

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Villa Marie		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the resident's needs for three residents (Resident #4, #5, and #6) out of three sampled residents. The facility census was 68.1. Review of the facility's Comprehensive Care Planning policy, dated 02/25, showed staff are directed as followed:-Develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and [NAME] and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality; -The care plan process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care; -The policy did not contain direction for staff in regard to revision after a change in condition or timeframes for updating the care plan. 2. Review of Resident #4's Quarterly Minimum Data Set (MDS) a federally mandated assessment tool, dated [DATE], showed staff assessed the resident as follows:-Severe cognitive impairment;-Did not contain documentation of preferences of customary routine and activities.-Did not exhibit of physical or verbal aggression towards others;-Did not significantly intrude on the privacy or activity of others;-Did not significantly disrupt care or living environment.Review of the resident's progress notes showed staff documented:-On [DATE], the resident held the arm of another resident and took him/her into the living room. Staff intervened and asked the resident to let go of the other resident's arm and eventually released the other resident's arm after the second request; -[DATE], the resident did not want to go to breakfast and refused to allow another resident to go to breakfast, grabbing the other resident left wrist and pulling him/her down into a chair despite staff intervention;-[DATE], the resident had been showing increased aggressive behavior with staff as they tried to care for another resident, he/she was fixated on;-[DATE], the resident was yelling at staff because he/she had another resident in his/her room and was attempting to prevent the resident from going to breakfast. Staff documented they went to resident's room, resident blocked the door and yelled at staff.Review of the resident's care plan, undated, showed the care plan did not contain interventions for resident behaviors. During an interview on [DATE] at 9:30 A.M., the Assistant Director of Nursing (ADON) said the resident believes he/she is Resident #5 caretaker. The ADON said the families approved the residents to sleep in the same room. The ADON said he/she believed it was documented in both resident's care plans. During an interview on [DATE] at 10:07 A.M., Certified Nurse Aide I said the resident interferes when staff are attempting to provide care to his/her roommate. During an interview at 12:67 P.M., the MDS Coordinator said he/she was aware the resident had behaviors but overlooked addressing interventions in the care plan. He/She said he/she was aware Resident #4 and Resident #5 were close, and Resident #5 liked to sleep in the room with resident #4, which should have been addressed in care plan. 3. Review of Resident #5's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and did not contain documentation of preferences of customary routine and activities.Review of the resident's Physician Order Summary (POS), dated [DATE], showed an order for Do Not Resuscitate (DNR) (a medical order instructing healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a person's heart stops beating or they stop breathing).Review of the resident 's care plan, revised [DATE], showed staff documented the resident's advance directive as full code (every possible measure that can be used to save a patient's life). The care plan did not contain documentation of the resident activity preferences or relationship with another resident to include sleeping in the same room as the resident. 4. Review of Resident #6's re-admission MDS, dated [DATE], showed it did not contain documentation of a Brief Interview Memory Status (BIMS) or preferences of customary routine and activities. Review of the resident's care plan, dated [DATE], showed it did not contain direction for staff in regard to the resident's activities preference.5. During an interview at 12:67 P.M., the MDS Coordinator said he/she reviewed and revised care plans on a quarterly basis. He/She said he/she would expect behaviors and activity preferences to be addressed in the resident's care plan. He/She said each department provides information to add to the resident's care plan. He/She said the activities department did not provide Resident's #4, #5 and #6's activity preferences and he/she overlooked adding the resident's preferences in the activity section of the care plan. During an interview on [DATE] at 1:08 P.M., the administrator said the purpose of the care plan was to provide direction to staff in providing person-centered care for each resident. He/She said the care plans are undated by the</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to change gloves and wash/sanitize hands during perineal care for two residents (Resident #1, and #2) of two sampled residents, and failed to properly dispose of contaminated linens from one resident's (Resident #3's) room. Facility staff failed to implement the enhanced barrier precautions (EBP) (an infection control intervention) policy when they did not properly alert staff of residents who required EBP and place appropriate personal protective equipment (PPE) in proximity for one resident (Resident #1) of one sampled resident that required EBP during perineal care and wound care. The facility census was 68. 1. Review of the facility's Infection Prevention and Control Manual-Standard Precautions policy, dated 2017, showed staff are directed as follows:-Hand hygiene continues to be the primary means of preventing the transmission of infections;-Alcohol-based hand rub (ABHR)/ hand sanitizer can be used instead of soap and water in all clinical situations except when hands are visibly soiled, or after caring for a resident with known or suspected infections;-Soap, water, ABHR, and a sink should be readily available in appropriate locations including but not limited to resident care areas;-Remove gloves after contact with a patient, bodily fluids, and the surrounding environment using proper technique to prevent hand contamination;-Change gloves during patient care if the hands will move from a contaminated body site (example, perineal area) to a clean body site (example, face, clothing);-Disposal of waste is also handled as though all body fluids are infectious;-Potential contaminated articles are stored and disposed of in appropriate containers (example, items saturated as evidenced by blood or body fluid should be placed in properly labeled biohazard bags).2. Review of Resident #1's Discharge-Return Anticipated-Minimum Data Set (MDS), a federally mandated assessment, dated 07/01/25, showed staff assessed the resident as severely cognitive impaired, dependent with toileting, and always incontinent of bowel and bladder.Observation on 07/09/25 at 1:34 P.M., showed Certified Medication Technician (CMT) D and Certified Nursing Assistant (CNA) E entered the resident's room to provide incontinence care. CMT D and CNA E did not wash his/her hands or use hand sanitizer between glove changes during incontinence care or before they left the room, to prevent the spread of infection. During an interview on 07/09/25 at 1:52 P.M., CNA E said he/she did not perform hand hygiene between glove changes because he/she did not have hand sanitizer close by, and he/she just forgot to wash his/her hands before he/she left the room. He/She said it is important to perform proper hand hygiene to prevent the spread of infection. During an interview on 07/09/25 at 2:32 P.M., CMT D said he/she did not perform hand hygiene between glove changes because of oversight and he/she did not have hand sanitizer close by. He/She said it is important to perform proper hand hygiene to prevent the spread of infection.3. Review of Resident # 2's Quarterly MDS, dated [DATE], showed the facility assessed the resident as follows:-Severe cognitive impairment;-Dependent on staff for toileting, transfers, personal hygiene and bathing;-Impairment to both lower extremities;-Always incontinent of bladder and bowel.Observation on 07/09/25 at 2:15 P.M., showed CNA F entered the resident's room to provide perineal care. CNA F did not wash his/her hands before he/she placed gloves on. CNA F removed the soiled brief and cleaned the residents front and back side. With the same soiled gloves, CNA F placed a clean brief, pants, and covered the resident with their blanket. CNA F gathered trash, removed gloves and left the room. During an interview on 07/09/25 at 2:35 P.M., CNA F said he/she should have washed his/her hands when he/she entered the room, before he/she placed his/her gloves on. CNA F said he/she should have changed his/her gloves between clean and dirty tasks. 4. During an interview on 07/09/25 at 3:25 P.M., the Assistant Director of Nursing (DON) said staff should wash hands before care, after care, when hands are visibly soiled, between dirty and clean tasks, and perform appropriate hand hygiene between glove changes. He/She said staff should also change gloves when soiled or when going from a dirty to clean task.During an interview on 07/09/25 at 3:54 P.M., the Director of Nursing (DON) said staff should wash hands before care, after care, when hands are visibly soiled, between dirty and clean tasks, and perform appropriate hand hygiene between glove changes. He/She said staff should change gloves when soiled or when going from a dirty to clean task, and he/she is responsible to ensure staff perform proper hand hygiene to prevent the spread of infections.5. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and received anticoagulant medications. Observation on 07/09/25 at 9:37 A M</p>		