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	03/13/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to remove and discard discontinued medication and improperly labeled medication from two of two medication carts and one of two medication rooms. The facility census was 62.1. Review of the facility's policy titled Labeling of Medication Containers, revised 04/07, showed medications shall contain the expiration date when applicable.Review of the facility's policy titled Storage of Medications, revised 04/07, showed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, all such drugs shall be destroyed.Review of the facility's policy titled Discarding and Destroying Medications, revised 10/16, showed medications will be disposed of in accordance with federal, state, and local regulations.2. Observation on 03/12/26 at 9:46 A.M., showed the rehabilitation medication cart contained:-One bottle of Oyster Shell Calcium 500 milligram (mg) with Vitamin D with expiration date of 11/25;-One Novolog Insulin (a short-acting insulin) pen with an open date of 02/11/26, and an expiration date of 03/11/26-One Aspart Insulin (a short-acting insulin) pen opened and labeled do not use after 12/12/25;-One bottle of Systane (dry eyes) eye drops 0.4-0.3 % opened and undated for;-One Humalog Insulin (a short-acting insulin) pen opened and undated;-One Novolog Insulin pen and one Lantus insulin pen opened and undated;-One Lantus Insulin (a long-acting insulin) and one Novolog pen with opened dates of 02/11/26, and expiration dates of 03/11/26.3. Observation on 03/12/26 at 9:46 A.M., showed Licensed Practical Nurse (LPN) H administered Novolog insulin to Resident #2 and did not check the expiration date. Observation showed the Novolog insulin pen had an open date of 02/11/26 and an expiration date of 03/11/26. During an interview on 03/12/26 at 2:30 P.M., LPN H said he/she did not check the expiration date prior to giving Resident #2 his/her insulin and should have. LPN H said he/she was not aware the insulin had expired when he/she gave it. 4. Review of the Novolog insulin manufacturer's recommendations showed the Novolog is to be discarded 28 days after being opened. Observation on 03/12/26 at 10:00 A.M., showed the Memory Care Unit medication room contained one vial of Tuberculosis (TB) solution (a medication used to test for tuberculosis) with an open date of 08/01/25. 5. Observation on 03/12/26 at 10:20 A.M., showed the Memory Care Unit medication cart contained:-One Aspart Insulin pen open and undated;-One Humalog Insulin pen open and undated;-One Humalog Insulin pen open and undated. 5. During an interview on 03/12/26 at 1:45 P.M., LPN A said whoever opens a medication is responsible to date it. LPN A said all insulins should be dated as they have an expiration date once opened of 28 to 30 days. LPN A said staff administering the medications should check the expiration date prior to giving to a resident. Expired medication should never be administered to a resident. LPN A said if a staff member finds an expired medication, they should remove it from the medication cart and destroy it. During an interview on 03/13/25 at 10:40 A.M., the Infection Preventionist (IP) said if a staff member opens a new medication, it is their responsibility to date it at the time of opening. The IP said all TB solution, eye drops, and insulins should be dated when opened because certain medications expire faster than others. The IP said staff should check the expiration date on each medication prior to administration and should never give a resident an expired medication. The IP said if the medication is expired staff (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
	265208	A. Building B. Wing	03/13/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should remove the expired mediation. During an interview on 03/13/25 at 11:40 A.M., the Director of Nursing (DON) said whoever opens the medication should date it at that time. The DON said all insulins, eye drops, and TB solutions should be dated when they are opened. The DON said medications all have different expiration dates after opening. The DON said he/she expects staff to check the expiration date prior to administer a medication to a resident a medication. The DON said if a medication is expired it should be destroyed. Expired medication should never be administered to a resident. During an interview on 03/13/25 at 12:10 P.M., the administrator said he/she expects all insulins, eye drops, and TB solutions to be dated when opened and the person opening the medication is responsible to do it. The administrator said staff administering medications are responsible to check the expiration date on the medication prior to giving it to a resident and should never give a resident an expired medication. The administrator said he/she expects staff to remove and destroy expired medications, so they are not administered.

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to use enhanced barrier precautions (EBP, an infection control practice that requires staff to wear personal protective equipment (PPE, protective equipment such as gowns, gloves, goggles, and masks) to prevent or minimize exposure to hazards) for four residents (Resident #1, #5, #20, and #28) of 17 sampled residents. The facility census was 62.1. Review of the facility policy titled Enhanced Barrier Precautions, dated 04/04/24, showed it is the policy of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO). EBP refers to the use of gowns and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required PPE, and the high-contact resident care activities that require the use of a gown and gloves. An order for EBP will be obtained for residents with any of the following: -Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes) even if the resident is not known to be infected or colonized with a MDRO; -Implementation of EBP is to make gowns and gloves available immediately outside of the resident's room, ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). High-contact resident care activities include dressing, bathing, transferring, providing hygiene, device care or use, and wound care – any skin opening requiring a dressing. EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/27/26, showed staff assessed the resident as cognitively intact with wounds. Review of the resident's care plan, revised 03/06/26, showed: -Risk for skin breakdown with venous ulcers on left lower extremity and foot; -Required assistance with cares; -Did not contain direction for EBP use. Review of the resident's physician's order sheet (POS), dated 03/10/26, showed: -03/04/26: Left dorsal foot wound: Apply Vaseline gauze cover with dressing, wrap with ACE bandage, change daily and as needed; -03/04/26: Left lower extremity: Cleanse wound, apply Vaseline gauze cover with dressing, cover with ACE bandage, change daily and as needed. (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/10/26 at 10:54 A.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. Observation showed the resident's room did not have an EBP sign to alert staff for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/11/26 at 9:04 A.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. Observation showed the resident's room did not have an EBP sign to alert staff for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/12/26 at 2:30 P.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. Observation showed the resident's room did not have an EBP sign to alert staff for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/13/26 at 8:55 A.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. Observation showed the resident's room did not have an EBP sign to alert staff for EBP. Observation showed the resident's room did not have PPE inside or outside. During an interview on 03/11/26 at 10:45 A.M., the Infection Preventionist (IP) said the resident's lower extremities swell and cause fluid filled blisters that weep and open. During an interview on 0/13/26 at 12:10 P.M., the administrator said the resident should be on EBP due to chronic wounds on his/her left lower extremity. The administrator said he/she was not aware the resident did not have an EBP sign on his/her door but should have. 3. Review of Resident #5's Quarterly MDS assessment, dated 01/09/26, showed staff assessed the resident as: -Severely cognitively impaired; -At risk for pressure ulcers; -Dependent on staff for mobility, toileting, and shower/bathe self; -Required substantial/maximum assistance from staff for personal hygiene, and upper/lower body dressing; -Diagnoses of diabetes, dementia, anxiety, depression, and psychotic disorder. Review of the resident's care plan, dated 10/22/25, showed staff did not document the need for EBP. Review of the resident's POS, dated March 2026, showed the following orders: -02/19/26 cleanse open area to left gluteal cleft with wound cleanser, apply Vaseline guaze and cover with dressing daily and as needed PRN; -03/11/26 left ischium (lower portion of hip bone): cleanse wound and apply hydrocolloid sheet (A (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gel-forming bandage used to block water and bacteria) twice a week on Wednesday and Saturday and as needed. Observation on 03/10/26 at 10:43 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/11/26 at 8:57 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/12/26 at 8:16 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/13/26 at 8:51 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/12/26 at 11:41 A.M., showed Licensed Practical Nurse (LPN) A performed wound care to resident's left ischium, and Certified Nurse Aide (CNA) I assisted the LPN. LPN A and CNA I did not wear a gown when they provided care. During an interview on 03/12/26 at 11:50 A.M., LPN A said he/she would use a gown if a resident had a chronic wound to limit bacteria exposure. LPN A said the resident's wound was not considered chronic. The LPN said gowns and gloves should be used for close patient care contact, and if a resident has a tube feeding, catheter, and wounds for greater than 90 days. The LPN said he/she had been taught if a resident has a wound longer than 90 days, EBP should be used. LPN A said usually the Assistant Director of Nursing (ADON) will put up the EBP signs and place the PPE supplies. 4. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -At risk for pressure ulcers; -Did not reject care. Review of the resident's POS showed an order, dated 01/16/26, for right hand wound care, apply antimicrobial foam dressing twice a week on Tuesday and Friday and as needed for saturation, soiling or dislodgment. Review of the resident's care plan, dated 12/15/25, showed staff did not document the need for EBP. Observation on 03/10/26 at 10:44 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/11/26 at 9:04 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/12/26 at 8:16 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside of the room. Observation on 03/13/26 at 8:52 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP, and showed the resident's room did not have PPE inside or outside the room. Observation on 03/13/26 at 10:36 A.M., showed LPN F performed wound care to the resident's right hand, and CNA G assisted. LPN F and CNA G did not wear a gown during the care. During an interview on 03/13/26 at 10:42 A.M., LPN F said with any resident who has active open wounds, staff should wear a gown and gloves during care, and the resident should have a sign on the door that directs staff regarding the type of PPE to wear. LPN F said he/she did not know why the resident was not on EBP, as the DON would normally put up the signs and place the supplies. During an interview on 03/13/26 at 10:53 A.M., CNA G said EBP requires the use of gowns and gloves, and he/she believes it is for wounds that are present for three or more months, catheters, and feeding tubes. The CNA said EBP is used if staff are providing direct care like transfers, or any high-contact care activities. He/she said there is usually a sign on the door and PPE supplies available in a cart outside the room. CNA G said his/her understanding is if the resident had not had the wound long enough, then he/she does not have to wear a gown and did not know why the resident did not have EBP signs posted, but it is probably because the resident has not had the wound for very long. 5. Review of Resident #28's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and had a surgical wound. Review of the resident's care plan, dated 02/13/26, showed: -Ostomy (Surgical procedure that brings one end of the intestine out through the abdominal wall) and need for assistance to care for it; -Did not contain direction for EBP use. Review of the resident's POS, dated 03/13/26, showed an order, dated 03/04/26, for abdominal midline wound, cleanse with wound cleanser, apply antimicrobial foam dressing and cover with transparent film three times a week and as needed. Observation on 03/10/26 at 11:08 A.M., showed the resident in bed and had an ostomy that hung from under his/her shirt. Observation showed the resident's room did not have an EBP sign to alert staff of the need for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/11/26 at 10:05 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/12/26 at 11:18 A.M., showed the resident's room did not have an EBP sign to alert staff of the need for EBP. Observation showed the resident's room did not have PPE inside or outside. Observation on 03/13/26 at 9:10 A.M., showed the resident's room did not have an EBP sign to alert (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff of the need for EBP. Observation showed the resident's room did not have PPE inside or outside. During an interview on 03/10/26 at 11:08 A.M., the resident said he/she had a newer ostomy that had not healed completely. During an interview on 03/13/26 at 10:40 A.M., the IP said the resident has an unhealed surgical wound from his/her ostomy site and should have an EBP sign on his/her door. The IP said he/she was not aware there was not a sign on the resident's door and not sure who is responsible to ensure EBP signs are placed on doors. During an interview on 03/13/26 at 12:10 P.M., the administrator said the resident should be on EBP due to an unhealed ostomy surgical wound site. The administrator said he/she was not aware the resident did not have an EBP sign on his/her door but should have. 6. During an interview on 03/13/26 at 10:40 A.M., the IP said the purpose of EBP is to protect the residents from any germs staff may be carrying, and if a resident requires EBP then staff are to wear a gown and gloves when providing cares. The IP said EPB would be required for any residents with a chronic wound over 90 days old, and any unhealed surgical wound. The IP said if a resident has a new wound EBP would not have to be used, EBP is only for wounds older than 90 days. The IP said he/she is not sure who is responsible to put the EBP signs on the doors, or remove them, but without a sign on the door staff would not know to wear the PPE when needed. During an interview on 03/13/26 at 11:41 A.M., the DON said he/she has trained staff on hire, yearly, and with training fairs on EBP. He/she understood that EBP would be used for chronic wounds with no improvement, and Centers for Medicare Medicaid (CMS) guideline does not give a time frame for chronic wounds. He/she said the facility has determined that to be 90 days, but he/she is open to better practice. The DON said bacteria could be introduced, and EBP is to protect the resident from staff, and should be used during high-contact care activities, and would be for any resident with wounds and/or colostomy. The DON said typically he/she or the IP would put up the signs and place the PPE carts, and they are also available in central supply for staff to have access if it is needed on nights or weekends, and staff have been educated on where to get the signs and PPE supplies. The DON said due to the facility's previous criteria for wounds requiring EBP to be present 90 days or longer, he/she would not have expected Resident #5 or Resident #20 to be on EBP. During an interview on 03/13/26 at 12:09 P.M., the Administrator said EBP should be used on chronic wounds, anyone on antibiotics, catheters, PICC lines, tube feeding, and open ostomy or open wound. The administrator said he/she is new to the facility and believes the wound criteria for the facility is if a wound is chronic or older than 90 days, due to the definition of a chronic wound. The Administrator said EPB is used to prevent the spread of Methicillin-Resistant Staphylococcus Aureus (MRSA, a type of staph bacteria resistant to common antibiotics), or anything like that. He/she said if a wound is open it should qualify for EBP. The administrator said there was a misunderstanding for when EBP should be started, and the DON is responsible for putting up the signs and placing the PPE carts, since there is not an Assistant Director of Nursing (ADON) right now, and if the DON or future ADON is not available, like on a weekend or night shift, then it would be the charge nurse's responsibility and they have been educated on where to get the supplies.

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	03/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to develop a comprehensive care plan to reflect the care needs of two residents (Resident #1 and #28) out of 17 sampled residents. The facility census was 62. 1. Review of the facility's policy titled Care Plans, Comprehensive Person Centered, revised 10/17, showed: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -The Interdisciplinary Team (IDT), in conjunction with the resident and his/her representative develops and implements a comprehensive, person-centered care plan for each resident; -Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change; -The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition; when the desired outcomes are not met; and at least quarterly in conjunction with the required quarterly Minimum Data Set (MDS), a federally mandated assessment tool. 2. Review of Resident #1's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with wounds. Review of the resident's care plan, revised 03/06/26, showed staff identified the resident as at risk for skin breakdown with venous ulcers on left lower extremity and foot. Review showed the care plan did not contain direction for EBP use. Review of the resident's Physician's Orders Sheet (POS), dated 03/10/26, showed: -03/04/26: Left foot: Cleanse wound, apply dressing, change daily and as needed; -03/04/26: Left lower extremity: Cleanse wound, apply dressing, cover with ACE bandage, change daily and as needed. Observation on 03/10/26 at 10:54 A.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. Observation on 03/13/26 at 8:55 A.M., showed the resident in his/her wheelchair with his/her left lower extremity wrapped in a bandage. During an interview on 03/11/26 at 10:45 A.M., the Infection Preventionist (IP) said the resident has fluid blisters that wept and popped open. 3. Review of Resident #28's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact, had a surgical wound, and received oxygen therapy. (continued on next page)

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	03/13/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 02/13/26, showed: -Chronic pain related to surgical non-healing wound; -Ostomy and need for assistance to care for it; -Did not contain direction for EBP use; -Did not contain directions for oxygen use. Review of the resident's POS, dated 03/13/26, showed: -02/03/26: Oxygen at 3 liters per nasal canula continuously; -02/05/26: Right ileostomy (opening in the abdominal wall with exposed intestine to rid the body of waste): Apply and change pouch every three days and at the first sign of a leak. -03/04/26: Abdominal surgical wound (from ostomy placement): Cleanse, apply methylene blue foam (a surgical wound dressing) and cover with transparent film three times a week and as needed. Observation on 03/10/26 at 11:08 A.M., showed the resident had an ostomy pouch that hung out from under his/her shirt. Observation showed the resident wore oxygen. During an interview on 03/10/26 at 11:08 A.M., the resident said he/she had a newer ostomy that had not healed completely, and his/her skin was irritated. Observation on 03/13/26 at 9:10 A.M., showed the resident wore oxygen. During an interview on 03/13/26 at 10:40 A.M., the IP said the resident has an unhealed surgical wound for his/her ostomy site and should have an EBP care plan. The IP said the resident requires continuous oxygen and he/she should have an oxygen care plan. 4. During an interview on 03/13/26 at 11:29 A.M., the MDS Coordinator said he/she had only been at the facility for a few weeks and is trying to get the care plans up to date. The MDS Coordinator said the floor staff can update the care plans. The MDS Coordinator said care plans should be updated quarterly and with any changes needed as they happen. The MDS Coordinator said the resident's care plan should contain EBP if the resident had wounds, and oxygen use. The MDS Coordinator said the care plan should be accurate and individualized so everyone would know what the resident needs. During an interview on 03/13/26 11:41 AM the Director of Nursing (DON) said EBP, and oxygen should be on the care plan so everyone knows what the resident requires for his/her care. The DON said he/she did not know the care plans were not updated, but he/she expects them to be updated quarterly and with changes as needed. During an interview on 03/13/26 at 12:09 P.M., the administrator said he/she has been at the facility for six weeks and there was not a MDS Coordinator in house until 2/23/26, so the interdisciplinary team was trying to keep on top of updating care plans. The Administrator said he/she would expect to see oxygen and EBP use on a residents' care plan. The Administrator said he/she would expect anything about how to care for the resident on the care plan.

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	03/13/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to update care plans to address the care needs of four residents (Residents #6, #7, #20, and #43) out of 17 sampled residents. The facility census was 62.1. Review of the facility policy titled Care Plans, Comprehensive Person-Centered, dated March 2017, showed a comprehensive, person-centered care plan will describe services that would otherwise be provided but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; and will aid in preventing or reducing decline in the resident's functional status and/or functional levels. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition; when the desired outcomes are not met; and at least quarterly in conjunction with the required quarterly Minimum Data Set (MDS), a federally mandated assessment tool. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies. 2. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -In a persistent vegetative state without discernable consciousness; -Dependent on staff for all cares and mobility;-Had limited range of motion impairment in both upper and lower extremities; -Diagnoses of traumatic brain dysfunction; hemiplegia (a form of paralysis affecting one side of the body, usually caused by brain damage), and aphasia (a disorder that affects the ability to speak).Review of the resident's physician order sheet (POS) showed an order, dated 02/19/26, to ensure the resident has his/her leg and arm braces during the day and night shift for contractures (permanent tightening and shortening of muscles and other tissue around a joint causing stiffness). Review of the resident's care plan, dated 12/26/25, showed staff did not document the resident's contractures or use of splints. Observation on 03/11/26 at 12:45 P.M. showed the resident in bed and did not have his/her splints on. During an interview on 03/13/26 at 10:42 A.M., Licensed Practical Nurse (LPN) G said if a resident has contractures and require splints, the splints should be on the care plan, so staff know. During an interview on 03/13/26 at 10:53 A.M., Certified Nurse Aide (CNA) G said contractures and splints should be on the care plan, so staff know whether to provide the devices. The CNA said he/she was told about a month ago the resident is supposed to wear hand and knee braces. 3. Review of Resident #7's Annual MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Received antipsychotics and antidepressants;-Diagnoses of Alzheimer's disease, dementia, anxiety and depression. Review of the resident's POS, dated March 2026, showed the resident did not have current orders for antipsychotics or antidepressants. Review of the resident's care plan, dated 03/10/26, showed staff did not document the discontinuation of the antipsychotic and/or antidepressant medications. During an interview on 03/13/26 at 10:42 A.M., LPN F said nursing does not typically update the care plans because the MDS Coordinator does. LPN F said he/she would expect if a resident was no longer taking antipsychotics or antidepressants that the information would be removed from the care plan. 4. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Unable to complete the Brief Interview for Mental Status (BIMS), used to determine cognitive function; -Had limited range of motion on one side of the upper and lower extremities; -Dependent on staff for all mobility; -Had a fall since the prior assessment, one fall with injury; -Diagnoses of Alzheimer's Disease, aphasia, dementia, and hemiplegia; -Does not reject care. Review of the resident's progress notes, dated 02/25/26, showed the resident had a fall out of his/her Broda chair. Review of the resident's care plan, dated 12/15/25, showed staff were directed to place a rolled washcloth in the resident's hand as needed. Review showed the care plan did not contain an intervention for the resident's fall on 02/25/26, or direction (continued on next page)

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	03/13/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for staff about the resident's refusal of care. During an interview on 03/12/26 at 3:17 P.M., LPN A said the resident's contracture is so tight the hand is hard to get open and he/she tried to use a washcloth when the resident lets him/her, but the resident will often pull it out, or refuse. LPN A said the resident does have a history of refusing care and it should be documented on the care plan. During an interview on 03/12/26 at 3:24 P.M., the Director of Nursing (DON) said the resident's hand is so tight it is hard to get anything in there. The DON said the resident will remove the washcloth or will refuse it. The DON said refusals should be documented. During an interview on 03/13/26 at 10:42 A.M., LPN F said falls should be updated on the care plan and can be complete by nursing staff or the MDS Coordinator. During an interview on 03/13/26 at 10:53 A.M., CNA G said contractures and falls should be listed on the care plan, so staff know how to provide care. The CNA said if a resident refuses care that should be on the care plan as well. The CNA said the resident refused the washcloth in his/her hand. 5. Review of Resident #43's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Moderate cognitive impairment;-Received an antipsychotic medication;-Diagnosis of dementia, major depressive disorder, anxiety and depression.Review of the resident's POS, dated 03/10/26, showed an order for Abilify (an antipsychotic medication) 2 milligrams (mg) daily. Review of the resident's care plan, revised 10/03/25, showed the care plan did not contain direction for antipsychotic medication use. 6. During an interview on 03/13/26 at 11:29 A.M., the MDS Coordinator said he/she had only been at the facility for a few weeks and is trying to get the care plans up to date. The MDS Coordinator said everybody can update the care plans. He/she said if a resident's psychotropic medications are discontinued the medications should be removed from the care plan, but behaviors to monitor for should be added. The MDS Coordinator said if a receives an antipsychotic medication it should be on the care plan. The MDS Coordinator said contractures, splint use and refusal of care should be on the care plan. During an interview on 03/13/26 11:41 AM the DON said care plans should be updated within 24 hours after a fall with a new intervention. The DON said contractures, devices, and splints should be on the care plan, so everyone knows what the interventions are and to help prevent further injury or decline. The DON said psychotropic use and refusal of care should be on the care plan, so staff can monitor for behaviors. The DON said he/she did not know the care plans were not updated, and had thought some of them had been updated with interventions, and that the MDS Coordinator, himself/herself and the interdisciplinary team (IDT) are able to update care plans. During an interview on 03/13/26 at 12:09 P.M., the Administrator said there was not a MDS Coordinator in house until 2/23/26, so IDT tried to stay on top of updating care plans. The administrator said nurses should be able to update care plans but does not know if they are trained to do that, as he/she has only been here since the middle of January. The Administrator said he/she would expect contractures, splints, and/or devices, anything about how to care for the resident should be on the care plan, and if the resident refuses cares or treatments that should be on the care plan as well.

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	03/13/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, facility staff failed to document falls and neurological assessment for one resident (Resident #1) of two sampled residents. The facility census was 62.1. Review of the facility's policy titled Falls, revised 04/22 showed staff will evaluate and document falls that occur including an observation of the event identifying them as witnessed or unwitnessed. The nurse will assess and report the resident's neurological status; Review of the facility's policy titled Neurological Assessment, revised 10/2010, showed a neurological assessment is to be completed upon physician's order, after an unwitnessed fall, after a fall with suspected head injury, and when indicated by resident condition. Perform neurological checks with frequency as ordered per fall protocol. If the resident refused the procedure document the refusal.Review of the facility's form titled Post Fall 72 Hour Monitoring Report, dated 07/08, showed this assessment should be completed at the following intervals for a fall that is unwitnessed or in which the head is struck requiring neurological checks:-Initial assessment, followed by every 15 minutes for four sets, every 30 minutes for two sets, every hour for two sets, every shift for 72 hours;-Document vital signs, orientation, skin assessment, pain, range of motion and strength of extremities, eye/pupil response. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/27/26, showed staff assessed the resident as cognitively intact and had falls with injury. Review of the resident's care plan, revised 03/06/26, showed:-Cognition concerns related to a stroke;-Resistive to care-Required assistance with cares;-At risk for falls with multiple falls documented.Review of the resident's medical record nurse's notes showed staff documented the resident had falls on:-01/24/26: unwitnessed fall and did not contain documentation staff completed neurological checks; -02/02/26: unwitnessed fall and did not contain documentation staff completed neurological checks; -02/09/26: unwitnessed fall and did not contain documentation staff completed neurological checks; -02/21/26: unwitnessed fall and did not contain documentation staff completed neurological checks; -03/05/36: unwitnessed fall and did not contain documentation staff completed neurological checks; -03/06/26: unwitnessed fall and did not contain documentation staff completed neurological checks; -03/06/26: staff documented the resident had a fall. Staff did not documentation if the fall was witnessed or unwitnessed and did not contain a completed neurological check; -03/10/26: staff documented the resident had a fall. Staff did not documentation if the fall was witnessed or unwitnessed and did not contain a completed neurological check.During an interview on 03/13/26 at 10:40 A.M., the Infection Preventionist (IP)/charge nurse said if a resident falls the charge nurse to document their findings and if the fall was witnessed or unwitnessed in the resident's nurse's notes. The IP/charge nurse said if the fall was unwitnessed, or they hit their head staff are expected to complete a neurological check per the facility protocol. The IP/charge nurse said the form should be filled out and there should not be blanks. During an interview on 03/13/26 at 11:40 A.M., the Director of Nursing (DON) said if a resident falls, he/she expects staff to document the details of the fall including if the fall was witnessed or unwitnessed, or if the resident hit their head. The DON said if the fall is unwitnessed or if the resident hit their head staff are expected to begin neurological checks and follow the facility's form protocol. The DON said he/she expects the form to be completed in its entirety and not have any blank areas. The DON said if staff do not document properly and completely the next shift will not know what to do to ensure the resident gets the proper care. The DON said he/she is responsible to oversee and follow up to ensure staff are charting as required. During an interview on 03/13/26 at 12:10 P.M., the administrator said staff should determine if a resident fall was witnessed or unwitnessed and perform the correct assessments. The administrator said he/she expects staff to complete neurological checks per the facility form protocol for any unwitnessed fall or a fall with a head injury. The administrator said he/she has been at the facility for six weeks and was not aware not all fall documentation and neurological checks were not being completed.

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	03/13/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, facility staff failed to obtain orders for a Bilevel Positive Airway Pressure (BiPAP) (a noninvasive ventilator) for one resident (Resident #2) of one sampled. The facility census was 62.1. Review of the facility's policy titled Oxygen Safety, revised 01/18, showed staff, residents and families will be educated on oxygen safety precautions in accordance with their roles and responsibility. Review of the facility's policy titled BiPAP Support, revised 03/25, showed only a qualified and properly trained staff member should administer oxygen through a BiPAP mask. Review the physician's order to determine the oxygen concentration and flow, and the Positive End Expiratory Pressure (PEEP) pressure for the machine. 2. Review of Resident #2's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/17/26, showed staff assessed the resident as cognitively intact with diagnoses of respiratory failure and obstructive sleep apnea (periods of breathlessness during sleep). Review of the resident's care plan, revised 02/21/26, showed BiPAP therapy per orders. Review of the resident's Physician Order Summary (POS), dated 03/10/26, showed POS did not contain orders for BiPAP use. Observation on 03/10/26 at 11:34 A.M., showed a BiPAP machine next to the resident's bed. Observation on 03/11/26 at 2:10 P.M., showed a BiPAP machine next to the resident's bed. Observation on 03/12/26 at 9:46 A.M., showed a BiPAP machine next to the resident's bed. Observation on 03/13/26 at 8:50 A.M., showed a BiPAP machine next to the resident's bed. During an interview on 03/13/26 at 10:40 A.M., the Infection Preventionist (IP)/charge nurse said the charge nurse is responsible to obtain any orders for a resident and ensure they are documented on the resident's POS. The IP/charge nurse said the Director of Nursing (DON) is responsible to oversee all staff and ensure the residents have proper orders and the orders are being followed. The IP/charge nurse said he/she was not aware the resident was missing orders for BiPAP. The IP/charge nurse said the resident should have those orders on his/her POS. During an interview on 03/13/26 at 11:40 A.M., the DON said the charge nurse is responsible to obtain orders for the resident and put the orders on the POS. The DON said he/she was not aware the resident did not have orders for BiPAP. The DON said the resident should have an order for BiPAP on his/her POS because the resident did use the BiPAP. The DON said the orders are needed so staff know what settings the BiPAP should be set on. The DON did not know why the resident did not have BiPAP orders but that it could have been missed to frequently admissions and discharges. During an interview on 03/13/26 at 12:10 P.M., the administrator said the DON is responsible to oversee the charge nurse to ensure a resident has correct orders to meet their care needs. The Administrator said the resident should have orders for his/her BiPAP.

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	03/13/2026

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to obtain physician's orders for the use of side rails for two residents (Resident #2 and #23) of three sampled residents. The facility census was 62. 1. Review of the facility's policy titled Proper Use of Side Rails, revised 09/22, showed the facility will obtain a physician's order for the use of the specific side rails and medical diagnosis, condition, symptoms, or functional reason for the use of side rails. 2. Review of Resident #2's Significant Change Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as cognitively intact. Review of the resident's care plan, revised 02/21/26, showed staff documented a physician's order will be current for side rails to be used. Review of the resident's Physician Order Sheet (POS), dated 03/10/26, did not contain orders for side rail use. Observation on 03/11/26 at 10:15 A.M., showed the resident in bed with both upper side rails in the upright position. Observation on 03/12/26 at 3:00 P.M., showed the resident in bed with both upper side rails up on his/her bed. Observation on 03/13/26 at 8:50 A.M., showed the resident laid in bed with both upper side rails up on his/her bed. 3. Review of Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact.Review of the resident's care plan, revised 01/18/26, showed a physician's order will be current for side rails to be used. Review of the resident's POS, dated 03/10/26, showed it did not contain and order for side rail use.Observation on 03/10/26 at 11:05 A.M., showed the resident in bed with both upper side rails up. Observation on 03/11/26 at 9:08 A.M., showed the resident in bed with both upper side rails in the upright position. Observation on 03/12/26 at 11:15 A.M., showed the resident in bed with both upper side rails up. 4. During an interview on 03/13/26 at 10:40 A.M., the Infection Preventionist (IP) said he/she was not aware these residents did not have orders for side rails. The IP said the residents should have an order for side rails on the POS.During an interview on 03/13/26 at 11:40 A.M., the DON said the charge nurse is responsible to obtain orders for the residents and document the orders on their POS. The DON said he/she was not aware these residents did not have orders for side rails. The DON said these residents should have an order for side rails. During an interview on 03/13/26 at 12:10 P.M., the Administrator said the charge nurse is responsible to obtain any new orders, and the DON is responsible to oversee the charge nurse to ensure a resident has correct orders to meet their care needs. The Administrator said if a resident has side rails on their bed, he/she would expect them to have a physician's order.

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	03/13/2026

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, interview, and record review, facility staff failed to post the required telephone number to the Department of Health and Senior Services (DHSS) hotline (to report allegations of abuse and neglect), or a list of names, addresses, and phone numbers of the State Survey Agency (SA) in an accessible location for residents and visitors to view in the memory care unit. The census was 62.1. Review of the facility's policy titled, Facility Postings, undated, showed facility staff will post the required postings in an area accessible to all staff and residents. Facility postings should include a list of names, addresses (mailing and email), and a telephone number of all pertinent state agencies including the SA. Observation on 03/10/26 at 10:30 A.M., showed staff did not post the name, address, and toll-free telephone number for the Elder Abuse Hotline in an accessible location on the memory care unit for residents or visitors to use if needed. Observation on 3/13/26 at 11:00 A.M., showed staff did not post the name, address, and toll-free telephone number for the Elder Abuse Hotline in an accessible location on the memory care unit for residents or visitors to use if needed. During an interview on 03/12/26 at 2:11 P.M., Certified Nurse Aide (CNA) C said he/she is unsure if there is a hotline number posted on the memory care unit. The hotline information is posted in employee break room. He/She said if a resident or family member had a concern, he/she would direct them to the charge nurse. During an interview on 03/12/26 at 2:18 P.M., Licensed Practical Nurse (LPN) A said he/she does not remember seeing the hotline number posted on the memory care unit. He/She said it is important to have the hotline number posted so residents, family members, and/or visitors can call if they have a complaint or need a resolution to a problem or concern. During an interview on 03/13/26 at 11:50 A.M., the Director of Nursing (DON) said he/she does not know if the elder abuse hotline number is posted on the memory care unit, but it should be. He/She said everyone should be able to call if they need to report something even on the memory care unit. During an interview on 03/13/26 at 12:26 P.M., the administrator said he/she does not know if the hotline number is posted on the memory care unit. The administrator said the hotline information is posted in the main entrance for everyone who comes and goes to see. He/She said he/she expects it to be visible for all residents and visitors. He/She said it's important to have the hotline number so residents can call if they feel threatened, abused, scared, or not treated right.