. LPN A called the physician's answering service with no call back. LPN A informed the Assistant Director of Nurses (ADON) who instructed LPN A to administer the resident's lactulose and watch the resident. The resident did wake up slightly following the lactulose administration. LPN A did not send the resident to the hospital, did not document any follow up assessments, or attempt to notify the physician again. He/She was not aware the resident was transferred to the hospital three days later. He/She should have sent the resident to the emergency room for treatment on 4/21/24. During an interview on 5/2/24 at 9:25 A.M. and 1:10 P.M. the Assistant Director of Nursing (ADON) said the following: -The CMP laboratory test ordered 3/7/24 was not done, no repeat blood draw was completed and the test was not completed as ordered; -The resident had a change in condition, was unresponsive and sent out to the emergency roiagnom on [DATE]. During an interview on 5/2/24 at 2:50 P.M. the Director of Nursing said the following: -Staff should ensure the resident received the lactulose and all medications as ordered. The resident would take the medication if mixed with something to hide the taste. Staff should know to work with the resident and not miss any doses of the lactulose. The resident had liver disease and missed doses of lactulose could cause the resident increased lethargy and drowsiness; -Staff should have ensured the CMP ordered 3/7/24 was redrawn and followed up to ensure the results were received. The charge nurse was responsible for laboratory follow up and reporting results to the physicians; -Staff should have notified her when the resident had a change in condition with additional symptoms of lethargy. During an interview on 5/2/24 at 3:00 P.M. the Administrator said the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Staff should follow the physician's orders and ensure laboratory tests were completed as ordered and follow up completed regarding the results. Staff should ensure medications were administered as ordered and if medication was not given or laboratory tests were not obtained staff should notify the physician; -If a resident had a decline or significant change in condition, staff should seek help immediately from the physician or send the resident to the emergency room for evaluation and treatment; -Staff should avoid prolonging a residents' illness by not getting treatment. Staff should monitor and assess residents, administer medications as ordered and follow the physicians' orders. During an interview on 5/16/24 at 7:50 A.M. the resident's physician said the resident was confused and refused medication at times. If staff were aware of ways to encourage the resident to take his/her medications, those suggestions should be shared with all staff. The resident had liver disease and had an elevated ammonia level as a result. The lactulose should help control the ammonia level. A level of 79 might cause the resident some increased lethargy and confusion, although the resident's ammonia level ran higher than normal. No staff had informed him on 4/21/24 the resident was not responding to any stimuli, stared into space, pupils were fixed and he/she had jerking motion with blood pressure of 135/110. The DON and ADON had his direct number and should have notified him directly of these changes in the resident's condition. The resident's emergency room laboratory results indicated the resident was dehydrated on hospital admission. He might have sent the resident to the hospital sooner than 4/24/24 if staff had notified him of the resident's condition on 4/21/24 and kept him informed of his/her condition and decline. Earlier treatment might have prevented the resident's further decline. MO235276