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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265486	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Maryland Heights	2963 Doddridge Avenue Maryland Heights, MO 63043

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident was provided with adequate supervision and staff oversight when the resident wandered outside and was brought back to their secured housing unit after approximately five to ten minutes of being outside unsupervised (Resident #1). The resident knocked on the door of a different housing unit and was brought back to their unit by a Certified Nursing Assistant (CNA). The sample was 9. The census was 136. The Administrator was notified on 3/26/26 of the past non-compliance. The facility in-serviced nursing staff on alarms and monitoring exits when alarms by the doors are making noise. They were in-serviced on identifying residents at risk of elopement and those who having exit seeking behavior. They were also given mock elopement drills to ensure the facility policy is followed when an alarm goes off or a resident is found to be missing. The deficiency was corrected on 3/25/26. Review of the facility's Elopement Policy, undated, showed:Policy Statement: Staff shall investigate and report all cases of missing resident and the appropriate staff will be notified. The resident will be located in a timely manner that does not disrupt or impede regular routines in all areas of the facility.Policy Interpretation and Implementation:-Reporting Practices: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.-Resident Leaving the Premises;2. If an employee observes a resident leaving the premises, he/she should:-Attempt to prevent the departure in a courteous manner;-Get help from other staff members in the immediate vicinity, if necessary; and-Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.-Procedure for Locating a Missing Resident: 3. Should a staff member become concerned with the possibility that a resident may be missing, complete the following steps:-Conduct a thorough search of the entire unit. Do not panic; be certain to check all rooms, restrooms, closets, etc.;-If unable to locate resident, notify the Nursing Home charge nurse;-The nursing home charge nurse will announce overhead, All units check your exits;-On duty staff will then thoroughly search areas within their scheduled assignment; including vacant rooms, restrooms, closets, etc.;-Staff will report a head count for their assigned area to the nursing home charge nurse. Head count for facility will be completed; Staff will inform the charge nurse of any residents who have signed out of the facility;-If the resident is located, the charge nurse will announce overhead, All exitsare clear;-If the search is unsuccessful, the nursing home charge nurse will notify the Administrator and Director Of Nursing (DON) immediately. If they are unavailable, then the on-call nurse will be notified;-The charge nurse will then assign staff to search the outside and surrounding grounds;-The Administrator or DON will make a decision to notify the police department with a physical description of the resident;-The Missouri Department of Health and Senior Services will be contacted within two hours if the resident is not located.4.Nursing Service Duties Upon Return of Resident Who Was Observed Leaving the Facility: When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall:-Examine the resident for injuries;-Notify the Attending Physician;-Notify the resident's legal representative (sponsor) of the incident; -Complete and file an Incident Report. Review of Resident #1's quarterly Minimum Data Set (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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