| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review, the facility failed to ensure an accurate reconciliation and documentation of destruction of Schedule II narcotic controlled substance medication (substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence), Schedule IV and schedule V narcotic controlled substance medications (substances in these schedules have a lower potential for abuse), for one sampled resident (Resident #51) and three additional residents (Resident #46, #27 and #50). Review showed staff documented the number of narcotic medications destroyed as two different amounts on two different forms for Resident #46 and Resident #27. Further review showed staff documented the removal of narcotic medication from the controlled drug record, after the medication had been destroyed, for Resident #46, #27, #51 and #50, but there was no documentation on the medication administration record to show staff had administered the medication. The facility census was 53. Review of the facility policy, Controlled Substance Administration and Accountability, dated 12/09/25, showed the following:-It is the policy of this facility to promote safe, high quality resident care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in to prevent loss, diversion or accidental exposure;-General Protocols:-All controlled substances are accounted for in one of the following ways: -All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided;-In all cases, the dose noted on the usage form must match the dose recorded on the medication administration record, controlled drug record or other facility specified form and placed in the resident's medical record;-The controlled drug record (or other specified form) serves the dual purpose of recording both narcotic disposition and resident administration;-Obtaining/Removing/Destroying Medications: The entire amount of controlled substances obtained or dispensed is accounted for. Review of the facility policy, Medication Administration, dated 02/07/24, showed the following:-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;-Policy Explanation and Compliance Guidelines: -Sign medication administration record (MAR) after administration; -If medication is a controlled substance, sign narcotic book. 1. Review of Resident #46's January 2026 Physician Order Sheets (POS) showed an order for hydrocodone/APAP (Schedule II narcotic controlled substance) 5/325 milligram (mg), take one tablet by mouth every six hours as needed for pain; start date of 05/21/25 and discontinued 01/29/26. Review of the resident's January 2026 Medication Administration Record (MAR) showed no documentation staff had administered the medication to the resident in the month of January. Review of the resident's Controlled Drug Receipt/Record/Disposition form (form used to reconcile the narcotic medication and document the date, time of administration, amount of narcotic administered and the remaining count and signature of the staff removing, administering or destroying the narcotic), for the resident's hydrocodone/APAP 50 mg tablets that was dispensed on 06/08/25, showed the following:-On 01/20/25 (incorrect year) (no time), the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) documented destroying three tablets;-Entries on the form after 01/20/26 (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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | included:-On 01/21/ (no year documented) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 15 tablets; this administration was not documented on the MAR;-On 01/23/ (no year) at 10:50 P.M., staff documented removing one tablet from the medication card, leaving a balance of 14 tablets; this administration was not documented on the MAR;-If the form and narcotic had been pulled and destroyed on 01/20/26, there would have been no way for the staff to be able to document the removal of this medication on the form after the identified destruction date. Review of a typed destruction log, provided by the facility, showed on 01/29/26 (later date than on the Controlled Drug Receipt/Record/Disposition form), 14 tablets of the resident's hydrocodone/APAP 5/325 mg medication, that was dispensed on 06/08/25, was destroyed via drug buster (a disposable system that uses activated charcoal to neutralize pills, liquids and patches in 15 minutes). The documented destruction amount on the Controlled Drug Receipt/Record/Disposition form did not match the documented destruction amount on the typed form. During an interview on 02/09/26 at 4:40 P.M. and 02/18/26 at 10:45 A.M., the DON said the following:-The documented destruction date on the disposition form was 01/29/26; she just had bad handwriting;-Staff should be documenting the administration of the narcotic on the MAR if they remove the narcotic from the count sheet log and should not be administering medication if the order has been discontinued;-The disposition form showed 30 tabs were destroyed in the destruction box, but the final count and typed destruction log showed 14 tabs were destroyed, so that was what she destroyed. Her handwriting was terrible, and she was in a hurry. 2. Review of Resident #27's December 2025 POS showed orders for the following:-Tramadol (schedule IV narcotic controlled substance) 50 mg, take one tablet by mouth four times a day for moderate to severe pain; start date of 12/02/25 at 5:00 P.M. and discontinue date of 12/13/25 at 7:02 A.M.;-Tramadol 50 mg, take one tablet by mouth three times a day for moderate to severe pain; start date of 12/13/25 at 9:00 A.M. and discontinue date of 12/19/25 at 10:53 A.M.;-Tramadol 50 mg, take one tablet by mouth two times a day for moderate to severe pain; start date of 12/19/25 at 5:00 P.M. and discontinue date of 12/23/25 at 09:10 A.M. Review of the resident's December 2025 MAR showed no documentation staff had administered the resident's tramadol medication after 12/23/25. Review of the resident's January 2026 POS showed no order for tramadol. Review of the resident's January 2026 MAR showed no documentation staff administered the resident's tramadol medication in the month of January. Review of the resident's Controlled Drug Receipt/Record/Disposition form for tramadol hcl 50 mg tablets, dispensed 12/02/25, showed the following:-On 12/23/25 (no time), the ADON and the DON documented destroying three tablets;-The last entry for 12/23 (no year), at 5:00 P.M., showed ten tablets remained;-On 12/24 (no year) at 8:00 A.M., staff documented removing one tablet from the medication card, leaving a balance of nine tablets; this administration was not documented on the MAR;-On 12/24 (no year) at 5:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of eight tablets; this administration was not documented on the MAR;-On 12/25 (no year) at 8:00 A.M., staff documented removing one tablet from the medication card, leaving a balance of seven tablets; this administration was not documented on the MAR;-On 12/25 (no year) at 5:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of six tablets; this administration was not documented on the MAR;-On 12/30 (no year) at 5:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of five tablets; this administration was not documented on the MAR;-On 01/12/26 at 6:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of four tablets; this administration was not documented on the MAR;-On 01/13/26 at 6:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of three tablets; this administration was not documented on the MAR;-If the form and narcotic had been pulled and destroyed on 12/23/25, there would have been no way for the staff to be able to document the removal of this medication on the form after the identified destruction date. Review of a typed destruction log, provided by the facility, showed on 12/23/25, 26 tablet of the resident's tramadol hcl 50 mg, that was dispensed on 12/02/25, was destroyed via drug buster. The documented destruction<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | amount on the Controlled Drug Receipt/Record/Disposition form did not match the documented destruction amount on the typed form. During an interview on 02/09/26 at 4:40 P.M. and 02/18/26 at 10:45 A.M., the DON said the following:-When an order is discontinued or changed, the medication is pulled from the medication cart by the nurse and brought to her or the ADON for destruction;-She must have documented an incorrect destruction date of 12/23/25 on the disposition form and the typed destruction log; it should have been 01/13/26;-The documentation of 26 tabs being destroyed on the typed destruction log was just an error as the disposition page showed 26 tabs had been delivered and she must have just looked at the wrong number. 3. Review of Resident #51's November 2025 POS showed orders for the following:-Pregabalin (schedule V narcotic controlled substance) 50 mg, take one capsule by mouth at bedtime for neuropathy; start date of 07/24/25, hold from 11/01/25 to 11/02/25 and discontinued 11/20/25;-Pregabalin 75 mg take one capsule by mouth at bedtime for chronic pain; start date 11/20/25. Review of the resident's November 2025 MAR showed no documentation staff administered pregabalin 50 mg after 11/19/25 to the resident. Review of the resident's December 2025 POS showed no order for pregabalin 50 mg. Review of the resident's December 2025 MAR showed no documentation staff administered the pregabalin 50 mg to the resident. Review of the resident's January 2026 POS showed no order for pregabalin 50 mg. Review of the resident's January 2026 MAR showed no documentation staff administered pregabalin 50 mg after 11/19/25 to the resident. Review of the resident's Controlled Drug Receipt/Record/Disposition form, for the resident's pregabalin 50 mg tablets, that was dispensed on 11/13/25, showed the following:-On 11/21/25, the ADON and the DON documented destroying 19 tablets;-Entries on the form after 11/21/25 included:-On 11/22 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 28 tablets; this administration was not documented on the MAR;-On 11/25 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 27 tablets; this administration was not documented on the MAR;-One 12/03 (no year) at HS, staff documented removing one tablet from the medication card, leaving a balance of 26 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/06 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 25 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/08 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 24 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/09 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 23 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/10 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 22 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/18 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 21 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 12/21 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 20 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-One 01/14 (no year) at 9:00 P.M., staff documented removing one tablet from the medication card, leaving a balance of 19 tablets; this administration was not documented on the MAR; there was no active order for this medication listed on the MAR;-If the form and narcotic had been pulled and destroyed on 11/21/25, there would have been no way for the staff to be able to document the removal of this medication on the form after the identified destruction date. Review of a typed destruction log, provided by the facility, showed on 11/21/25, 19 tablets of the resident's pregabalin 50 mg medication, dispensed on 11/13/25, was destroyed via drug buster. During an interview on 02/09/26 at 4:40 P.M., the DON said she must have documented an incorrect destruction date of<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 11/21/25 on the disposition form and the typed destruction log. It should have been 01/14/26. 4. Review of Resident #50's September 2025 POS showed an order for oxycodone hcl (schedule II narcotic controlled substance) 5 mg, take one capsule by mouth every 12 hours as needed for moderate to severe pain; start date of 08/04/25 and discontinued 09/25/25. Review of the resident's October 2025 POS showed the following:-No order for oxycodone hcl 5 mg;-An order for oxycodone/acetaminophen 10/325 mg, give one tablet by mouth two times a day for chronic pain; start date of 10/25/25 and discontinue 01/24/26. Review of the resident's Controlled Drug Receipt/Record/Disposition form, for the resident's oxycodone hcl 5 mg tablets, dispensed on 08/02/25, showed the following:-On 09/26/25 (no time), the ADON and the DON documented destroying five tablets;-On 09/26 (no year) at 8:00 A.M., staff documented removing one tablet from the medication card, leaving a balance of seven tablets; this administration was not documented on the MAR-On 10/26 (no year) at 6:00 P.M., staff documented removing two tablets from the medication card, leaving a balance of five tablets; this administration was not documented on the MAR; there was no active order for this dose of medication listed on the MAR;-If the form and narcotic had been pulled and destroyed on 09/26/25, there would have been no way for the staff to document the removal of this medication on the form after the identified destruction date.Review of a typed destruction log, provided by the facility, showed on 09/26/25, five tablets of the resident's oxycodone hcl 5 mg medication, that was dispensed on 08/02/25, was destroyed via drug buster. Interview on 02/09/26 at 4:40 P.M. and 02/18/26 at 10:45 A.M., showed the DON said the following:-She must have documented an incorrect destruction date of 09/26/25 on the disposition form and the typed destruction log; it should have been 10/26/25;-The documentation of the removal of two tablets on 10/26/25 she believed was due to staff taking two tablets to administer which would have been a correct amount for the current order at that time. Interview on 02/09/26 at 12:02 P.M., showed Registered Nurse (RN) A said the following:-When narcotic orders are changed or discontinued, the count sheet and card are pulled and given to the DON. There was no documentation of the handover that he/she was aware of or has ever done;-The floor staff does not destroy any narcotics; the medication and the form are pulled and given to the DON;-The DON destroys the narcotics. Interview on 02/18/26 at 10:33 A.M., showed the ADON said the following:-When a narcotic medication order was changed or discontinued, the nurse pulls the medication and the log off the cart and brings it to him/her and the DON for destruction;-Her initials in the destruction box of the disposition form shows she acknowledged the medication had been destroyed;-She checks the final count with the documented amount destroyed and the numbers should match;She may have been in a hurry with the destruction process and errors were made in the documentation. During an interview on 02/09/26 at 5:55 P.M. and 02/18/26 at 10:55 A.M. the Administrator said the following:-She would expect the documentation on the disposition form to be clear and accurate, including the documentation of the destruction;-The documented destruction on the disposition form should match the documented destroyed amount on the typed destruction log;-If staff remove a narcotic from a medication card and document the removal of that medication on the disposition form, staff should also be documenting the administration on the MAR. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent (%). Out of 25 opportunities observed, six errors occurred, resulting in a 24.0% error rate, affecting one resident (Resident #45), in a medication administration review of four sampled residents. The facility census was 53. Review of the facility, Medication Administration Policy, dated 02/07/24, showed the following:-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician;-Review the Medication Administration Record (MAR) to identify medication to be administered;-Compare the medication source (bubble pack, etc.) with the MAR to verify resident name, medication name, form, dose, route and time;-Administer medication as ordered in accordance with manufacturer specifications;-Do not crush medications with do not crush instructions;-Do not crush medications include slow release and enteric coated medications. 1. Review of drugs.com for pantoprazole sodium delayed release (medication used to reduce stomach acid) showed the following:-Do not crush, chew or break the tablet; swallow it whole;;-Crushing the tablet can lead to the medication being released too soon in the stomach rather than the small intestine and the medication will not be absorbed properly, resulting in suboptimal treatment for conditions like acid reflux. 2. Review of drugs.com for venlafaxine hcl extended release 24 hour (medication used to treat depression) showed the following:-Swallow the extended-release tablet whole and do not crush, chew or break;-Crushing the tablet destroys the mechanism that slows the release of the medication and causes dose dumping, where the entire, daily, long-acting dose is released at once, rather than over 24 hours. Releasing the full dose at once significantly increases the risk of side effects, including dizziness, vomiting, racing heart, seizures and increased blood pressure. A sudden high dose can lead to serotonin syndrome, a potentially life-threatening condition marked by extreme agitation, hallucinations, high body temperatures, tremors and coma. The medication will not last the full 24 hours, leading to premature wearing off, which may cause withdrawal-like symptoms. 3. Review of drugs.com for enteric coated baby (used to treat pain, fever and heart conditions) showed the following:-This is a delayed-release form of medication designed to bypass the stomach and dissolve in the intestines to minimize stomach irritation;-Swallow whole. Do not chew, break or crush;-Crushing makes the tablet dissolve in the stomach instead of the intestine, increasing the risk of side effects such as heartburn, stomach pain, stomach ulcers and bleeding. The drug will be released immediately rather than delayed and will be destroyed by stomach acid before it is absorbed, meaning the intended dose will not be given. 4. Review of drugs.com for potassium chloride extended release (mineral supplement used to treat low potassium levels in the blood) showed the following:-Swallow whole. Do not chew, break or crush;-This extended-release medication is specifically designed to release the potassium slowly over several hours;-If you crush or chew this medication, you release the entire dose at once, causing a dose dump, which can cause serious health conditions, including severe stomach irritation/damage, cardiac risks, throat/esophageal irritation and loss of effectiveness. 5. Review of Resident #45's February 2026 Physician Order Sheets (POS) showed the following:-Diagnoses included gastroesophageal reflux disease (GERD) (digestive disorder where stomach acid flows back into the esophagus), major depressive disorder, vitamin B12 deficiency anemia, high blood pressure, heart failure and dysphagia (difficulty swallowing);-Pantoprazole sodium delayed release 20 milligrams (mg), give one tablet daily;-Venlafaxine hcl extended release 24 hour 75 mg tablet, give one tablet daily for depression;-Aspirin tablet chewable 81 mg, give one tablet by mouth one time a day for pain;-Potassium chloride extended release 20 milliequivalents (meq), give one tablet by mouth one time a day related to hypertension;-Cyanocobalamin (vitamin B12) 1000 mcg, give one tablet by mouth one time daily related to vitamin B12 deficiency anemia;-No order to crush medications. Review of Resident #45's February 2026 Medication Administration Record (MAR) showed the resident's morning medications included the following:-Pantoprazole sodium delayed release 20 mg, give one<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | tablet daily, scheduled for 8:00 A.M.;-Venlafaxine hcl extended release 24 hour 75 mg tablet, give one tablet daily for depression, scheduled for 8:00 A.M.;-Aspirin tablet chewable 81 mg, give one tablet by mouth one time a day for pain, scheduled for 9:00 A.M.;-Potassium chloride extended release 20 meq. give one tablet by mouth one time a day related to high blood pressure, scheduled for 10:00 A.M.;-Cyanocobalamin 1000 mcg, give one tablet by mouth one time daily related to vitamin B12 deficiency anemia, scheduled for 9:00 A.M. Observation on 02/10/26 at 9:05 A.M. showed the following:-Certified Medication Technician (CMT) D prepared one tablet of the resident's pantoprazole sodium delayed release 20 mg from the resident's pharmacy medication card and placed the tablet in a medication cup;-He/She prepared one tablet of the resident's venlafaxine hcl extended release 24 hour 75 mg from the resident's pharmacy medication card and placed the tablet in a medication cup;-He/She prepared one tablet of enteric coated baby aspirin 81 mg from a facility stock bottle (not chewable as ordered) and placed the tablet in a medication cup;-He/She prepared one tablet of potassium chloride extended release 20 meq from the resident's pharmacy medication card and placed the tablet in a medication cup;-He/She prepared one tablet of cyanocobalamin 100 mcg from a facility stock bottle (not 1000 mcg as the order read) and placed the tablet in a medication cup;-Observation of the medication cart drawer showed there was a stock bottle of cyanocobalamin 1000 mcg available for use;-CMT D then poured all the medications into a plastic sleeve, crushed the medications and placed the crushed medications in a pudding cup;-CMT D administered the medications to the resident. During an interview on 02/10/26 at 9:20 A.M., CMT D said the following:-He/She was aware of what medications could be crushed and what medications should not be crushed;-He/She had placed all the medications in the plastic sleeve, but made sure the aspirin was in the middle, so it did not get crushed;-He/She thought the 1000 mcg dose must have been a mistake because that was too large a dose and all he/she had to use was the 100 mcg bottle of cyanocobalamin. During an interview on 02/11/26 at 11:10 A.M. the Director of Nursing (DON) and Administrator said the following:-They would expect staff to follow physician orders;-They would expect staff to verify doses of ordered medications with the MAR and the bottles of medication;-They would expect staff to only crush medications that could be crushed;-Staff should not crush enteric coated medications, extended-release medications or delayed release medications |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview and record review, the facility failed to ensure staff maintained infection control practices for one additional resident (Resident #45), in a medication administration review of four residents. Additionally, the facility failed to ensure staff used Enhanced Barrier Precautions (EBP) (a Centers for Disease Control and Prevention recommended infection control intervention for nursing homes designed to reduce multidrug-resistant organism transmission) for one resident (Resident #3), in a review of 18 sampled residents. Resident #3 had a gastrostomy tube (a device inserted through the nose, mouth, or directly into the stomach/intestine to deliver essential nutrients, fluids, and medication directly to the gastrointestinal tract) and documented methicillin resistant staphylococcus aureus (MRSA - a bacteria that spreads through skin to skin contact or contaminated surfaces) in a wound. Staff failed to use appropriate infection control practices during incontinence care. The facility census was 53. Review of the facility, Medication Administration Policy, dated 02/07/24, showed the following:-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, in a manner to prevent contamination or infection;-Remove medication from source, taking care not to touch medication with bare hand. 1. Review of Resident #45's February 2026 Physician Order Sheets (POS) showed the following:-Aspirin (medication used to treat pain, fever and heart conditions) tablet chewable 81 milligrams (mg), give one tablet by mouth one time a day for pain;-Metoprolol tartrate (medication used to treat high blood pressure) 12.5 mg, give by mouth two times daily for high blood pressure;-Potassium chloride extended release (mineral supplement used to treat low potassium levels in the blood) 20 milliequivalents (meq), give one tablet by mouth one time a day related to high blood pressure. Review of the resident's February 2026 Medication Administration Record (MAR) showed the following:-Aspirin tablet chewable 81 mg scheduled for 9:00 A.M.;-Metoprolol tartrate 12.5 mg scheduled for 10:00 A.M.;-Potassium chloride extended release 20 meq scheduled for 10:00 A.M. Observation on 02/10/26 at 9:05 A.M. showed the following:-Certified Medication Technician (CMT) D prepared one tablet of enteric coated baby aspirin 81 mg from a facility stock bottle, placed the tablet in his/her bare hand, and then put it into a medication cup;-He/She prepared one tablet of metoprolol tartrate 12.5 mg from the resident's pharmacy medication card and placed the tablet in his/her bare hand and then into a medication cup;-He/She prepared one tablet of potassium chloride extended release 20 meq from the resident's pharmacy medication card and placed the tablet in his/her bare hand and then into a medication cup;-CMT D poured all the medications into a plastic sleeve, crushed the medications and placed the crushed medications in a pudding cup;-CMT D administered medications to the resident. During an interview on 02/10/26 at 9:20 A.M., CMT D said the following:-He/She should not touch medications with bare hands;-He/She did not realize he/she used his/her bare hands to touch the resident's medications. During an interview on 02/11/26 at 11:10 A.M., the Director of Nursing (DON) and Administrator said staff should not put medications from a pharmacy medication card or stock bottle into their hand when preparing medications for administration. 2. Review of the facility policy, EBP, revised 04/23/25, showed the following: -It is the policy of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDROs);-EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing;-Additional epidemiologically important MDROs may include, but are not limited to methicillin-resistant staphylococcus aureus (MRSA);-Implementation of EBP: -a. Make gowns and gloves available near or outside of the resident's room; -b. PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room;-High-contact resident care activities include: -d. Providing hygiene; -f. Changing briefs or assisting with toileting; -g. Device care or use: central lines, urinary catheters,<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | feeding tubes; -h. Wound care: any skin opening requiring a dressing. 3. Review of the facility policy, Perineal Care, revised 05/01/25, showed the following: -It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown;-Policy explanation and compliance guidelines:-Change gloves if soiled and continue with perineal care;-Apply skin protectants as need and according to facility policy regarding skin care. 4. Review of Resident #3's undated face sheet showed the following: -Diagnoses included oropharyngeal phase dysphagia (difficulty initiating a swallow, coughing or choking), stroke and unspecified dementia (a progressive decline in cognitive function - memory, thinking, and reasoning - severe enough to interfere with daily life). Review of the resident's electronic health record, lab results, showed the following: -Wound culture of the left heel collected on 12/24/25;-Results of the wound culture showed moderate growth of MRSA. Review of the resident's significant change in status Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 01/06/26, showed the following:-Severe cognitive impairment;-Dependent on staff for toileting hygiene;-Always incontinent of bowel and bladder;-Coughing or choking during meals or when swallowing medications;-Feeding tube;-At risk for pressure ulcers;-Has one or more unhealed pressure ulcers;-Infection of the foot;-Applications of dressings, ointments/medications, and dressings to feet. Review of the resident's care plan, revised on 01/09/26, showed the following:-The resident required EBP for an indwelling medical device and chronic wounds;-EBP included the use of gown and gloves during high-contact resident care activities, including, but not limited to dressing, bathing, transfers, linen changes, incontinent care, wound and/or indwelling device care;-The resident required tube feeding related to swallowing problems;-He/She has a self-care performance deficit related to cognitive impairment, decreased strength and history of cerebral vascular accident (stroke);-Dependent on staff for toileting hygiene and personal hygiene. Review of the resident's February 2026 POS showed EBP for g-tube (a tube inserted through the abdomen into the stomach for the purpose of administration of nutrition) and chronic wound. Gown and gloves required for high-contact resident care activities every shift for isolation precautions. Observation on 02/10/26 at 9:33 A.M. showed the following:-A sign on the resident's door that read STOP: Enhanced Barrier Precautions;-Everyone must: Clean their hands, including before entering and when leaving the room;-Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing;-Do Not wear the same gown and gloves for the care of more than one person;-EBP supplies, including gowns, were available directly outside the resident's room;-The surveyor entered the resident's room after Certified Nursing Assistant (CNA) B and Licensed Practical Nurse (LPN) C had already begun providing incontinence care; both staff wore gloves but no gowns; -The resident was incontinent of bowel and bladder;-CNA B performed incontinence care while LPN C provided help with positioning and turning the resident from side to side;-During incontinence care, CNA B needed additional supplies and removed his/her soiled gloves, completed hand hygiene, put on a new pair of gloves, collected needed supplies and completed additional incontinence care until all feces were removed from the resident's skin;-Without changing gloves, CNA B picked up a tube of barrier cream from the resident's bedside table, touched the resident's right hip and applied the barrier cream to the resident's bilateral buttocks;-CNA B and LPN C positioned the resident and removed their gloves, completed hand hygiene and left the room; -The resident had a feeding tube in his/her abdomen; -There was an intact wound dressing on the resident's left heel;-During cares, CNA B and LPN C did not wear a gown when providing high contact resident care. During an interview on 02/10/26 at 9:45 A.M. and 02/11/25 at 11:20 A.M., CNA B said the following: -He/She wore gloves but did not wear a gown;-There was a sign on the resident's door for EBP and he/she was aware the resident needed EBP related to his/her tube feeding and<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265118 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Point Health and Rehabilitation | 2840 West Clay St<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | wounds;-EBP should be used to prevent the spread of infection;-Gloves should be changed when going from a clean area to a dirty area;-Gloves should be changed when they become dirty, and before touching barrier cream or applying barrier cream after peri-care has been completed;-He/She did not realize that he/she touched the tube of barrier cream with dirty gloves. During an interview on 02/18/26 at 4:05 P.M., LPN C said the following: -Staff is made aware of what resident's need EBP by the sign on the door, the order in the computer and the PPE bin outside the resident's door;-EBP was required during care for residents with a urinary catheter (a tube inserted in a bladder to drain urine), a feeding tube or with wounds;-Staff should be using a gown and gloves when providing care to Resident #3;-On 2/10/26, he/she assisted CNA B in providing incontinence care for the resident;-He/She wore gloves only and should have also worn a gown because the resident had a feeding tube and wounds;-He/She did not realize a gown was needed until they had already started providing care;-He/She and CNA B should have stopped providing care and put on a gown. During an interview on 2/10/25 at 12:35 P.M., the Infection Preventionist (IP) said the following: -Staff should utilize EBP for all direct care provided for Resident #3;-She noticed staff did not have EBP on when she was in the room;-She would expect staff to wear gloves and a gown when providing care for the resident as the resident had a gastrostomy tube and wounds on his/her left heal with MRSA. During an interview on 02/11/26 at 4:59 P.M., the Director of Nursing (DON) said the following: -EBP should be worn for any resident that required it when they are performing high contact prolonged care;-EBP would be required for indwelling medical devices, catheters, MDRO wounds and residents with a feeding tube;-EBP, including gowns and gloves, are to be worn during high contact care;-She would expect staff to change their gloves when going from clean to dirty or when they become soiled;-Staff should not touch a barrier cream tube with soiled gloves;-Staff should not apply barrier cream with soiled gloves. |