STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265208	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Villa Marie	1030 Edmonds Street Jefferson City, MO 65109

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39440 Based on record review and interview, facility staff failed to thoroughly investigate an allegation of sexual assault for one resident (Resident #1) out of one sampled resident. The facility census was 69. 1. Review of the facility's policy titled, Abuse, Neglect, and Exploitation Program Responsibilities, dated September 2022, showed staff are directed as follows: -abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology; -The Abuse Coordinator in the facility is the Administrator, or facility appointed designee when the Administrator is absent. -Report allegations or suspected abuse, neglect, or exploitation immediately to the Administrator, Law Enforcement, and State Survey and Certification Agency through established procedures. --For investigation of alleged abuse, neglect and exploitation: When suspicion of abuse, neglect or exploitation, or reports of abuse neglect or exploitation occur, an investigation is immediately warranted. Components of an investigation may include: -Interview the involved resident, if possible, and document all responses; -If resident is cognitively impaired, interview the resident several times to compare responses; -Interview all witnesses separately; -If there is no discernable response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident; -Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area, obtain witness statements, according to appropriate policies; -All statements should be signed and dated by the person making the statement; (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document the entire investigation chronologically. -In response to allegation of abuse, neglect, exploitation or mistreatment, the facility must have evidence that all allegations are thoroughly investigated and completed within five days of forming a suspicion; -Report the results of all investigation to the resident's designated representative and to other officials including the State Survey Agency, within five working days of the incident. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/31/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Independent with bed mobility, supervision with transfers and ambulation; -Diagnoses to include Dementia, Traumatic Brain Injury, anxiety disorder. Review of the facility's investigation report, dated 01/14/25, showed the Director of Nursing (DON) documented he/she had been notified by LPN A the resident made an allegation of rape, started an investigation, and he/she interviewed the resident at approximately 12:10 P.M. Review showed the facility investigation did not contain signed and dated statements from staff or witnesses to the allegation, and did not contain documentation of interviews with other residents. During an interview on 01/17/25 at 1:40 P.M., the administrator said the DON & ADON gathered most of the information for the investigation, the DON had all the documentation on his/her computer, but he/she was off work at the time. During an interview on 01/17/25 at 2:42 P.M., Licensed Practical Nurse (LPN) A said he/she was not asked to provide a signed statement of the resident's allegation. MO00248175

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39440 Based on record review and interview, facility staff failed to contact local law enforcement, and failed to report to the Department of Health and Senior Services (DHSS) within the two-hour required timeframe for one resident (Resident #1) out of one sampled resident with an allegation of sexual abuse. The facility's census was 69. 1. Review of the facility's policy titled, Abuse, Neglect, and Exploitation Program Responsibilities, dated September 2022, showed staff are directed as follows: -Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology; -Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or resulting in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency and if a crime is suspected, law enforcement. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/31/24, showed staff assessed the resident as follows: -Severe cognitive impairment; -Independent with bed mobility, supervision with transfers and ambulation; -Diagnoses to include Dementia, Traumatic Brain Injury, Anxiety Disorder, a bladder infection. Review of the facility's investigation report, dated 01/14/25, showed the Director of Nursing (DON) documented he/she interviewed the resident at approximately 12:10 P.M., and the resident reported an allegation he/she had been sexual assualted two nights prior. The report did not contain documentation facility staff reported the allegation to DHSS within the two-hour timeframe after the resident reported the allegation of sexual abuse and did not notify the local law enforcement department. Review of the DHSS complaint/facility self-report database showed facility staff did not report the resident's allegation of sexual abuse to DHSS 72 hours after the resident initially reported his/her allegation to facility staff. During an interview on 01/17/25 at 1:40 P.M., the administrator said DHSS should be contacted within two hours after he/she receives a report/allegation of abuse. He/She said when staff reported the resident's allegation 01/16/25, he/she did not contact DHSS within two hours because after doing his/her internal investigation, the resident's allegation of abuse was not determined to be substantiated, so he/she made the report to DHSS within 24 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/17/25 at 2:26 P.M., the Assistant Director of Nursing (ADON) said he/she was aware the resident reported the initial allegation at least two days prior to Licensed Practical Nurse (LPN) A, who had immediately reported it to the administrator and DON. The ADON said all allegations of abuse should be reported to DHSS within two hours after the allegation is made, and he/she was not sure why the DON or administrator did not report to DHSS within the two-hour timeframe. During an interview on 01/17/25 at 2:42 P.M., LPN A said the resident reported to him/her at least two days prior around lunch time, he/she was raped the night before. The LPN said he/she immediately reported the resident's allegation to the administrator, and the DON came to the unit and started an investigation. During an interview on 01/21/25 at 10:30 A.M., the DON said he/she started an investigation on 1/14/24 for the resident's allegation of abuse. He/She said abuse allegations should be reported to DHSS within two hours, but he/she did not report to DHSS because the internal investigation did not reveal that the resident was abused. MO00248175