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	08/22/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents had access to mail delivered on Saturday. This failure had the potential to affect all residents who received mail at the facility. The census was 66. During a group interview on 8/20/25 at approximately 9:45 A.M., five residents, whom the facility identified as alert and oriented, attended the group meeting. All five residents said mail was no longer delivered on Saturdays. The mail is placed in the office, which was closed on the weekends, then distributed to the residents on Monday. One resident said this was frustrating because packages often arrive, and they can't access it until Monday. During an interview on 8/22/25 at 10:37 A.M., the Activity Director initially said mail was delivered on Saturdays and distributed as it arrived. The main office was closed on the weekend, but the mail carrier delivered it to the East side of the facility. However, they had not received any mail on Saturdays lately. She later clarified she spoke with the receptionist, who confirmed the post office did stop delivering mail on Saturdays because the office was closed, and they could not get the packages to any staff members. The Activity Director said someone from activities was at the facility on the weekend and she would contact the post office to resume mail being delivered on Saturdays. During an interview on 8/22/25 at 3:12 P.M., the Administrator said he expected mail to be delivered to residents on Saturdays.

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
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The census was 66.Review of the facility's Daily Census, dated 8/17/25, showed:-Available beds: 109;-Percent of occupancy: 61.5%. Review of the facility's payroll-based journal (PBJ) report, showed:-No RN hours on Saturday, 1/11/25;-No RN hours on Sunday, 1/12/25;-No RN hours on Saturday, 1/25/25;-No RN hours on Sunday, 3/9/25. During an interview on 8/20/25 at 12:30 P.M., the Administrator said the facility did not have any documentation or time sheets to show the facility had an RN on the days listed on the PBJ report. During an interview on 8/22/25 at 3:13 P.M., the Administrator said he expected to have an RN in the facility at least eight consecutive hours a day, seven days a week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed for the final accounting for residents who expired, within 30 days. This affected two of three sampled residents who expired and had money in their accounts (Residents #74 and #75). The sample size was 17. The census was 66.Review of the facility's Resident Trust Fund Account Policy and Procedure, revised 2/2025, showed:-Policy: It is the policy of the facility to manage personal funds of our residents, upon request, and written authorization of the resident or legal representative. Funds will be managed in accordance with Federal and State Regulations;-Procedure: Upon the death of a resident with a balance in the Resident Trust Fund, the facility will complete a form and submit to Department of Social Services, Missouri Healthnet Division. The form shall be submitted within 30 days from the date of the resident's death. 1.Review of Resident #74's medical record, showed:-Resident expired on [DATE];-An ending balance of $453.14-TPL submitted [DATE]. 2. Review of Resident #75's medical record, showed:-Resident expired on [DATE];-An ending balance of $3547.24;-TPL submitted [DATE]. 3. During an interview on [DATE] at 8:28 A.M., the Business Office Manager (BOM) said TPL notifications should be sent within 60 days of a resident's death. She was busy and sent them in late. 4. During an interview on [DATE] at 3:12 P.M., the Administrator said he expected TPL notifications to be sent within the required time frame.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide written information to the resident and/or the resident's representative of the notice of the bed hold at the time of transfer to the hospital for two of 17 sampled residents (Residents #68 and #32). The census was 66. Review of the facility's Bed Hold policy, dated October, 2017, showed:-Policy Statement: Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy. Bed hold status exists when a resident temporarily leaves the facility for medical or other therapeutic reasons and their return is anticipated. Hospitalizations are examples of leaves;-Policy Interpretation and Implementation; -Upon admission and when a resident is transferred for hospitalization or therapeutic leave, the facility will provide information regarding the bed-hold policy to the resident or representative in a written format that is understood by the resident or representative; -When emergency transfers are necessary, the facility will provide the resident or resident representative with information concerning our bed-hold policy within 24 hours of such transfer. 1.Review of Resident #68's medical record, showed:-discharged to the hospital on 8/7/25;-Returned to the facility on 8/12/25;-No documentation regarding a notice of bed-hold provided to the resident or residents representative. 2. Review of Resident #33's medical record, showed:-discharged to the hospital on 8/10/25;-Returned to the facility on 8/13/25;-No documentation regarding a notice of bed-hold provide to the resident or resident's representative. 3. During an interview on 8/22/25 at 2:00 P.M., the Director of Nursing (DON) said the notice of bed-hold should be sent to with the resident or provided to the resident's representative upon discharge. There was no documentation indicating a bed-hold was provided to Residents #68 and #33. 4. During an interview on 8/22/25 at 3:12 P.M., the Administrator said he expected the notice of bed-hold be sent with the resident and/or communicated with the resident's representative upon discharge to the hospital with an anticipated return to the facility.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document physician orders were verified for one resident (Resident #74) admitted for respite care. The sample was 17. The census was 66. Review of the facility's Admissions and admission Agreement Policy, dated February 2025, showed: Prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: medication orders, including (as necessary) a medical condition or problem associated with each medication; and routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary care plan. Review of the facility's Reconciliation of Medications on admission Policy, dated revised 2017, showed:-Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility;-Preparation: Gather the information needed to reconcile the medication list: approved medication reconciliation form; admission order sheet; all prescription and supplement information obtained from the resident/family during the medication history;-Steps in procedure: If a medication history has not been obtained from the resident or family, complete this first;-Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous Medication Administration Record (MAR) (if applicable), and the admitting orders (sources);-Review the list carefully to determine if there are discrepancies/conflicts;-If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy;-Document the medication discrepancy on the medication reconciliation form;-Document what actions were taken by the nurse to resolve the discrepancy;-If the discrepancy was unresolved, document how the discrepancy was communicated to the charge nurse, physician, pharmacy, and/or next shift;-If the discrepancy was resolved, document how the discrepancy was resolved. Review of Resident #74's medical record, showed:-Resident was alert with confusion;-admitted [DATE] and left against medical advice (AMA) on 6/15/25;-readmitted on [DATE] for respite care and discharged on 7/28/25;-Diagnoses included diabetes, anoxic brain injury (brain completely loses its oxygen supply, leading to potential brain cell death), polysubstance abuse, history of stroke, seizure disorder, high cholesterol, high blood pressure and chronic end stage renal failure (irreversible kidney disease). Review of the physician order sheet, dated active orders as of 8/22/25, showed: -A physician order for amlodipine besylate oral tablet 5 milligrams (mg), Give 5 mg by mouth one time a day for blood pressure, order date 7/24/25;-A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics, order date 6/13/25;-A physician order for atorvastatin calcium oral tablet (used to treat high cholesterol) 40 mg, give 1 tablet by mouth one time a day for prophylactic, order date 6/13/25;-A physician order for farxiga oral tablet (used to treat diabetes) 10 mg, give 1 tablet by mouth one time a day for give prior to breakfast, order date 6/13/25;-A physician order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety, order date 7/24/25;-A physician order for insulin glargine solution 100 unit/milliliter (ml), inject 14 unit subcutaneously (under the skin) one time a day for diabetes, order date 7/24/25;-A physician order for Keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant, order date 6/13/25;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure, order date 7/24/25;-A physician order for Novolog flex pen subcutaneous solution pen-injector 100 UNIT/ml, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia (blood glucose levels are elevated above normal), order date 7/24/25;-A physician order for oxycodone hcl oral tablet 5 mg, give 5 mg by mouth as needed for pain take one (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet by mouth as needed two times daily, order date 7/24/25;-A physician order for ramelteon tablet 8 mg, give 1 tablet by mouth at bedtime for insomnia, order date 7/24/25;-A physician order for trazodone hcl tablet 50 mg, give 50 mg by mouth at bedtime for insomnia, order date 7/24/25. Review of the progress notes, dated 7/24/25 at 7:30 P.M., showed no documentation the physician orders were verified with the physician. Review of the hospital records, dated 7/21/25, provided by the Administrator, after the surveyor asked for the information staff used for admitting the resident to the facility, showed there was no discharge summary or after care summary. During an interview on 8/20/25 at 6:34 A.M., Assistant Director of Nursing (ADON) A said if a resident was admitted on respite care, the admission process would be the same as any other admission. The floor nurse was responsible for completing the admission, which included completing the assessments and entering the medications into the computer. The physician orders were verified with the physician. The nurse should make a progress note showing the orders had been verified with the physician. ADON A looked through the hospital records packet, dated 7/21/25, and said there was no discharge summary or after visit summary. If a discharge summary or after care visit summary was not available, she would use the medication summary, medication outpatient medications as of 7/21/25 for the physician orders. ADON A said she did not enter the physician orders into the computer. Review of the Medication Summary, outpatient medication as of 7/21/25, showed:-A physician order for blood glucose sensor, use as directed to test blood sugar and change sensor every 10 days;-A physician order for hydroxyzine 10 mg four times daily;-A physician order for glucagon (glucagon emergency) 1 mg, inject 1 mg subcutaneous injection;-A physician order for hydrochlorothiazide 12.5 mg, no directions;-A physician order for lisinopril 40 mg (used for blood pressure) take 40 mg daily;-A physician order for insulin glargine 100 unit/ml, inject 14 units subcutaneous injection daily with breakfast;-A physician order for insulin Novolog flex pen, inject 5 units by subcutaneous injection three times daily with meals;-A physician order for MiraLAX 17 gram/dose powder (used for constipation), take 1 scoop (17 gm) twice daily, dissolve in 8 ounces of fluid and drink entire liquid;-A physician order for hydrophilic wound dressing (triad, paste that creates a moist wound healing environment, ideal for wounds with light to moderate exudate) apply to affected area twice daily;-A physician order for amlodipine 5 mg, take 5 mg daily;-A physician order for aspirin enteric coated (EC), take 81 mg daily;-A physician order for atorvastatin 40 mg daily;-A physician order for Plavix 75 mg (antiplatelet), take 75 mg daily;-A physician order for farxiga 10 mg, take 10 mg daily;-A physician order for Keppra 500 mg, take 500 mg twice daily;-A physician order for metoprolol tartrate 50 mg, take 50 mg twice daily;-A physician order for oxycodone 5 mg, take 5 mg every 12 hours as needed for pain; -A physician order for ramelteon 8 mg, take 8 mg daily at bedtime;-A physician order for senna (stool softener and laxative), take 2 tablets daily at bedtime;-A physician order for trazodone 50 mg, take 50 mg daily at bedtime. Review of the physician order sheet, dated active orders as of 8/22/25, showed the blood glucose sensor, glucagon, hydrochlorothiazide, lisinopril, Novolog insulin routine three times a day, MiraLAX, hydrophilic wound dressing, Plavix and senna were not on the physician order sheet. Review of the progress notes, dated 7/24/25 through 7/28/25, showed no documentation the physician orders were verified with the physician. During an interview on 8/20/25 at 2:00 P.M., Registered Nurse (RN) D said the floor nurse was responsible for completing the admission assessments and entering the orders into the computer. RN D looked at the hospital packet provided by the facility and dated 7/21/25, and said he/she used the medication list at end of the visit as of 7/10/25 for the physician orders. The family wrote the insulin instructions on a sheet of paper. RN D looked in the packet and said she thought the insulin orders were Novolog 3 units if eats small meal, 4 units if eats medium size meal and 5 units if eats large meal and Lantus insulin 14 units daily. RN D said he/she called the physician and verified the orders and documented it in the medical record. Review of the Medication List at the End of Visit, dated as of 7/10/25, showed:-A physician order for amlodipine 5 mg, take 5 mg daily;-A physician order for aspirin EC, take 1 tablet daily;-A physician order for atorvastatin 40 mg, take 40 mg at bedtime;-A physician order for Plavix 75 mg, take 75 mg (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily;-A physician order for farxiga 10 mg, take 1 daily;-A physician order for glucagon .1 mg, inject 1 mg subcutaneous injection;-A physician order for hydrochlorothiazide 12.5 mg, no directions;-A physician order for hydrophilic wound dressing, apply to affected area twice daily;-A physician order for hydroxyzine 10 mg, take 10 mg four times daily;-A physician order for novolog flex pen u-100 insulin, inject 5 units by subcutaneous injection three times daily with meals;-A physician order for Lantus 100 unit/mL, inject 14 units by subcutaneous injection daily with breakfast;-A physician order for Keppra 500 mg, take 500 mg twice daily;-A physician order for lisinopril 40 mg, take 40 mg daily;-A physician order for metoprolol tartrate 50 mg, take 50 mg twice daily;-A physician order for oxycodone 5 mg, take 5 mg every 12 hours as needed;-A physician order MiraLAX 17 gram/dose, take 1 scoop (17 grams) twice daily. Dissolve in 8 ounces of fluid and drink entire liquid;-A physician order ramelteon 8 mg, take 8 mg daily at bedtime;-A physician order for senna-s, take 2 tablets daily at bedtime;-A physician order for trazodone 50 mg, take 50 mg daily at bedtime. Review of the physician order sheet, dated active orders as of 8/22/25, showed glucagon, hydrochlorothiazide, lisinopril, NovoLog insulin routine three times a day, MiraLAX, hydrophilic wound dressing, Plavix and senna s were not on the physician order sheet. During an interview on 8/21/25 at 10:53 A.M., ADON B said the hospital records packet, dated 7/21/25, is not what the facility would have used for the admission physician orders. The packet was the information sent over for the referral. During an interview on 8/21/25 at 12:18 P.M., ADON B said he/she was notified the resident was admitted on [DATE] with a bag that contained home medications and a list of the medications including insulin instructions. The facility did not keep a copy of the list. ADON B said the family may not comply and send the list if requested today since the resident has been discharged from the facility. Whoever the ADON assigned to the resident was expected to review and follow-up after the admitting nurse's admission process. ADON B said RN D and ADON A failed to obtain a copy of the resident's admission information for medical records. ADON B looked at the resident's electronic medical records and said RN D's admission assessment only showed two out eight assessments were completed. He/She said the admission process should be completed upon admission. During an interview on 8/22/25 at 11:35 A.M., the physician said the facility usually calls him when a resident is admitted to the facility to verify the orders. He did not recall if the facility called him to verify the orders. During an interview on 8/22/25 at 11:52 A.M., the Administrator said if a resident is admitted for respite care, the family will bring in the orders or the facility will take the orders from the family. They also often bring the medications from home. The nurse should call the physician to verify orders and document it. During an interview on 8/22/25 at 3:13 P.M., the Administrator said the admission assessment should be completed upon admission. The Regional Nurse said any residents' documents should be part of the medical records. During an interview on 8/22/25 at 4:30 P.M., the Regional Nurse said the resident was here for a very short time. They talked with the staff and the resident did not bring in any paperwork with physician orders. He/She brought a bag with his/her medications in it. If the physician changed the medications when they were verified, the old order would not be on the physician order sheet. The nurse did an assessment when the resident was admitted and it was documented in the progress notes. Review of the progress notes, dated 7/24/25 at 7:30 P.M., showed the patient is [AGE] years old with past medical history of diabetes, anoxic brain injury, polysubstance abuse, stroke history, seizure disorder, hyperlipidemia, hypertension and chronic end stage renal failure. Patient is here at the facility for respite care 7/24 through 7/28. Daughter takes care of patient at home regularly. Patient arrived at the facility in the hour of 1300. Resident was given a lunch tray and insulin was given after intake of 100%. Patient was calm and toileted soon after. In the hour of 1700 patient became combative and repeatedly trying to get out of chair without assistance. The nurse and other nursing staff tried to redirect patient, patient was not directable. The nurse tried to call family and let them know that patient was not taking the change of environment well. Family stated, what do you expect me to do. This nurse stated that, we do not want your (father/mother) to fall, what are some alternatives that you try at home to help redirect (him/her). (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family stated to give patient his/her atarax, the nurse proceeded to give patient medication along with trazodone. Patient refused to sit down in the chair and threated to hit this nurse, and verbally got violent with the nurse, patient stood up and urinated on the floor in front of the nurse. Patient presumed to walk to down the hall and had a fall, and it was unwitnessed. Patient then was redirected to have a seat, where he/she then fell again by the central bathroom. Patient refused initial vital signs, the nurse, redirected patient, patient is now sitting at the nurse's station, no further report at this time 2573803

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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 interview and record review, the facility failed to ensure residents received care consistent with professional standards when staff failed to do neurological check (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status) after an unwitnessed fall for one resident (Resident #74). The sample was 17. The census was 66. Review of the facility's Fall policy, dated revised April 2022, showed:-The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen and any observations of the events, etc. Review of the facility's Neurological Assessment policy, dated revised October 2010, showed:-Purpose: the purpose of this procedure is to provide guidelines for neurological assessment: when following an unwitnessed fall;-General guidelines: neurological assessments are indicated: following an unwitnessed fall;-When assessing neurological status always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic (top number) and diastolic (bottom number) pressures). This may be indicative of increasing intracranial pressure (ICP, a life-threatening condition that happens when there's an imbalance between your brain tissue, cerebrospinal fluid and brain blood volume);-Any change in vital signs or/neurological status in a previously stable resident should be reported to the physician immediately;-Steps in the procedure: perform neurological checks with the frequency as ordered or per fall protocol; -Determine residents' orientation to time, place and person; -Observe resident's pattern of speech and speech clarity; -Take temperature, pulse, respirations, blood pressure; -Use oral thermometer only if safe with this type of resident; -Respirations are increased and shallow with ICP; -Pulse usually increases with ICP; -Blood pressure usually increases with widening pulse pressure with ICP; -Check pupil reaction; -Determine motor ability; -Have resident move all extremities; -Ask resident to squeeze your fingers. Note strength bilaterally; -Have resident plantar (move the foot downward) and dorsiflex (move foot upward). Note strength bilaterally. Ask resident if he/she has any numbness or tingling in legs/feet/toes and document accordingly;-Determine sensation in extremities. Rub resident's arm at the same time to see if the resident has decreased sensation in either arm. Check sensation in lower extremities and document;-Check gag reflex with tongue depressor, if safe for resident.-Have the resident smile to determine if there is any facial drooping and document accordingly;-Documentation: the following information should be recorded in the resident's medical record: -The date and time the procedure was performed; -The name and title of the induvial(s) who performed the procedure; -All assessment data obtained during the procedure; -If the resident refused the procedure, the reason(s) why and the intervention taken;-Reporting: notify the supervisor if the resident refuses the procedure. Report other information in accordance with the facility's policy and professional standards of practice. Review of the facility's Post Fall 72-Hour Monitoring Report (neuro check form), undated, showed:-This assessment should be completed at the following intervals for follow-up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. Initial assessment; followed by every 15 minutes times four; every 30 minutes times 2; every hour times two; once per shift for 72 hours. Review of Resident #74' s medical record, showed:-Resident was alert with confusion;-Diagnoses included diabetes, anoxic brain injury (brain completely loses its oxygen supply, leading to potential brain cell death), polysubstance abuse, history of stroke, seizure disorder, high cholesterol, high blood pressure and chronic end stage renal failure (irreversible kidney disease). Review of the resident's care plan, in use at the time of survey, showed:-Focus: I have had multiple falls since entry;-Goal: I will not have any injuries related to falls x 90 days;-Interventions: 7/24 referred to therapy; Ensure that resident has appropriate footwear;-Focus: I have a history of falling/falls. Review of the progress notes, dated 7/24/25 at 7:30 P.M., in the hour of 1700 (5:00 P.M.) patient became combative and repeatedly trying to get out of chair without assistance. The nurse and other nursing staff tried to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redirect patient; patient was not directable. The nurse tried to call family and let them know that patient was not taking the change of environment well. Family stated, what do you expect me to do. The nurse stated that, we do not want your (father/mother) to fall, what are some alternatives that you try at home to help redirect (him/her). Family stated to give patient his/her atarax (antihistamine), the nurse proceeded to give patient medication along with trazodone (antidepressant). Patient refused to sit down in the chair and threatened to hit the nurse, and verbally got violent with the nurse, patient stood up and urinated on the floor in front of the nurse. Patient presumed to walk to down the hall and had a fall, and it was unwitnessed. Patient then was redirected to have a seat, where he/she then fell again by the central bathroom. Patient refused initial vital signs. The nurse redirected patient; patient was now sitting at the nurse's station. No further report at this time;-No documentation neuro checks were started after the unwitnessed fall. During an interview on 8/20/25 at 5:50 A.M., Certified Nurse Aide (CNA) H said if a resident fell, he/she would notify the nurse, and the nurse would assess the resident and let them know if the resident can get up or not. The nurses complete the vital signs. During an interview on 8/19/25 at 4:30 P.M., Licensed Practical Nurse (LPN) C said if a resident had an unwitnessed fall, he/she would assess the resident and notify the physician and the responsible party. Neuro checks would be started as soon as the incident happened. Neuro checks are completed on paper. If a resident refused to have their vital signs checked, LPN C would complete the rest of the assessment and try again later or when the next neuro check was due. During an interview on 8/20/25 at 2:03 P.M., Registered Nurse (RN) D said the resident had an unwitnessed fall once during his/her shift. Since then, the resident had been monitored and placed by the nurses' station. RN D said the neurological checks were initiated and documented in the resident's electronic health records. He/She said if residents refused neurological checks, staff should re-direct the resident and try the assessment again. The staff were expected to notify the physician and document residents' refusal of care or assessment. Neurological checks should be continued and completed within 72 hours. During an interview on 8/20/25 at 6:34 A.M., Assistant Director of Nursing (ADON) A said if a resident had an unwitnessed fall, staff should assess the resident from head to toe and do neuro checks. The schedule for how often the assessments is completed is on the paper form. The physician and family should be notified. If the resident refused to have vital signs checked, staff should educate the resident, document the refusal and notify the physician. They could also ask another nurse for help. During an interview on 8/21/25 at 9:50 A.M., Certified Medication Technician (CMT) F said the resident's medication was held on 7/25/25 because the resident was sleeping. During an interview on 8/22/25 at 3:13 P.M., the Director of Nursing (DON) said the neurological checks should be initiated and completed during residents' unwitnessed falls. The staff were expected to notify the family and the physician and acquire orders as needed. The Regional Nurse said if the resident refused neurological checks, staff are expected to notify the physician and re-attempt to complete within 72 hours. 257380325770892576585

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Stonebridge Florissant	6768 North Highway 67 Florissant, MO 63034

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide care consistent with professional standards of practice, when staff failed to document a thorough assessment of a wound weekly and failed to transcribe treatment order for another wound when the resident returned from the hospital for one resident (Resident #33). The sample was 17. The census was 66.Review of the Wound Care policy, dated revised October 2018, showed:-Documentation: the following information should be recorded in the resident's medical record, if the resident refused the treatment and the reason(s) why;-Reporting: Notify the supervisor if the resident refuses the wound care;-Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol policy, dated revised March 2020, showed:-The nurse shall describe and document/report the following: full assessment of the pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue;-The physician will assist the staff to determine etiology (for example, arterial (ulcer caused by decreased blood circulation) or statis ulcer (a non-healing open sore on the lower leg or ankle that results from poor blood circulation) and characteristic (necrotic (dead) tissue, status of wound bed, etc.) of the skin alteration;-Monitoring: weekly skin evaluations should evaluate the skin integrity of residents. Any skin integrity issues shall be reported to the licensed nursing staff. Review of Resident #33's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/4/25, showed:-Ability to express ideas, and wants to consider both verbal and non-verbal expression: rarely/never understood;-Select best description of speech pattern: No speech-absence of spoken words;-Both long- and short-term memory problem;-Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Behavior not exhibited;-Required total care for all activities of daily living (ADLs, grooming, dressing, bathing);-Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device? No;-Is this resident at risk of developing pressure ulcers/injuries? Yes;-Does this resident have one or more unhealed pressure ulcers/injuries? No;-Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)? Yes;-Pressure ulcer/injury care? No;-Application of dressings to feet (with or without topical medications)? No;-Diagnoses included Down's Syndrome (a genetic condition where a person has an extra copy of chromosome 21, leading to distinct physical and developmental characteristics and intellectual disability), non-Alzheimer's dementia, and non-traumatic brain dysfunction (occurs when a medical condition or internal disease damages the brain). Review of the care plan, in use at the time of survey, showed:-Focus: resident was incontinent of bowel and bladder. Resident was dependent on staff for all peri-care (cleansing between the legs and buttocks area). Resident was at risk for pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction). open area to lateral malleolus (bony bump on outer side of ankle) added to wound doctor rounds, revised 8/18/25;-Goal: skin will remain intact X 90 days;-Interventions: incontinent, monitor for signs and symptoms of skin breakdown/excoriation. Report if noted, weekly skin assessment per protocol. Review of the facility's wound report, dated 7/23/25 through 8/13/25, showed the resident was not on the wound report. Review of the progress notes, dated 7/22/25 at 1:30 P.M., showed open area non pressure injury (any localize injury to the skin or under lying tissue caused by something other than sustained pressure) to right lateral ankle noted. Appears as though patient rubbed or hit his/her foot along the foot pedal of wheelchair. Area measured about 1.1-centimeter (cm) length x 1.2 cm width x 0.5cm depth. No odor noted. Minimal bleeding noted. No signs and symptoms of pain during assessment. Cleansed with wound cleanser, calcium alginate and dry dressing applied. Heel protector/boots applied. Physician and family made aware. Review of the skin assessment, dated 7/29/25 at 1:49 P.M., showed skin issue has not been evaluated.-Location: Right lateral foot;-Additional location information: ankle;-Issue type: Pressure ulcer/injury;-Wound acquired (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-house.-Wound is new;-Staged by: In-house nursing;-No undermining and no tunneling;-Skin Issues Note: No new skin issues noted;-The assessment did not include the measurements, description of the wound bed, and the stage of the pressure ulcer/injury. Review of the Treatment Administration Record (TAR), dated 7/1/25 through 7/31/25, showed:-A physician order for cleanse area to right outer lateral with normal saline. Apply calcium alginate and dry dressing every other day until healed, order date 7/22/25;-Documentation on 7/24, 7/26, 7/28 and 7/30 as blank;-A physician order for heel protectors/boots to be worn at all times every shift for skin breakdown prevention, start date was 7/23/25;-Documentation of 18 out of 18 opportunities as blank. Review of the progress notes, dated 7/22/25 through 8/10/25, showed:-7/22/25 through 7/31/25, no documentation the physician orders were changed and no documentation the resident refused;-On 8/5/25 at 1:12 P.M., Skin issue has not been evaluated;-Location: Right lateral foot;- Additional location information: ankle;-Tissue type: pressure ulcer/ injury;-Wound acquired in-house;-Wound is new;-Staged by in-house nursing;-No undermining, no tunneling;-Skin Issues Note: Skin issues remain. Treatments in progress;-The assessment failed to include the measurements, description of the wound bed, and the stage of the pressure ulcer/injury;-On 8/10/25, resident was sent to the hospital. Review of the TAR, dated 8/1/25 through 8/9/25, showed:-A physician order for heel protectors/boots to be worn at all times every shift for skin breakdown prevention;-Documentation of 18 out of 18 opportunities as blank. Review of the hospital records, dated 8/10/25, showed:-Active wounds assessment: wound 8/10/25 pressure injury left heel-posterior (back);-Date ˆrst assessed 8/10/25;-Present on admission: yes;-Primary wound type: pressure injury;-Wound 8/11/25 pressure injury ankle/malleolus anterior (front) right;-Date ˆrst assessed: 8/11/25;-Present on admission: yes;-Primary wound type: pressure injury;-Wound 8/11/25 pressure injury left heel lateral (outer side):-Date ˆrst assessed: 8/11/25,-Present on admission: yes:-Primary wound type: pressure injury. Review of the after-summary care, dated 8/10/25 through 8/13/25, showed:-Wound care instructions: post discharge dressing care:-Right ankle/malleolus anterior, cleanse with Vashe (wound cleanser) and apply moist aquacel alginate (absorbent wound dressing) and cover with foam dressing every 3 days and as needed;-Left posterior heel, cleanse with Vashe and paint with betadine daily. Review of the clinical assessment, dated 8/13/25, showed:-Location: right lateral foot;-Laterality/orientation: right lateral;-Additional location information: ankle;-Skin issue: pressure injury;-Acquired: in house;-Onset: new;-Staged by: in house nursing;-Undermining: no;-Tunneling: no;--The assessment did not include the measurements, description of the wound bed, and the stage of the pressure ulcer/injury;-No documentation identifying the wound on the left heel. Review of the progress notes, dated 8/13/25 through 8/20/25, showed:-On 8/13/25 at 5:14 P.M., head to toe assessment complete. Open area to right lateral ankle treatment in place. Wore podus (used to manage and prevent heel pressure) boots at all times;-On 8/13/25 at 5:59 P.M., Skin issue has not been evaluated;-Location: Right lateral foot;-Right. Additional location information: ankle;-Tissue type: pressure ulcer / injury;-Wound acquired in-house;-Wound is new;-Staged by in-house nursing;-No undermining, no tunneling;-Skin Issues Note: open area to right lateral ankle to be treated with calcium alginate with silver (highly absorbent antimicrobial dressing that promotes healing) to be changed every other day;-The assessment failed to include the measurements, description of the wound bed, and the stage of the pressure ulcer/injury;-On 8/18/25 at 8:04 A.M., Skin issue has not been evaluated;-Location: Right lateral foot;-Additional location information: ankle;-Tissue type: Pressure ulcer / injury;-Wound acquired in-house;-Wound is new;-Staged by in-house nursing;-No undermining, no tunneling;-Skin Issues Note: skin measures 1.5 cm x 1.0 cm, open area located in lateral malleolus. Treatment completed and added to wound doctor rounds.-The note did not describe the wound bed and include the stage of the wound. Review of the order sheet summary, dated active orders as of 8/22/25, showed:-A physician order for heel protectors (used to relief pressure of the heel) to be worn at all times for skin breakdown preventions;-A physician order for wound doctor to evaluate and treat, order date 8/18/25;-A physician order for calcium alginate (highly absorbent dressing that promotes (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing), cleanse area with wound cleanser, apply calcium alginate to lateral right ankle, cover with dry dressing every day and as needed, order date 8/18/25;-A physician order for skin prep (fast drying skin protectant) to left heel topically daily for wound care, order date 8/20/25; Review of the TAR, dated 8/13/25 through 8/20/25, showed:-A physician order for cleanse area to right outer lateral ankle with normal saline. Apply calcium alginate and dry dressing every other day until healed, order date 8/13/25, discontinue date 8/20/25;-The order failed to show calcium alginate was with silver;-A physician order for heel protectors/boots to be worn at all times every shift for skin breakdown prevention;-Documentation showed 8/1/25 through 8/9/25, 18 out of 18 opportunities were blank; and 8/14/25 through 8/20/25, 14 out of 14 opportunities were blank.-A physician order for skin prep to left heel every day for wound care, start date was 8/20/25;-There were no treatment orders for the left heel prior to 8/20/25. Observation on 8/20/25 at 7:58 A.M., showed the resident was up in his/her wheelchair in the hall by the nurse's station. The resident wore slipper socks. At 8:45 A.M., the resident ate breakfast in the assisted dining room and wore heel protectors. During an interview on 8/22/25 at 11:50 A.M., ADON A said she checked the resident's hospital records when he/she returned to the facility. In the hospital, they used the aquacel alginate but when he/she came back to the facility, it was changed to calcium alginate. She did not recall seeing an order for betadine for the resident's heel. Observation and interview on 8/20/25 at 1:35 P.M., showed the resident lying in bed. The resident had a dark purplish colored irregular shaped area on his/her left heel. There was a small open area on the right lateral ankle. The wound doctor said today was the ˆrst time she saw the resident. She described the left heel as a deep tissue injury (DTI, (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-ˆlled blister) size was 1.7 x 2.6, depth not measured. The cause of the DTI was pressure. She ordered skin prep to the area daily. The right lateral ankle was a Stage 3 pressure ulcer/injury (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) size was 0.9 x 1.1 x 0.1 cm. Review of the wound physician's note, dated 8/20/25, showed:-This was the resident's initial wound evaluation and management summary;-Chief complaint: presents with wounds on his/her left heel and right lateral ankle;-Site 1: unstageable DTI of the left heel undetermined thickness;-Etiology: pressure;-Wound size: 1.7 cm X 2.6 cm X not measurable cm;-Primary dressing: skin prep applies daily and as needed, if saturated, soiled, or dislodged. For 30 days;-Site 2: Stage 3 pressure wound of the right lateral ankle full thickness;-Etiology: pressure;-Stage: 3;-Duration: > 8 days, noted to be present on admission per staff;Size: 0.9 cm X 1.1 cm X 0.1 cm;-Exudate: moderate sero-sanguinous (light pink or yellowish thin ˆuid);-Granulation tissue: 100%;-Dressing treatment: primary dressing: calcium alginate applies once daily and as needed; if saturated, soiled or dislodged. For 30 days; Secondary dressing: gauze island with border applies once daily and as needed, if saturated, soiled or dislodged. For 30 days. During an interview on 8/21/25 at 12:18 P.M., Assistant Director of Nursing (ADON) B said the nurse on the ˆoor completes a weekly skin assessment. If a wound is noted, the nurse should describe and measure the wound. The wound doctor stages the wound. Staff used the measurements and description to determine if the wound was getting better or worse. During an interview on 8/21/25 at 3:25 P.M., ADON A said when the wound on the resident's right outer ankle was discovered, she measured it and obtained treatment orders. She documented the wound as a non-pressure area. The treatment was placed on the wound TAR, in place of the regular TAR, not the proper spot. The treatments were completed and that's why the wound did not get worse. During an interview on 8/21/25 at 3:25 P.M., the Director of Nursing (DON) said the ˆoor nurse completes a weekly skin assessment. If an area is noted, the nurse management will check the wound. The physician is notiˆed, and orders are obtained. The wound doctor visited the facility weekly. The wound doctor measured and staged the wounds. The ˆoor nurse is responsible for completing the treatments and documenting the treatment was completed. If a treatment is not documented, it would (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mean it was not done. The nurse should go see the resident to see if the area has healed. The ADON should investigate why the treatment was not completed, and document their ˆnding, and notify the physician. The DON expected the nurse to document a description of the wound bed, peri-wound (the surrounding edges of the wound) and the measurements when a wound is discovered so they can determine if the wound is better or worse. During an interview on 8/22/25 at 11:52 A.M., the Administrator said if the resident had a pressure ulcer/injury, staff should notify the physician and obtain orders. A description of what the wound looks like, and the measurements should be documented weekly. If the resident was seen by the wound doctor, the wound doctor will do the weekly documentation. If the resident is not seen by the wound doctor, the facility should complete the weekly documentation. Once an order is obtained for the wound doctor, the wound doctor will usually see the resident the next week. During an interview on 8/22/25 at 3:12 P.M., the DON expected the staff to identify residents' skin issues during the skin assessment and to document in the medical records. Skin assessments were to be done and documented weekly. The staff were expected to follow physician's orders and follow the facility's policies and procedures.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary medications as ordered by the physician. In addition, they failed to notify and document the physician was made aware of the missed medications for one of 17 sampled residents (Resident #74). The census was 66. Review of the facility's Administering Medications Policy, dated revised December 2012, showed:-Medications shall be administered in a safe and timely manner, and as prescribed;-Medications must be administered in accordance with the orders, including any required time frame;-Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals);-If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administrating the medication shall document appropriately in the clinical chart. Review of the facility's Obtaining a Fingerstick Glucose Level, dated revised October 2011, showed:-Purpose: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level;-Documentation: The person performing this procedure should record the following information in the resident's medical record:-If the resident refused the procedure, the reason(s) why and the intervention taken;-The blood sugar results;-The signature and title of the person recording the data;-Reporting: Report results promptly to the supervisor and the attending physician;-Notify the supervisor if the resident refuses the procedure;-Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Adverse Consequences and Medication Errors Policy, dated revised April 2017, showed:-A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of professional(s) providing services. Examples of medication errors include omission-a drug is ordered but not administered. Review of Resident #74's medical record, showed:-Resident was alert with confusion, he/she could make needs known;-Was readmitted on [DATE] for respite care and discharged on 7/28/25; -Diagnoses included diabetes, anoxic brain injury (brain completely loses its oxygen supply, leading to potential brain cell death), polysubstance abuse, history of stroke, seizure disorder, high cholesterol, high blood pressure and chronic end stage renal failure (irreversible kidney disease). Review of the physician order sheet, dated active orders as of 8/22/25, showed: -A physician order for amlodipine besylate oral tablet 5 milligrams (mg), give 5 mg by mouth one time a day for blood pressure, order date 7/24/25;-A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics, order date 6/13/25;-A physician order for farxiga oral tablet 10 mg, give 1 tablet by mouth one time a day for give prior to breakfast, order date 6/13/25;-A physician order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety, order date 7/24/25;-A physician order for insulin glargine solution 100 unit/milliliter (ml), inject 14 units subcutaneously (under the skin) one time a day for diabetes, order date 7/24/25;-A physician order for keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant, order date 6/13/25;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure, order date 7/24/25;-A physician order for novolog flex pen subcutaneous solution pen-injector 100 UNIT/ML, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia, order date 7/24/25. Review of the Medication Administration Record (MAR), dated 7/24/25 through 7/25/25, showed:-A physician order for amlodipine besylate oral tablet 5 milligrams (mg), Give 5 mg by mouth one time a day for blood pressure; -7/25/25, A.M., HD (hold, see progress notes) was documented; -A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics; -7/25/25, 8 A.M., HD was documented; -A physician order for farxiga oral tablet 10 mg, give 1 tablet by mouth one time a day, give prior to breakfast; -7/25/25, 8 A.M., HD was documented; -A physician (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety; -7/25/25 at 8 A.M., 12:00 P.M. and 4:00 P.M., HD was documented;-A physician order for keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant; -7/25/25 at 8 A.M. and 4:00 P.M., HD was documented;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure; -7/25/25 at 4:00 P.M., HD was documented;-A physician order for novolog flex pen subcutaneous solution pen-injector 100 unit/ml, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia; -Documentation showed:-On 7/24/25, was blocked off for medication to start on 7/25/25;-On 7/25/25 at 8 A.M., 12:00 P.M., 4:00 P.M. HD was documented; -On 7/26/25 at 8 A.M. and 12:00 P.M. were blank, at 5:00 P.M. the blood sugar was 400. Review of the progress notes, dated 7/24/25 through 7/25/25, showed:-On 7/24/25 at 7:30 P.M., patient arrived at the facility in the hour of 1300. Resident was given a lunch tray, and insulin was given after intake of 100%;-No documentation the results of the blood sugar or the type and amount of insulin administered. In addition, no documentation the physician was notified when the medications were held. During an interview on 8/19/25 at 4:30 P.M., Licensed Practical Nurse (LPN) C said the resident slept the first day he/she was at the facility. The second day, the resident would arouse to eat and take medications. The Certified Medication Technicians (CMTs) administer the scheduled medications, and the nurses complete the finger stick blood sugars and administered the insulin. The fingerstick blood sugars are documented on the MAR. If a medication was not administered or held, it should be documented on the MAR and the physician should be notified. The physician should be notified for each dose of medication not administered. During an interview on 8/20/25 at 10:28 A.M., CMT E said if a medication was held, it should be documented. The nurses are responsible for doing the fingerstick blood sugars and administering the insulin. During an interview on 8/21/25 at 9:50 A.M., CMT F said if the doctor held a medication, the nurse would enter it in the computer. The resident's medications were held because the resident was sleeping. Typically, the resident would go to bed at the beginning of day shift and sleep until lunch. He/She did not know if the resident was diabetic or not. The nurse would do the fingerstick blood sugars and the insulin. Sometimes, something for the nurses will pop up on the CMT MAR, but he/she never saw anything for the resident pop up on the CMT MAR. During an interview on 8/20/25 at 6:34 A.M., Assistant Director of Nursing (ADON) A said finger stick blood sugars should be documented on the MAR. If a medication was not administered, it should be documented in the progress notes and the physician should be notified. The physician is notified for each missed dose of medication. If a medication was held, it should be documented why the medication was held. She did not know what a blank on the MAR meant. During an interview on 8/21/25 at 12:18 P.M., ADON B said he/she was not sure why the staff held the medications. CMT F was not supposed to do fingerstick and insulin administration. ADON B looked at the resident's records and said that on 7/26/25, it looked like the resident did not receive the insulin because of the hole in the MAR. There's no documentation in the progress notes related to the medications being held and fingerstick results. Upon further review of the resident's record, ADON B said Registered Nurse (RN) D transcribed the insulin order incorrectly into the MAR. RN D entered the orders into the CMT MAR instead of the nurse MAR. The nurse did not see the insulin order until RN I revised and entered the insulin in the nurse MAR. ADON B said he/she expected the CMT to report to the nurse any medications held and to document in the MAR and progress notes. During an interview on 8/22/25 at 11:35 A.M., the physician said he could not recall if the facility called to report the resident's medications were not administered. During an interview on 8/22/25 at 11:52 A.M., the Administrator said residents who are admitted on respite care usually bring their medications from home. He expected staff to follow physician orders. If staff was unable to follow the orders, they should notify the physician and document it. Fingerstick blood sugars results should be documented. During an interview on 8/22/25 at 3:13 P.M., the Director of Nursing (DON) said she expected staff to notify the physician if medications were held or not given and to (continued on next page)

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	08/22/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document appropriately. The Regional Nurse said fingerstick results should be documented anywhere in the residents' medical record, typically in the MAR. 25770892573803