STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265365	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Florissant	6768 North Highway 67 Florissant, MO 63034

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to keep residents free of accidents and injuries when a Certified Nurse Assistant (CNA) left a resident (Resident #7) unattended, rolled to his/her side on a low air loss mattress (LAL, a mattress designed with a system of air cells that are constantly inflated and deflated to prevent and treat pressure injuries (injury to skin and underlying tissue resulting from prolonged pressure on skin)), causing the resident to fall out of his/her bed on to a fall mat. The facility also failed to ensure residents were assessed immediately after a fall for injury and failed notify the Primary Care Physician (PCP), the resident's responsible party (RRP) and a member of the Interdisciplinary Team (IDT) after a fall because the CNA failed to immediately report the fall to the charge nurse for one resident (Resident #7) who sustained a head injury. The sample size was three. The census was 70. The Administrator was notified on 4/21/25, of the past non-compliance. The facility responded appropriately when they were made aware of the resident's fall. The resident was assessed for injury and the resident was sent out to the hospital for evaluation. Education was provided to nursing staff on caring for the resident in pairs and to report falls immediately. The deficiency was corrected on 1/17/25. Review of the facility's Accident and Incident - Investigating and Reporting Policy, dated 9/20/24, showed: -Policy Statement: All accidents or incidents involving residents, employees, visitor, vendors, etc., occurring on the facility premises shall be investigated and reported to the Administrator; -The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document the investigation of the accident or incident; -The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident; -Incident/Accident Reports will be reviewed by the Interdisciplinary Team. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/29/24, showed: -Cognitively intact; (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Makes self understood; -Impairment on both sides of upper and lower body; -Total dependence on staff for all activities of daily living (ADLs); -Always incontinent of bowel and bladder; -Diagnoses included traumatic brain injury (TBI), quadriplegia (paralysis of all four limbs) and seizure disorder. Review of the resident's skin check dated 1/17/25 at 9:06 A.M., showed there were no skin issues present. Review of the resident's progress notes, showed: -On 1/17/25 at 10:10 A.M., the resident stated he/she fell out of bed last night while the CNA was changing him/her. He/She said he/she fell out of the right side of the bed, hurting his/her neck. The resident said the CNA placed him/her back into his/her bed. The resident was complaining of neck pain. There was no swelling or redness noted at the site. The resident was lying supine (on the back) in bed; -On 1/17/25 at 10:16 A.M., the resident was alert and able to give details on what happened; -On 1/17/25 at 10:19 A.M., the resident's blood pressure (read in milliliters of mercury (mmHg) when referring to systolic (SBP, top number, normal is below 140), diastolic (DBP, bottom number, normal is below 90) was 109/90, pulse rate (rate of heart beat, normal range is between 60 to 100 beats per minute) was 89 beats per minute, body temperature (measured in degrees of Fahrenheit (F), normal range is 97 to 99 degrees F) was 98.1 degrees F and the resident had a blood oxygen saturation (amount of oxygen in blood) rate of 93% on room air; -On 1/17/25 at 10:25 A.M., the resident's responsible party was made aware; -On 1/17/25 at 10:40 A.M., the ambulance service was notified to transport the resident to the emergency department (ED) for evaluation; -On 1/17/25 at 11:12 A.M., the PCP was present to see the resident before the resident left for the ED. The resident was resting in bed with no visible injuries noted to the neck or upper or lower torso; -On 1/17/25 at 11:25 A.M., the ambulance was present to transport the resident to the ED; -On 1/17/25 at 4:06 P.M., the Registered Nurse (RN) at the ED said that there was no injury noted yet. They were waiting on one more test result; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/17/25 at 10:44 P.M., the resident returned from the hospital via ambulance. There were no new orders. The resident's skin remains intact. Vital signs were normal. The resident was in bed resting in a low bed with fall mats on either side. The RRP was aware the resident had arrived back at the facility; -On 1/18/25 at 6:17 P.M., the resident remained on incident follow up observation. The resident had no signs or symptoms of distress or discomfort. The resident was resting in bed in the lowest position with call button in place. Review of the resident's 72 hour post fall monitoring report, dated 1/17/25, showed: -The assessment should be completed at the following intervals for all falls. A fall that is unwitnessed or in which the head is struck, required neurological checks (an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status); -Documentation showed the nursing staff completed neurological checks for 72 hours. Review of the resident's hospital discharge papers, dated 1/17/25, showed: -Reason for visit: Neck pain; -Diagnoses at discharge: Fall, initial encounter and injury of head, initial encounter. Review of the facility's investigation report, dated 1/17/25, showed: -A statement from CNA B, dated 1/17/25 at 4:54 P.M., on 1/17/25 at 1:00 A.M., after giving the resident a bed bath, the resident fell on to the floor. The resident was fully clothed and bathed, left lying on his/her side when CNA B left the resident's room to care for other residents. CNA B returned to the resident's room to retrieve the Hoyer Lift (mechanical device used to assist in transferring individuals with limited mobility from one place to another) and saw the resident had fallen to the floor. There was no other staff around, so CNA B asked the resident if he/she was ok and checked the resident's body parts to see if he/she was hurt. CNA B then returned the resident back into his/her bed with the Hoyer lift; -On 1/17/25, education was given to nursing staff to reiterate falls must be reported immediately to the charge nurse; -On 1/17/25, education was given to nursing staff to place fall mats on both sides of the resident's bed (while the resident was in bed) and to position the resident's blow call light so he/she could operate it at all times. The resident's bed was relocated so that it was up against one wall with the use of one fall mat; -On 1/17/25, the Assistant Director of Nursing (ADON), addressed CNA B with a teachable moment; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/20/25, the IDT met to discuss the event that involved the resident rolling from the bed while the CNA was providing care. The Team discussed the totality of the resident falls and reviewed the interventions that the resident had in place at the time. Investigation of the event revealed the resident did have two fall mats in place and was on a low air loss mattress, which was inflated per manufacturer's recommendations. The Team had previously spoken to the RRP, recommending the removal of the LAL mattress for the resident's safety. The RRP had refused. The Team was going to call the resident's family again with the recommendation of removal of the LAL mattress for the resident's safety; -Inservice sign in sheet, dated 1/17/25, for education on caring in pairs and keeping the resident's blow call light in reach. In-services were given to nursing staff; -Inservice sign in sheet, dated 1/17/25, for education on the fall policy and reporting falls immediately to nurses. In-services were given to nursing staff. Review of the resident's care plan, dated 3/21/25, showed: -Problem: The resident was dependent of all Activities of Daily Living (ADLs) and was totally dependent on staff. Interventions included: Care in pairs; Two staff were required for repositioning and turning in bed; Two staff were required to use Hoyer lift at all times for transfers; -Problem: The resident had multiple falls and was at risk for falls. Interventions included: Anticipate and meet resident needs; Follow facility fall protocol; The resident used a blow call light. Ensure it was in place, near the resident's face for use. Observation on 4/16/25 at 10:34 A.M., showed the resident asleep in his/her bed. The mattress had raised edges which scooped upwards. The resident's bed side table had a blow call light attached which was positioned near the resident's head. The bed was positioned on the right side against a wall and there was a fall mat in place on the left side of the bed. The bed was in a lowered position. During an interview on 4/16/25 at 12:58 P.M., Licensed Practical Nurse (LPN) A said: -He/She came to work on 1/17/25 at approximately 5:00 A.M.; -He/She received report from LPN C, who was the night shift nurse in care of the resident; -LPN C reported a CNA said he/she had dropped the resident to the floor and then got the resident up off the floor, using a Hoyer lift back into the resident's bed; -LPN A was not sure what time the incident occurred or when the CNA notified the night nurse; -He/She went and assessed the resident. The resident was free of injury, there were no bumps, swelling or redness to the resident's head and the resident's vital signs were normal; -The resident did not complain of any pain; -He/She asked the resident what occurred and the resident was able to tell LPN A what had happened; (continued on next page)

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