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	08/31/2022

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Based on observation, interview, and record review, the facility failed to appropriately transfer one resident (Resident #1), who required assistance with transfers, using a gait belt. Staff failed to use a gait belt when transferring Resident #1 on 7/23/22. Both the staff member and the resident fell to the floor during the transfer and the staff member landed on top of the resident. Staff failed to document and investigate the fall or ensure interventions were put in place to prevent reoccurrence. On 7/27/22, staff obtained a physician order for X-rays of the resident's ankle and foot as well as a venous Doppler of the resident's leg left leg, due to edema (swelling caused by fluid trapped in the body's tissues) and pain. On 7/28/22, another staff member attempted to transfer the resident without using a gait belt. Both the staff member and the resident fell to the floor. The resident was sent to the emergency room and admitted to the hospital for treatment of a femoral neck (top of the thigh bone) fracture, humerus (upper arm) fracture, knee dislocation, acute pain, and acute blood loss. A sample of six residents was selected for review. The facility census was 104. The administrator was notified on 8/23/22 at 2:38 P.M. of an Immediate Jeopardy (IJ) which began on 7/23/22. The IJ was removed on 8/24/22 as confirmed by surveyor onsite verification. Review of the facility's Fall Prevention Program policy revised 9/21/21 showed the following: -Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; -A fall is an event in which an individual unintentionally comes the rest on the ground, floor, or other level, but not as a result of an overwhelming external force (resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere; -The facility uses a standardized risk assessment for determining a resident's fall risk; -When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program; -Each resident's risk factors and environmental hazards when developing the resident's comprehensive plan of care; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Interventions will be monitored for effectiveness; -The plan of care will be revised as needed; -When any resident experiences a fall, the facility will: a. Assess the resident; b. Complete a post fall assessment; c. Complete an incident report; d. Notify the physician and family; e. Review the resident's care plan and update as indicated; f. Document all assessments and actions; g. Obtain witness statements in the case of injury. Review of the facility's Use of Gait Belt policy revised 5/4/22 showed the following: -It is the policy of the facility to use gait belts (a device put on a resident who has mobility issues, by a caregiver prior to that caregiver moving the resident. Residents may have problems with balance and a gait belt may be used to aid in their safe movement) with residents that cannot independently ambulate or transfer for the purpose of safety; -Gait belts will be available for staff to use; -All employees will receive education on the proper use of gait belts during orientation and annually; -It will be the responsibility of each employee to ensure they have it available for use at all times when at work; -Any and all repairs needed or issues with gait belts will be reported to the supervisor immediately for replacement; -Failure to use a gait belt properly may result in termination. 1. Review of Resident #1's annual Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 5/15/22 showed the following: -Diagnoses included stroke, hemiplegia (one-sided paralysis), diabetes, osteoporosis, anxiety, and depression; -Cognition was intact; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Required limited assistance of one staff for bed mobility, transfers, and hygiene; -No falls since the previous assessment. Review of the resident's care plan revised 5/23/22 showed the following: -The resident had a self-care performance deficit (deficiency or failing) related to a history of stroke with left sided weakness, contracted left elbow, hand, and left contracted foot. The resident used a wheelchair for locomotion and fatigues easily; -Assistance of one staff for transfers; -Monitor/document/report as needed, any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function; -The resident was at risk for falls due to history of stroke with left sided weakness. The resident would attempt to transfer himself/herself; -Be sure the call light is in reach and encourage him/her to use it for assistance as needed; -Ensure the resident wore appropriate footwear; -Keep the resident's wheelchair near the bed; -Review information on past falls and attempt to determine the cause of falls. Record possible root causes. Alter or remove any possible causes if possible. Educate resident/family/caregivers/Interdisciplinary team as to causes. During an interview on 8/22/22 at 3:31 P.M. Certified Nurse Aide (CNA) B said towards the end of July (exact date unknown), Resident #1 asked to be changed so CNA B changed the resident while the resident was in bed. CNA B tried to transfer the resident to the wheelchair. The resident's foot got caught and both the resident and CNA B fell to the floor. CNA B landed on the resident during the fall. CNA B had another aide help get the resident up off the floor. The resident complained of his/her leg hurting. CNA B reported this to the charge nurse at the time. CNA B did not remember the name of the aide that assisted him/her to get the resident off the floor or the name of the nurse he/she reported the fall to. CNA B wrote a statement about the incident which he/she gave to the charge nurse. CNA B made a copy of the statement and placed it in the Director of Nurses (DON)'s box. CNA B said he/she did not use a gait belt during the transfer with Resident #1. During an interview on 8/24/22 at 1:38 P.M. Licensed Practical Nurse (LPN) F said he/she was not the charge nurse, but he/she was working on 7/23/22 when Resident #1 fell . It was about 7:00 P.M., right as LPN F was finishing his/her shift. LPN F could not recall who the charge nurse was at the time. LPN F collected statements from CNA B and the other staff involved, but was unsure who the other staff member was. LPN F placed the statements in the former DON's mailbox. LPN F also called and notified the former DON that evening before he/she left. LPN F did not assess Resident #1 or call his/her physician as this would have been the charge nurse's responsibility. LPN F's only involvement was collecting the statements and notifying the former DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/23/22 at 4:00 P.M. the former DON said she became aware Resident #1 fell on [DATE], a Saturday, during a transfer with CNA B when the former DON found a written statement from CNA B the following Monday, 7/25/22. The former DON did not recall who the charge nurse was at the time. The former DON did not think CNA B used a gait belt during the transfer, but she wasn't certain. The former DON said she thought she got a statement from the charge nurse as well and had a file on the incident that she left in the facility. The former DON instructed CNA B to use two staff when transferring Resident #1 in the future after the fall on 7/23/22. The former DON expected staff to transfer Resident #1 with a gait and expected two staff to transfer Resident #1 with a gait belt after his/her fall on 7/23/22. The former DON said there should have been a nurse's note made by the charge nurse regarding Resident #1's fall on 7/23/22. The former DON did not know if the charge nurse completed an investigation or conducted an assessment of Resident #1 after the fall on 7/23/22. Record review showed no documentation the resident fell on [DATE]. During an interview on 8/23/22 at 5:50 P.M., the Regional Director of Operations said she could not locate the file the former DON said she had made regarding Resident #1's fall on 7/23/22. Review of the resident's physician order sheet (POS) for July 2022 showed an order dated 7/27/22 for venous Doppler (a special ultrasound technique that evaluates blood as it flows through a blood vessel) of the left leg for diagnoses of edema/pain and an order for an X-ray (a photographic or digital image of the internal composition of something, especially a part of the body) of the ankle and foot for diagnoses of edema, pain, status post injury. Review of the resident's nurse's note dated 7/28/22 at 2:22 P.M. showed the resident was transferring from the bed with the assistance of a CNA. The resident pivoted in the opposite direction and fell to the floor. The resident said he/she hit his/her head and back. 911 was called and responded and the resident was in route to the hospital. Review of the resident's Incident Report, dated 7/28/22 at 2:22 P.M., showed the following: -The incident occurred in the resident's room; -The resident was transferring from bed with the assistance of a CNA. The resident pivoted in the opposite direction and fell to the floor. The resident said he/she hurt his/her head and back. 911 called and responded and the resident was transported to the hospital via Emergency Medical Services (EMS). Review of the resident's Fall Risk Assessment Worksheet dated 7/28/22 at 3:22 P.M. showed the following: -The resident was a high risk for falls; -The resident had two falls in the last 30 days; -The resident's cognitive status had changed in the last 90 days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's discharge information from the hospital, dated 8/4/22, showed the resident's discharge diagnoses from the hospital was femoral neck fracture, humerus fracture, knee dislocation, and acute blood loss anemia (a condition in which you lack enough healthy red blood cells to carry adequate oxygen to your body's tissues). Observation on 8/22/22 at 10:48 A.M. showed the resident had dark purple bruising to his/her left arm from the elbow up to his/her shoulder. During interviews on 8/22/22 at 10:48 A.M., and 8/23/22 at 3:03 P.M., the resident said the following: -He/She had a fall when transferring with staff out of bed. Their feet got tangled together and they both fell to the floor. The staff member fell on top of the resident; -The resident said the fall shook him/her up and caused some pain. The staff member did not use a gait belt during the transfer; -The resident said he/she fell again a few days later with a different staff member during a transfer. Both the resident and the staff member landed on the floor. The staff member did not use a gait belt during this transfer. The resident had to be transferred to the emergency room ; -His/Her first fall was with CNA B. CNA B was a large, heavyset person, and CNA B landed on top of the resident. CNA B's knee landed on the resident's left thigh and the resident hit his/her head on the floor. CNA B yelled for help and another aide came in and assisted CNA B to get the resident off the floor. The nurse never came and assessed Resident #1 after this fall. Other staff, who the resident could not recall the names, did come and talk with him/her about it a few days later, trying to figure out what happened; -A few days later the resident fell again, this time during a transfer with CNA A on 7/28/22. The resident was sent to the emergency room . During an interview on 8/22/22 at 1:45 P.M., the resident's significant other said he/she thought the first fall occurred on 7/22/22 or 7/23/22, when the resident was being transferred by a staff member. The staff member ended up landing on top of the resident. He/She found out about the fall from the resident. The resident's significant other spoke to the administrator about the fall on the following Monday. The resident's significant other said he/she is at the facility each day for several hours and staff never used a gait belt when transferring the resident. The only staff who ever used a gait belt when transferring the resident was therapy staff. During an interview on 8/23/22 at 2:45 P.M. Resident #6 said he/she was Resident #1's roommate and Resident #6 was in the room and observed Resident #1 fall while being transferred by CNA B (on 7/23/22). Both CNA B and Resident #1 fell to the floor. Resident #1 did complain of pain. CNA B and another aide assisted Resident #1 off the floor. Review of the undated statement from CNA A (referring to the fall on 7/28/22) showed the following: -At approximately 2:00 P.M. the resident was wheeled to his/her room by his/her significant other who had asked CNA A to change the resident; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Prior to the transfer CNA A locked the wheelchair and was going to the stand the resident on his/her right side which was his/her strong side; -During the transfer both CNA A and the resident lost their balance and fell to the floor; -The resident isn't steady on his/her feet; -CNA A was in front of the resident and the resident was holding onto CNA A's left side; -As CNA A and the resident stood from the wheelchair, the resident leaned towards his/her left side and CNA A and the resident fell to the floor; -The resident fell on the floor on his/her left side; -CNA A immediately checked to see if the resident was injured and got the nurse and notified the Assistant Director of Nursing (ADON), nurse manager, and administrator of the incident; -The resident complained of pain in his/her left thigh and arm; -EMS was called to send the resident to the emergency room for evaluation. During an interview on 8/22/22 at 1:14 P.M. CNA A said on 7/28/22 around 2:00 P.M. he/she attempted to transfer Resident #1 from the wheelchair to the bed. The resident was a stand and pivot transfer. CNA A did not use a gait belt during this transfer. Resident #1 lost his/her balance and leaned to one side. Resident #1 had his/her arm around CNA A's shoulder. CNA A had a hold on the resident's pants and under his/her armpit. Resident #1 pivoted in the opposite direction of the bed. Both CNA A and Resident #1 landed on the floor. CNA A was able to get up and got the charge nurse who assessed the resident and sent the resident to the emergency room . CNA A said a few days prior to 7/28/22, Resident #1 fell with another aide, CNA B. CNA B was transferring the resident and ended up falling on him/her. CNA A said CNA B wrote out a statement about the incident so the administrator should know about it. During an interview on 8/22/22 at 1:40 P.M. CNA C said Resident #1 fell during a transfer with a staff member and then a few days later fell again with a different staff member. The resident required assistance of one staff and a gait belt at that time. CNA C said the resident was being transferred by CNA B when the first fall occurred. During an interview on 8/22/22 at 3:26 P.M. CNA D said he/she was not aware of Resident #1 falling prior to 7/28/22. Sometimes CNA D transferred Resident #1 using a bear hug method because sometimes the resident would complain about the gait belt. During an interview on 8/22/22 at 4:05 P.M. Licensed Practical Nurse (LPN) E said Resident #1 had swelling in his/her left leg and had complained of pain. LPN E received an order on 7/27/22 to obtain an X-ray and a venous Doppler of the left leg and foot. The tests were scheduled for the following Friday, but before the tests were obtained the resident ended up going to the emergency room after a fall on 7/28/22. LPN E was not aware of the resident having a fall prior to 7/28/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/22 at 2:15 P.M. the Director of Nursing (DON) and the administrator said they expected staff to utilize a gait belt with residents who required manual assistance for transfers and staff should have used a gait belt when assisting Resident #1 with transfers. The DON and administrator expected staff to complete an assessment of the resident after a fall occurred, complete an incident report, contact the physician, and document all findings. During an interview on 8/22/22 at 2:57 P.M., the administrator said she was not aware of the resident having any fall prior to 7/28/22. No one had reported anything about it to her. During an interview on 8/23/22 at 4:15 P.M. Resident #1's physician and the facility's medical director, said he was not sure if the facility notified him of Resident #1's fall on 7/23/22. The physician would expect staff to follow the facility protocol following a resident fall, including obtaining vital signs and neurological checks if the resident hit their head. The resident may need to be seen emergently. If there was no injury from the fall, the physician would expect increased monitoring for any changes and the physician would expect to be notified of any changes. The physician did order some imaging tests for Resident #1 which were not able to be obtained prior to the resident's second fall. The physician was notified after the resident's second fall. The resident was sent to the emergency room and admitted to the hospital with fractures. The physician was aware there were issues and problems related to documentation in the facility. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).