

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Stonebridge Maryland Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39411</p> <p>Based on observation, interview, and policy review, the facility failed to provide knives with meals for two residents (Resident (R) 56 and R107) and staff was observed to stand while feeding (R) 22. These failures to promote dignity in dining had the potential to affect the 38 residents in the dining room.</p> <p>Findings include:</p> <p>Review of the facility policy dated January 2009 titled Dining Room Audits indicated the Food Service Department should ensure the residents needs are met, and that dining is a pleasant experience.residents at each table should be served together and table should be in a homelike setting.</p> <p>During an interview on 01/28/25 at 12:27 PM, R56 stated that they never give knives at meals, and it made her feel like a child.</p> <p>During an interview on 01/28/25 at 12:30 PM, R107 stated that they never get knives with their meals. R107 stated that he is a grown man and feels like they should get a knife even if they do not use it.</p> <p>During a meal observation on 01/28/25 at 5:10 PM, residents were observed to get a spoon and fork and no knife with their meals. Staff were observed to serve meals randomly to tables while other residents sat without meals at the same table. Staff were observed to call out names to deliver meals. Residents raised their hand when they heard their name to get their meal served.</p> <p>During an interview on 01/29/25 at 1:03 PM the Dietary Manager (DM) stated she did not know why residents were not getting knives and they should be provided. The DM stated that they have knives so there is no reason the residents cannot have them.</p> <p>During an interview on 01/29/25 at 1:55 PM the Registered Dietitian (RD) stated that all residents should receive full service ware with their meals.</p> <p>11599</p> <p>3. Review of the Face Sheet located under the Profile tab in the EMR revealed R22 was initially admitted on [DATE] with diagnoses including cerebral palsy and seizure disorder.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265486
		If continuation sheet Page 1 of 34

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the annual MDS, located under the RAI tab in the EMR with an ARD of 12/22/24 revealed R22 required assistance with eating.</p> <p>During an observation of the assisted dining room on 01/29/25 at 8:22 AM, Licensed Practical Nurse (LPN)2 was observed standing to feed R22. When asked if she should be standing or sitting, LPN2 stated, I always do, doesn't matter who it is. Whenever I'm helping, I stand. I didn't know I can't [sic] stand. LPN2 continued to stand to feed R22.</p> <p>During an interview on 01/29/25 at 8:24 AM, the Director of Nurses (DON) and two other staff members were observed standing at the half-wall looking toward the dining room, located next to the assisted dining room. On 01/29/25 at 8:25 AM, the DON was asked what her expectations were when a resident required to be fed by staff. The DON stated, They have to prepare the tray, make sure the meal is what they are to have, and sit to feed. The DON, by observation, confirmed that LPN2 was standing to feed R22.</p> <p>During an interview on 01/30/25 at 7:29 PM, the Administrator stated, Oh, she doesn't always feed residents, she was just helping out. She knows, she knows [not to stand].</p> <p>No policy was provided as of 01/30/25 for dining assistance.</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on interview and record review, the facility failed to ensure six of seven (Residents (R)121, R5, R65, R107, R7, and R136) reviewed for care planning of 33 sampled residents was afforded the right to participate in their care planning process. This failure placed the resident at risk of not being aware of the goals and outcomes of their care.</p> <p>Findings include:</p> <p>1. Review of R121's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R121 was admitted to the facility on [DATE] with the diagnoses of anemia, orthostatic hypotension, and generalized weakness.</p> <p>Review of R121's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represented R121 was cognitively intact.</p> <p>Review of R121's Care Plan Sign in Sheet provided by the facility revealed the only documentation of a care plan meeting being held in 2024 was dated 06/25/24.</p> <p>During an interview on 01/28/25 at 9:03 AM, R121 stated, I don't understand what you are asking. I don't know what a care plan meeting is.</p> <p>During an interview on 01/29/25 at 3:30 PM, Minimum Data Set Coordinator (MDSC)1 stated, I could not find any more care plan meetings in 2024 for [R121]. That was all that she had.</p> <p>During an interview on 01/30/25 at 4:30 PM, the Administrator stated, I cannot confirm there were any more care plan meetings held for [R121] other than what is documented. The care plan meetings are to be held once a quarter and documented in PCC [Point Click Care].</p> <p>11599</p> <p>2. Review of the Face Sheet located under the Profile tab (EMR) revealed R5 was initially admitted on [DATE] with diagnoses that included anxiety disorder, chronic pain, and cerebral infarction.</p> <p>Review of the quarterly MDS, located under the RAI tab in the EMR, with an ARD of 12/11/24 revealed a BIMS score of 13 out of 15 which indicated R5 was cognitively intact.</p> <p>During an interview on 01/27/25 at 1:08 PM, R5 was asked if she was invited to and attended care plan conferences. R5 stated, I used to, but only when I first came, I've been here for five years. They don't invite me anymore, but I would really like to go. They're important.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/29/25 at 4:14 PM, the MDS Coordinator (MDSC)1, responsible for care plan conference invitations, stated, I'll have to check who was invited when. MDSC1 was unable to provide any documentation that R5 had been invited or attended her care plan conferences. No explanation was given why R5 was not invited.</p> <p>3. Review of the Face Sheet, located under the Profile tab in the EMR, revealed R65 was admitted on [DATE] with diagnoses that included myocardial infarction type 2, hemiparesis and hemiplegia following cerebral infarction affecting the left dominant side, and diabetes mellitus.</p> <p>Review of the significant change MDS, located under the RAI tab in the EMR, with and ARD of 11/05/24 revealed a BIMS of 15 out of 15 which indicated R65 was cognitively intact.</p> <p>During an interview on 01/28/25 at 10:31 AM, R65 was asked if she was invited to and attended care plan conferences. R65 stated, No, I've never been invited to a care conference.</p> <p>During an interview on 01/29/25 at 4:14 PM, the MDSC1 responsible for care plan conference invitations stated, I know for sure that (R65) has not been invited to care conferences. No explanation was given why R65 had not been invited.</p> <p>39411</p> <p>4. Review of R107's Admission Record, located under the Profile tab of the EMR revealed R107 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, epilepsy, depression, and hypertension.</p> <p>Review of R107's quarterly MDS with an ARD of 12/31/24 and located under the MDS tab of the EMR, revealed R107 scored 12 out of 15 on the BIMS, which indicated R107 was moderately cognitively impaired.</p> <p>Review of R107's Care Plan Sign in Sheet, dated 12/31/24 provided by the SSD revealed a signature that R107 had attended the care plan meeting for that quarter. There was no other evidence provided indicating R107 had been invited to attend any other care plan meeting.</p> <p>During an interview on 01/28/25 at 11:00 AM, R107 stated he had not been invited to or attended any care plan meetings for a long time and would go if he was invited.</p> <p>5. Review of R7's Care Plan Sign in Sheet, dated 01/20/25 provided by the SSD revealed a signature sheet. There were no signatures of any family members of R7. There was no other evidence provided indicating R7's family had been invited to attend any other care plan meeting.</p> <p>During an interview on 01/28/25 at 1:02 PM Family Member (FM)1 stated her mother (R7) had been in the facility since 12/13/23 and she had never been invited to a care plan meeting. FM1 stated she is in the facility every day to feed her mother and make sure she is comfortable so she could have easily been invited. FM1 stated she would have attended the care plan meeting because she is very concerned about her mother's care.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Review of R136's Care Plan Sign in Sheet, dated 12/06/24 provided by the SSD revealed a signature sheet. There were no signatures of any family members of R136. There was no other evidence provided indicating R136's family had been invited to attend any other care plan meeting.</p> <p>During an interview on 01/28/25 at 1:02 PM, FM2 stated his family member (R136) had been in the facility since 08/23/24 and he had never been invited to a care planning meeting. FM2 stated he is in the facility every day to check on his family member and make sure she is comfortable so he could have been invited. FM2 stated he would have attended the care plan meeting because he likes to be involved in her care.</p> <p>In an interview on 01/30/25 at 2:32 PM, MDSC1 confirmed R7, R107, and R136 had not been sent notifications or been invited to care plan meetings.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39857</p> <p>Based on observation, record review, staff interview, and policy review, the facility failed to ensure that a resident was assessed for self-administration of medications prior to medications being left at the bedside for one of one resident (Resident (R)68) reviewed for self-administration out of a total sample of 33 residents. This failure had the potential for the medication errors to be made.</p> <p>Findings include:</p> <p>Review of R68's Face Sheet located under the Resident Info tab in the electronic medical record (EMR) revealed R68 was readmitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease, chronic diastolic congestive heart failure, and morbid obesity.</p> <p>Review of R68's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/01/25 and located under the MDS tab in the EMR revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated that R68 was cognitively intact.</p> <p>Review of R68's Physician Orders located under the Orders tab in the EMR revealed an order dated 09/16/24 for Advair Diskus inhalation aerosol powder breath activated 250-50 mcg (micrograms)-4.5 mcg/actuation HFA one puff twice a day. There was no order for the medication to be kept at the bedside of R68.</p> <p>During an observation on 01/27/25 at 11:30 AM, R68 had an inhaler (Advair) lying on a shelf, next to the resident's recliner. R68 stated he used the inhaler if he became short of breath.</p> <p>Observation on 01/28/25 at 9:24 AM the inhaler was at bedside. On 01/29/25 at 10:45 AM, the resident had an inhaler on the shelf next to the recliner.</p> <p>On 01/30/25 at 10:20 AM a request was made to the Administrator for a self-administration assessment. The Administrator stated she could not locate the document.</p> <p>On 01/30/25 at 11:17 AM R68 stated, a nurse came and snatched my inhaler from the shelf a few minutes ago without an explanation.</p> <p>During an interview with Licensed Practical Nurse (LPN)1 on 01/30/25 at 11:45 AM, LPN1 confirmed that R68 did not to have a self-administration assessment and there was no order for medications to be left at the bedside. LPN1 stated, I found the inhaler this morning after the Administrator called, I took it and placed it back in the medication cart. I have called the doctor and will be doing a self-administration assessment on [R68] later today.</p> <p>During an interview on 01/30/25 at 3:30 PM, the Director of Nursing (DON) confirmed that R68 had not been assessed for self-administration of the inhaler found by the bedside of R68 on 01/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Self-Administration of Medications undated, stated, As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident .</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30687</p> <p>Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected 12 residents who expired and had money in their accounts (Residents #301, #302, #303, #304, #305, #306, #307, #308, #309, #310, #311 and #312). The financial sample was 12. The census was 146.</p> <p>Review of the facility's Resident Trust Fund Account Policy and Procedures, revised [DATE], showed the following:</p> <p>-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;</p> <p>-Procedure: Upon discharge of a resident with a balance in the Resident Trust Fund, the facility will provide a final accounting within thirty days. If the facility is the Representative Payee for the resident, the facility will refund the balance to Social Security. If we are not Representative Payee, this accounting will be provided to the resident or the legal representative along with a check for the remaining balance in the fund. Upon the death of a resident with a balance in the Resident Trust Fund, the facility will complete the appropriate forms and submit to: Department of Social Services. This form shall be submitted within 60 days from the date of the resident's death. No funds shall be paid out of the resident's trust fund account, except for qualified funeral expenses, until notification is received from the Department of Social Services instructing the facility as to how the funds are to be distributed.</p> <p>1. Review of Resident #301's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$655.30;</p> <p>-TPL was completed on [DATE].</p> <p>2. Review of Resident #302's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$205.32;</p> <p>-TPL was completed on [DATE].</p> <p>3. Review of Resident #303's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Ending balance of \$1473.88;</p> <p>-TPL was completed on [DATE].</p> <p>4. Review of Resident #304's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$268.78;</p> <p>-TPL was completed on [DATE].</p> <p>5. Review of Resident #305's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$315.75;</p> <p>-TPL was completed on [DATE].</p> <p>6. Review of Resident #306's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$0.88;</p> <p>-TPL was completed on [DATE].</p> <p>7. Review of Resident #307's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$117.13;</p> <p>-TPL was completed on [DATE].</p> <p>8. Review of Resident #308's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$2018.08;</p> <p>-TPL was completed on [DATE].</p> <p>9. Review of Resident #309's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Ending balance of \$153.54;</p> <p>-TPL was completed on [DATE].</p> <p>10. Review of Resident #310's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$50.41;</p> <p>-TPL was completed on [DATE].</p> <p>11. Review of Resident #311's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$62.67;</p> <p>-TPL completed on [DATE].</p> <p>12. Review of Resident #312's medical record, showed the following:</p> <p>-Expired on [DATE];</p> <p>-Ending balance of \$37.23;</p> <p>-TPL completed on [DATE].</p> <p>13. During an interview on [DATE] at 11:44 A.M., the Business Office Manager (BOM) said based on the state regulation form, he/she thought she had 60 days to complete the TPL. She did not realize the timeframe was 30 days.</p> <p>14. During an interview on [DATE] at 11:46 A.M., the Administrator said she knew the TPL needed to be completed within 30 days. The BOM told her it was changed to 60 days, so she assumed it was now 60 days.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on record review, staff interviews, review of Centers for Medicare and Medicaid Services (CMS) website, and policy review, the facility failed to issue the appropriate notice for termination of Medicare part A benefits for three (Resident (R)92, R1, and R49) residents reviewed for beneficiary notification out of a total sample of 33 residents. These failures had the potential to result in a lack of understanding of appeal rights and/or the termination of the current level of care against the residents'/representative's wishes.</p> <p>Findings include:</p> <p>Review of the CMS site, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 accessed at <a href="https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf">https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf</a> on 06/04/24 revealed, The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select . If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: beneficiary refused to choose an option.</p> <p>Review of the facility's policy Advanced Beneficiary Notices dated December 2018 and provided by the facility stated, . A liability notice shall be issued to Medicare beneficiaries and will explain: i. An item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary . A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending .</p> <p>1. Review of R92's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R92 was readmitted to the facility on [DATE] with the diagnosis of heart failure, diabetes mellitus, and hypertension.</p> <p>Review of R92's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 10/25/24 coded R92 was having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that R92 was cognitively intact.</p> <p>Review of R92's Notice of Medicare Non-Coverage (NOMNC), dated 09/11/24 and provided on paper, revealed R92's last covered day (LCD) of Medicare Part A services was 09/13/24. The Skilled Services in which would not be covered after 09/13/24 did not specifically tell the resident which therapy would be discontinued.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Stonebridge Maryland Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R92's Advanced Beneficiary Notice of Noncoverage (ABN) dated 09/11/24 and provided on paper, revealed the notice was signed by the resident; however, no option was checked to indicate whether R92 wanted skilled services to be continued with responsibility for payment, skilled services to be discontinued, or skilled services to continue with an appeal to Medicare for further coverage. On this form was also noted to be left blank were the areas of Reason Why Medicare Will Not Pay and the Estimated Cost of the skilled service if the resident wishes to pay out of pocket for this service to continue.</p> <p>2. Review of R1's updated Face Sheet located under the Profile tab in the EMR, revealed R1 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, and congestive heart failure.</p> <p>Review of R1's quarterly MDS located under the MDS tab in the EMR with an ARD of 12/01/24 revealed R1 was coded as having a BIMS score of 14 out of 15 indicating R1 was cognitively intact.</p> <p>Review of R1's NOMNC, dated 01/10/25 and provided on paper, revealed R1's LCD of Medicare Part A services was 01/13/25. The Skilled Services in which they would not be covered after 01/10/25 did not specifically tell the residents which therapy would be discontinued.</p> <p>Review of R1's ABN dated 0/10/25 and provided on paper, revealed the notice was signed by the resident; however, no option was checked to indicate whether R92 wanted skilled services to be continued with responsibility for payment, skilled services to be discontinued, or skilled services to continue with an appeal to Medicare for further coverage. On this form was also noted to be left blank were the areas of Reason Why Medicare Will Not Pay and the Estimated Cost of the skilled service if the resident wishes to pay out of pocket for this service to continue.</p> <p>3. Review of R49's undated Face Sheet located under the Profile tab in the EMR revealed R49 was readmitted to the facility on [DATE] with the diagnosis of heart failure, and renal failure.</p> <p>Review of R49's quarterly MDS located under the MDS tab in the EMR with an ARD of 01/05/25 revealed R49 was coded as having a BIMS score of seven out of 15 indicating R49 was moderately cognitively impaired.</p> <p>Review of 49's NOMNC, dated 11/08/24 and provided on paper, revealed R49's LCD of Medicare Part A services was 11/10/24. The Skilled Services in which would not be covered after 01/10/25 did not specifically tell the resident/representative which therapy would be discontinued.</p> <p>Review of R49's ABN dated 11/08/24 and provided on paper, revealed the notice was verbally consented by the resident representative; however, no option was checked to indicate whether R49 wanted skilled services to be continued with responsibility for payment, skilled services to be discontinued, or skilled services to continue with an appeal to Medicare for further coverage. On this form was also noted to be left blank were the areas of Reason Why Medicare Will Not Pay and the Estimated Cost of the skilled service if the resident wishes to pay out of pocket for this service to continue.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/30/25 at 3:00 PM, the Social Services Designee (SSDE) stated, I just put skilled serves and don't write out which therapy will be discontinued. On the other form [referring to the ABN form], I do not know the estimated cost of the skilled service, so I leave that blank. I really do not know where to get this information from. These options, I don't mark for the residents, so if they leave them blank, I won't do anything with them.</p> <p>During an interview on 01/30/25 at 5:00 PM, the Administrator was notified of the ABN forms not being filled out correctly and of the NOMNC not telling the residents and/or representative which specific skilled service is being discontinued. The Administrator stated, The social services [SSDE] is to make sure all areas of the forms are filled out completely and correctly even if they need to ask the resident to fill out which option they choose.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on staff interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) for one of 35 sampled residents (Resident (R)121). This failure reflected R121 was receiving care or treatments that was inaccurate.</p> <p>Findings include:</p> <p>Review of R121's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R121 was admitted to the facility on [DATE] with the diagnoses of anemia, orthostatic hypotension, and generalized weakness.</p> <p>Review of R121's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represented R121 was cognitively intact. R121 was also coded as receiving dialysis while a resident in the facility.</p> <p>Review of R121's Physician Orders located under the 'Orders tab in the EMR revealed no orders for dialysis.</p> <p>During an interview on 01/27/25 at 4:43PM, R121 stated, I have never been on dialysis.</p> <p>During an interview on 01/29/25 at 7:33 AM, Minimum Data Set Coordinator (MDSC)1 stated, No, [R121] is not on dialysis, I get her [R121], and another resident mixed up. I made a mistake.</p> <p>During an interview on 01/29/25 at 9:00 AM, the Director of Nursing (DON) confirmed R121 was not receiving dialysis.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39857</b></p> <p>Based on record review and staff interview, the facility failed to ensure the Pre-Admission Screen and Resident Review (PASARR) Level I screen was completed prior to admission for one of four residents (Resident(R) 112) reviewed for PASARR out of a total sample of 33 residents. This created a potential failure to identify what specialized or rehabilitative services the resident needed and whether placement in the facility was appropriate prior to admission.</p> <p>Findings include:</p> <p>Review of R112's Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, Parkinson's disease without dyskinesia, with fluctuations.</p> <p>Review of R112's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/06/25 and located in the MDS tab of the EMR, revealed she scored five out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe impairment. R112 was admitted from another nursing home but the facility had no Level I PASRR upon admission to their facility.</p> <p>Review of the Orders tab of R112's EMR revealed the resident is not taking psychotropic medications. He is taking Carbidopa Levodopa, used to treat Parkinson's disease</p> <p>Review of R112's Care Plan, dated 01/10/23 and located in the Care Plan tab of the EMR revealed, [R112] has a dx of Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. The approaches included: administer medications as ordered . Allow me time to answer questions and to verbalize feelings perceptions, and fears. Assist/encourage/support me to set realistic goals. Consult with: Pastoral care, social services, Psychiatric consult. Monitor/document resident's usual response to problems: Internal - how individual makes own changes, External - expects others to control problems or leaves to fate, or luck There were no planned specialized services for mental health.</p> <p>Review of R112s EMR revealed there was no evidence of PASARR level one screen and determination prior to admission.</p> <p>During an interview on 01/30/24 at 03:29 PM, the Social Services Director (SSD) stated she was under the impression the PASRR level one screen had to be completed by the hospital before the resident was admitted . But if it were not done, the facility would have 72 hours to complete it.</p> <p>During an interview on 01/30/24 at 03:40 PM, Assistant Director of Nurses (ADON) she stated the PASRR level one screen had to be completed by the hospital before the resident was admitted . But if it wasn't done, I don't have the slightest idea who does it.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/30/24 at 03:55 PM, the Administrator stated the resident had a C form done but since resident did not need a Level 2 it was deleted. The PASRR level one screen should have been completed by the hospital before the resident was admitted . But if it were not done, the admission person would do it and social services would follow up.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36917</p> <p>Based on interviews and record review, the facility failed to provide an ongoing program of resident preferred activities three residents (Resident (R)27, R93, and R137) reviewed for activities in sample size of 33 residents. This failure placed R27, R93 and R137 at risk for increased feelings of isolation, depression, helplessness, and boredom.</p> <p>Findings include:</p> <p>1. Review of R27's Resident Face Sheet located in the Resident tab, in the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnosis to include but not limited to unspecified psychosis, anxiety disorder, chronic obstructive pulmonary disorder, restless legs syndrome, schizoaffective disorder, and insomnia.</p> <p>Review of R27's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/24 and located in the Resident Assessment Instrument (RAI) tab of the EMR, revealed she scored 14 of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact. The MDS did not indicate preferences for daily activities.</p> <p>Review of R27's Care Plan dated 10/15/23 and located in the RAI tab of the EMR, revealed her activity preferences were watching television and some music with request to be offered and assisted to activities. Activity attendance logs of participation were requested but were not provided during the survey.</p> <p>During an interview with R27 on 01/29/25 at 10:47 AM, she stated they don't have activities here. All they do is color, they bring me a page to color, but I don't like to color. She stated no one came to visit her in her room to talk about activities and personal interests.</p> <p>2. Review of R93's Resident Face Sheet located in the Resident tab, of the EMR revealed she was admitted to the facility on [DATE] with diagnosis to include but not limited to unspecified dementia, peripheral vascular disease, and osteoarthritis.</p> <p>Review of R93's annual MDS with an (ARD) of 01/01/25 and located in the Resident Assessment Instrument (RAI) tab of the EMR, revealed she scored 13 of 15 on the BIMS which indicated she was cognitively intact. The MDS did not indicate a staff assessment of her daily activity preferences.</p> <p>Review of R93's Care Plan dated 10/06/23 and located in the RAI tab of the EMR, revealed her activity preferences were attending group activities of her choice that included bingo, trivia, movies, nail/hair care, socials, talking with peers, and independent catholic studies. The care plan indicated staff would invite and encourage her to attend her favorite activities. Activity attendance logs of participation were requested but were not provided during the survey.</p> <p>During an interview with R93 on 01/29/25 at 11:23 AM, she stated they don't have activities here because no one invites me to anything. R93 stated she enjoyed the activities when she was first admitted to the facility, but it had been a long time since she had talked to anyone about things to do around here.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of R137's Resident Face Sheet located in the Resident tab, of the EMR revealed she was admitted to the facility on [DATE] with diagnosis to include but not limited to unspecified dementia, depression, and anxiety disorder.</p> <p>Review of R137's quarterly MDS with an ARD of 11/24/24 and located in the Resident Assessment Instrument (RAI) tab of the EMR, revealed she scored 11 of 15 on the Brief Interview for Mental Status (BIMS) which suggested she was cognitively intact. The MDS did not indicate a staff assessment of her daily activity preferences.</p> <p>Review of R137's Care Plan dated 09/09/24 and located in the RAI tab of the EMR, revealed her activity preferences were attending two group activities of her choice The care plan also indicated staff would invite and encourage her to attend her favorite activities and would talk with her to record her prior level of activity involvement and interests. Activity attendance logs of participation were requested but were not provided during the survey.</p> <p>During an interview with R137 on 01/29/25 at 11:49 AM, she stated she did not know of any activities in the facility. She said more than anything, she would love to go outside for some fresh air.</p> <p>During an interview with the Administrator on 01/29/25 at 10:32 AM, she stated her activity director resigned on 01/13/25 and she had not yet found another qualified activity director for the facility. She said the Certified Nursing Assistants (CNA) were helping out the activity assistant (AA) with the activity program, but she could not provide a current activity calendar or documentation of resident attendance and participation logs for the six months prior to the survey.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observation, interview, and record review, the facility failed to provide range of motion treatment to one of one residents (Resident (R) 65) reviewed for range of motion out of a total sample of 33 residents creating the potential for decline.</p> <p>Findings include:</p> <p>Review of the Face Sheet, located under the Profile tab in the electronic medical record (EMR) revealed R65 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis (muscle weakness/paralysis) following cerebral infarction (stroke) affecting the left dominant side, depression, and anxiety disorder.</p> <p>Review of the significant change Minimum Data Set (MDS), located under the Resident Assessment Instrument (RAI) tab in the EMR with an Assessment Reference Date (ARD) of 11/05/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R65 was cognitively intact. Neither the admission MDS with an ARD of 09/05/24 nor the significant change MDS with an ARD of 11/05/24 noted that R65 received any physical therapy, occupational therapy, or range of motion on the assessment.</p> <p>Review of the Care Plan, located under the RAI tab in the EMR, updated 11/12/24, revealed Resident requires assist per staff with ADLs [activities of daily living] and mobility with ability to actively participate post CVA [cerebral vascular accident]. Mobility status will improve as evidenced by increased independence and mobility participation this review period. Allow resident time to complete tasks. Transfer assist per staff x [times] 1 with gait belt. and I have Hemiplegia/Hemiparesis Stroke affecting left dominant side. I will maintain optimal status</p> <p>and quality of life within limitations imposed by Hemiplegia/Hemiparesis (specify) through review date. Reposition/Ambulate as tolerated and at least every 2 hours.</p> <p>During an observation and interview on 01/28/25 at 10:31 AM, R65 stated, The worst thing is I don't have any insurance, I get told we can't offer that and we're working on it. I would like therapy, but they won't give it to me because I'm Medicaid pending. I want to get stronger so I can move back with my husband. I'm too young to be here. R65 said her financial status has been pending since she was admitted .</p> <p>During an interview on 01/29/25 at 11:20 AM, the Business Office Manager (BOM) stated, It can take a very long time for Medicaid.</p> <p>During an interview on 01/29/25 at 4:01 PM, the Restorative Aide (RA) stated, (R65) does not receive restorative treatment. If a resident is Medicaid pending, the facility can pay for an evaluation by the therapist and then we can have a plan to follow. R65 had no such evaluation or restorative plan. The RA said, She would have range of motion with the nursing assistants and there's an exercise class in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/30/25 at 4:20 PM, the Administrator stated, We provide whatever they need, it doesn't matter what the payment source is. The Administrator did not state why services had not been provided to R65 while she awaited her Medicaid status. When asked for a policy to address provision of services during a pending financial status, the Administrator stated, We don't have a policy for that.</p>		

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599</b></p> <p>Based on observation, interview, and record review, the facility failed to provide counseling due to no payor source for two of six residents (Resident (R) 65 and R113) sampled for mental and psychosocial health out of a total sample of 33 residents. R65 was not provided counseling when suicidal ideations were expressed and R113 was not provided supportive services following the unexpected death of her husband who was her roommate in the facility due to being Medicaid pending. The failure to provide counseling resulted in psychosocial harm to both R65 and R113.</p> <p>Findings include:</p> <p>1. Review of the Face Sheet, located under the Profile tab in the electronic medical record (EMR), revealed R65 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis (muscle weakness/paralysis) following cerebral infarction (stroke) affecting the left dominant side, depression, and anxiety disorder.</p> <p>Review of the significant change Minimum Data Set (MDS), located under the RAI tab in the EMR, with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R65 was cognitively intact.</p> <p>Review of the Care Plan, located under the RAI tab in the EMR, updated [DATE], revealed that R65 was prescribed an antidepressant every day. The goal was noted as to be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Approaches were listed as Monitor/document/report to MD [physician] prn [as needed] ongoing s/sx [signs/symptoms] of depression unaltered by antidepressant meds [medications]: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance.</p> <p>Review of the Clinical Physician Orders, located under the Orders tab in the EMR revealed R65 was prescribed Zoloft 200 mg (milligrams), on [DATE], for depression; and Bupropion HCl ER(XL) tablet extended release 24 Hour 150 mg, on [DATE], for depression.</p> <p>Review of the Nursing Notes located under the Progress Notes tab in the EMR revealed R65 was transferred to the hospital on [DATE] for statements of wanting to die; on [DATE] for suicidal post home visit; and on [DATE] for suicide ideals, after calling the suicide hotline for help.</p> <p>During an observation and interview on [DATE] at 10:31 AM, R65 stated, The worst thing is I don't have any insurance, I get told we can't offer that [counseling] and we're working on it, because I'm Medicaid pending. I have depression, they don't understand, they just say oh well, you have meds. When asked did the Social Service staff provide services, R65 stated, the facility Social Worker [SW] doesn't talk with me, doesn't know what to do about it, she's not equipped.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Psychiatric Notes located under the Miscellaneous tab in the EMR revealed an initial psychiatric encounter on [DATE] which noted a medication reconciliation and follow up for medication management. The [DATE] note read seen for medication management. On [DATE], R65 was seen for follow up medication management, reports I don't want to be here, no changes to medications, staff to call 911 in case of emergency if patient is in imminent danger to self or others. No further psychiatric notes were located addressing the [DATE], [DATE], or [DATE] hospital visits.</p> <p>Further review of the Care Plan for antidepressant use revealed no new interventions added after R65's verbalizations of suicidal thoughts.</p> <p>During an interview on [DATE] at 3:47 PM, the Social Service Designee (SSDE) stated, [R65] gets upset a lot, once Medicaid kicks in she can have a counselor. We'll find someone that she can go see. When asked what medically related social services were being provided to R65 while in a pending financial situation, the SSDE said, I talk to her every day, but I'm not a counselor. When asked if she monitored the specified signs/symptoms identified on R65's care plan and if there was documentation to show the monitoring and/or interventions provided, the SSDE stated, I guess not.</p> <p>During an interview on [DATE] at 4:20 PM, the Administrator stated, We provide whatever they need, it doesn't matter what the payment source is. The Administrator did not state why medically related social services had not been provided to R65 while she awaited her Medicaid status. When asked for a policy to address provision of services during a pending financial status, the Administrator stated, We don't have a policy for that.</p> <p>28306</p> <p>2. Review of R113's undated Face Sheet located under the Profile tab in the EMR revealed R113 was admitted to the facility on [DATE] with the diagnosis of atrial fibrillation and glaucoma.</p> <p>Review of R113's quarterly MDS located under the MDS tab in the EMR with an ARD of [DATE] revealed R133 was coded as having a BIMS score of 15 out of 15 indicating that R113 was cognitively intact.</p> <p>During an interview on [DATE] at 2:35 PM, R113 stated, My husband got sick after he ate nachos and some dip with beans in it last Wednesday night. He started coughing and got sick. They gave him something for nausea and he went to sleep. I heard him sound kind of funny and I called the staff. The nurse came in and told me he was barely breathing and called 911. 911 came and started CPR [Cardiopulmonary Resuscitation] and he did not make it. He was my life. And now he is gone. I do not want to live anymore. I pray that I will die in my sleep each night. R113 was asked if anyone had come into to talk to her about the grieving process or have the Psychiatrist and or Psychologist talk to her since her husband had passed. The resident stated, No. Asked if the MD (Medical Doctor) or the NP (Nurse Practitioner) had come to see her since her husband had passed and she stated, No one has come in. The social worker came in briefly and talked to me about clothes for my husband to be laid in and if I wanted to have him cremated or not. Other than that, no one has talked to me. While speaking with R113, the resident was crying, appeared anxious and visibly upset and stated, I was this close to him, and I couldn't do anything to help him.</p> <p>Review of R113's Care Plan located under the Care Plan tab in the EMR revealed no documentation of a care plan for grieving the loss of R113's husband.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Stonebridge Maryland Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 2963 Doddridge Avenue Maryland Heights, MO 63043	
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F 0745  Level of Harm - Actual harm  Residents Affected - Few	<p>During an interview on [DATE] at 9:40 AM, the Assistant Director of Nursing (ADON)1 stated, I go in and make rounds and ask her [R113] if she [R113] is doing ok, is there anything I can do for her, then she will become tearful. I have asked her [R113] if she wants me to reach out to psych [Psychiatrist] to get her an antidepressant. [R113] told me that she was already on antidepressant and did not want another one. I really don't chart that part. ADON1 was asked why she does not chart it, and ADON1 stated, It slipped my mind, I get busy with my managerial duties but if the resident has unusual behaviors, then I will document that.</p> <p>During an interview on [DATE] at 1:30 PM, the surveyor shared with the Social Services Designee (SSDE) of R113 stating on [DATE] that she (R113) does not want to live without her husband, and she prays nightly that she wants to die in her sleep. The SSDE stated, I am not a counselor, I just go in and ask her how she is doing and visit with her. Asked if R113 had been referred to counseling, psychiatrist, or psychologist services for the grieving of the loss of R113's husband and the SSDE stated, She [R113] hasn't been referred yet. Her [R113's] Medicaid is not approved yet and I do not know if they have heard anything yet or not. I can't schedule a consultation until the Medicaid is approved.</p> <p>During an interview on [DATE] at 2:22 PM, the Social Services Director (SSD) was asked how she monitors the SSDE's job performance. The SSD stated, I usually check to make sure her documentation is what she is doing. The SSD was notified of R113 losing her husband that was her (R113's) roommate in the facility. R113 has verbalized that she does not want to live anymore, and she (R113) prays nightly that she wants to die in her sleep. The SSD stated, I didn't know that.</p> <p>During an interview on [DATE] at 5:00 PM, the Administrator was notified of R113 stating she does not want to live anymore, and she (R113) prays nightly that she wants to die in her sleep. The Administrator was asked if a consultation to either counseling services or to the psychiatrist/psychologist could be made for R113 even though the resident does not have Medicaid approved yet. The Administrator stated, Most certainly we can make these consults [consultations] if the resident is in need of them. We do not have to wait until her [R113's] Medicaid is approved to do that. The Administrator was notified of no consultations had been made thus far since R113's husband passed away on [DATE] or R113 not having a care plan addressing grief and the loss of R113's husband on [DATE].</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on record review, staff interview, and facility document review, the facility failed to monitor targeted behaviors for one of six residents (Resident (R)133) reviewed for psychotropic medication out of a total sample of 33 residents. This failure had the potential for R133 to receive medications unnecessarily.</p> <p>Findings include:</p> <p>Review of R133's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R133 was admitted to the facility on [DATE] with the diagnosis of vascular dementia, and hallucinations.</p> <p>Review of R133's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 12/19/24 revealed R133 had been coded as receiving an antipsychotic and antidepressant medications while in the facility.</p> <p>Review of R133's Physician Orders located under the Orders tab in the EMR revealed an order dated 10/23/24 for Seroquel (an antipsychotic) 75 mg (Milligram) by mouth two times a day for unspecified dementia with psychotic disturbance, and an order dated 09/25/24 for Sertraline (antidepressant) 25 mg by mouth one time a day for depression.</p> <p>Review of R133's Care Plan located under the Care Plan tab in the EMR revealed on 12/23/24 R133 was care planned for the use of a psychotropic medication, Seroquel for vascular dementia. The interventions were: 1 Administer medications as orders. Monitor/document for side effects and effectiveness. 2 Discuss with MD [medical doctor] and family for ongoing need for the use of the medication. 3 I have behaviors of: I pick at my skin and will scratch it, I get agitated and will start yelling or hitting at staff, I have periods of hallucinations, and refusing care .</p> <p>Review of R133's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated December 2024 and January 2025, revealed no targeted behaviors documented for R133.</p> <p>During an interview on 01/30/25 at 10:29 AM, Licensed Practical Nurse (LPN)1 reviewed the EMR and stated, I don't see any behaviors documented in her [R133] chart.</p> <p>During an interview on 01/30/25 at 10:49 AM, Minimum Data Set Coordinator (MDSC)2 reviewed R133's EMR then stated, I don't see any behaviors documented.</p> <p>Review of the facility's policy Behavioral Assessment, Intervention and Monitoring provided by the facility, dated November 2016, stated, .When medications are prescribed for behavioral symptoms, documentation will include .Specific target behavioral and expected outcomes .Monitoring for efficacy and adverse consequences .</p> <p>(continued on next page)</p>		

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F 0758  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of the facility's policy Antipsychotic Medication Use, provided by the facility and dated December 2016 stated, .The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications .		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39857</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of five errors occurred out of 33 opportunities for error due to residents not receiving their medications that were ordered and one medication not being the ordered strength, for one resident (Resident (R)50) of five residents observed for medication administration. The facility medication error rate was 15.15%. This failure had the potential to affect the accurate dosing of medication administered to the residents.</p> <p>Findings include:</p> <p>During medication administration observation on 01/29/25 at 8:37AM, Certified Medical Technician (CMT)3, administered/applied a four percent lidocaine patch to R50's right knee.</p> <p>Review of R50's Physician Orders dated May 31, 2024, in the electronic medical record (EMR) under the Orders tab indicated the physician's order was for a five percent lidocaine patch to R50's right knee.</p> <p>Further review of the Physician's Orders revealed physician orders for Fexofenadine HCl Tablet 60 MG BID (twice a day), Spironolactone 25mg QD (every day), Artificial Tears 1.4% 1 drop both eyes TID (three times a day), and Gabapentin 100mg TID (three times a day), all were due during the morning medication administration, but not given. These medications were initialed and signed off as given.</p> <p>Review of R50's Progress Notes dated 01/29/25 in the (EMR) under the Progress Notes tab, revealed no notes indicating a change in the strength of the lidocaine patch or the omission of above medications.</p> <p>Interview on 01/29/25 at 3:00 PM, CMT3 was asked about the five percent lidocaine patch, she stated the insurance won't pay for the five percent lidocaine patches, so they use the four percent patches. When CMT3 was asked about the medications Fexofenadine HCl Tablet 60 MG BID, Spironolactone 25mg QD, Artificial Tears 1.4% 1 drop both eyes TID, and Gabapentin 100mg TID, not being given, she stated I guess it slipped my mind, until later. I did let the Director of Nurses [DON] know about my error.</p> <p>Interview on 01/29/25 at 4:15 PM, the DON was asked about CMT3 using four percent lidocaine patches instead of five percent lidocaine patches, she stated Well I heard about that this morning, I'm not sure why the correct patches weren't ordered, probably just a simple mistake. She was asked about the medications CMT3 did not give during the morning medication pass, she stated I also heard about that this morning, CMT3 overlooked those medications, but was too nervous to say anything once she realized her mistake.</p> <p>Review of the facility policy Administering Medications undated, stated, The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document appropriately in the clinical chart .</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observations, interview, and facility policy review, the facility failed to ensure menus were followed and food preferences were honored for four residents (Resident (R)5, R65, R56, and R107) reviewed out of a total sample of 33 residents. The failure placed 140 of the 142 residents in the facility at risk of nutritional problems and dissatisfaction with their meals.</p> <p>Findings include:</p> <p>Review of the facility policy dated October 2017 titled Menus indicated the menus would be followed and provide a variety of foods and be approved by the Registered Dietitian (RD).</p> <p>Review of the facility policy dated October 2017 titled Food and Nutrition Services Staffing indicates the facility must take into consideration the preferences of each individual.</p> <p>Review of the week one menu provided to the survey team indicated that on 01/27/25 the lunch meal would be spaghetti with meat sauce, Italian tossed salad, brownie, and breadstick. An observation of the meal at 11:55 AM revealed the resident received peas and carrots in place of the salad, a slice of white bread in place of the bread stick and oranges in place of the brownie.</p> <p>Review of the week one dinner menu for 01/27/25 indicated that the residents would receive Beef and Bean Burrito with cheese sauce, Fiesta corn salad and fruit salad. An observation of the dinner meal at 5:45 PM revealed the residents received chicken tenders, peas and carrots, French fries, and animal crackers.</p> <p>1. Review of the Face Sheet, located under the Profile tab in the electronic medical record (EMR) revealed R5 was initially admitted on [DATE] with diagnoses that included anxiety disorder, chronic pain, and cerebral infarction.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R5 was cognitively intact.</p> <p>During an observation and interview on 01/27/25 at 1:08 PM, R5 had just received her lunch. R5 stated, I eat all my meals in my room. I'm more comfortable here. Observation of R5's diet card noted the resident disliked pork and was to receive juice with each meal. R5 stated, I don't dislike pork, I really enjoy pork, I just don't like pork breakfast sausages or patties. I've tried to get that changed but can't. I gave up. What I really want them to put on is coffee with breakfast. I ask every day, and they tell me they didn't send any up. Seems like it's been going on for [AGE] years. My kids bring me coffee sometimes in the evening when they visit so I make it last for a few days.</p> <p>R5's breakfast trays were observed on the following dates:</p> <p>01/28/25 at 9:59 AM, no coffee served</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/29/25 at 10:11 AM, no coffee served, received two pork breakfast patties that R5 did not eat</p> <p>01/30/25 at 10:02 AM, coffee was provided after asking the Certified Nursing Assistant (CNA2)</p> <p>During an interview on 01/28/25 at 10:05 AM, CNA5 stated, They don't usually send [R5] coffee. I can't always go get it.</p> <p>During an interview on 01/29/25 at 10:29 AM, R5 stated she did not get coffee again and was drinking leftover coffee her family brought her two days ago.</p> <p>2. Review of the Face Sheet, located under the Profile tab in the EMR revealed R65 was admitted on [DATE] with diagnoses that included myocardial infarction type 2, hemiparesis and hemiplegia following cerebral infarction affecting the left dominant side, and diabetes mellitus.</p> <p>Review of the significant change MDS, located under the RAI tab in the EMR, with and ARD of 11/05/24 revealed a BIMS of 15 out of 15 which indicated R65 was cognitively intact.</p> <p>During an interview on 01/28/25 at 9:59 AM, R65 stated there was no coffee served to her.</p> <p>During an observation and interview on 01/28/25 at 10:31 AM, R65 stated, The food is terrible, tastes terrible, it's not food for a young person, they serve hot dogs a lot on white bread, no ketchup or mustard, just dry, always serve the same thing.</p> <p>3. During an interview on 01/28/25 at 10:12 AM, R56 stated that it was impossible to get coffee when requested. She stated they only have one pot in the dining room, and it runs out all the time and there is not anyone to make more. R56 stated she now keeps coffee in her room because that is the only way to get any.</p> <p>During a continued interview on 01/28/25 at 10:12 AM, R56 stated that the meals never match the menus and there is never an alternative to choose from. R56 stated that they were served chicken strips at dinner which was not even close to the menu posted. R56 stated that they received peas and carrots twice in one day and they are often served leftover food.</p> <p>4. During an interview on 01/28/25 at 10:49 AM, R107 stated that they are given a flat piece of bread for a hot dog bun. R107 stated that they also never get condiments like mustard, ketchup, and relish. R107 stated he has never received butter or jelly with his meals and when he asks, he is told they do not have them. R107 stated that it makes him feel like a child and becomes very frustrating.</p> <p>During an interview on 01/29/25 at 1:40 PM, the Dietary Manager (DM) stated that staff are not supposed to change the menu without telling the residents. The DM had no explanation as to why the correct menu was not served.</p> <p>During an interview on 01/29/25 at 1:55 PM, the RD stated that staff should not be changing the menu. The RD stated that staff should be planning the menu far enough ahead so that they would know they can make the menu and get any approval for appropriate substitutions.</p> <p>MO00244432</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>MO00245053</p> <p>MO00246536</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39411</p> <p>Based on observation, interview, and review of the Dietary Manager's (DM) job description, the facility failed to provide palatable meals for four of four residents (Residents (R) 56, R9, R54, and R107) who complained their meals were not appetizing out of a total sample of 33 residents. This failure increased the risk of residents not being satisfied with their meals.</p> <p>Findings include:</p> <p>During an interview on [DATE] at 11:48 AM R56 stated that the food was horrible. R56 stated that she keeps food in her room so she can have something to eat when the meal tastes bad.</p> <p>The meal observation on [DATE] at 5:10 PM revealed patty melt, French fries, vegetable soup, chicken dumpling soup and a mixed fruit cup was served to residents.</p> <p>During an observation on [DATE] at 5:55 PM, R9 was observed licking the bread. R9 stated that she could not eat the sandwich because the bread was tough and soggy. R9 was observed to drink the soup and leave the table without finishing the meal.</p> <p>During an observation on [DATE] at 6:10 PM, R54 was observed throwing his sandwich off his plate. R54 was observed to eat a few French fries and leave the table. When asked why he did not eat his meal he responded that the meal tasted bad so why bother to eat it?</p> <p>During an interview on [DATE] at 6:15 PM, R107 stated the meal could not be eaten. R107 stated the bread, and the meat was tough, and the bread was soggy. R107 stated that even the alternate which was grilled cheese was not worth ordering because it was the same soggy bread with cheese.</p> <p>A test tray was requested on [DATE] at 1:03 PM. The menu listed the lunch as baked ham, scalloped potatoes, candied carrots, pie of the day, dinner roll with margarine. The Dietary Manager (DM) verified the temperature of the items on the plate. The temperature of the ham was 80 degrees Fahrenheit (F), the temperature of the potatoes was 85 degrees F, and the temperature of the carrots was 81 degrees F. There was no dinner roll and no pie with the meal. Upon sampling the food items the ham was dry and could not be chewed easily, the carrots had no seasoning and no glaze, and the potatoes were dry. The DM could not explain why there was no seasoning, or any margarine provided with the meal. The DM stated that they have condiments in the kitchen and did not know why the meal tray did not have any condiments.</p> <p>A review of the DM Job Description dated [DATE] indicated that the DM was responsible to inspect the meals to ensure the meals meet the standards for appearance, and palatability.</p> <p>MO00244432</p> <p>MO00245053</p> <p>MO00246536</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39411</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure food stored in the main kitchen was labeled, dated, and disposed upon expiration. These failures had the potential to increase the prevalence and spread of foodborne illnesses for 140 of the 142 facility residents.</p> <p>Findings include:</p> <p>Review of the facility policy dated September 2022 titled Food Safety Requirements indicated the facility should label, date, and monitor refrigerated food so it is used by its use-by-date. Open foods should be covered or in tight sealed containers.</p> <p>During an observation of the kitchen on 01/27/25 at 10:00 AM the following opened items were observed and verified by the Dietary Manager (DM) in the kitchen reach-in refrigerator:</p> <p>One container of unidentified white sauce with no label or date or discard date.</p> <p>One quart of Thick and Easy orange juice with no date. Instructions on the bottle indicated the product was to be used within 10 days of opening.</p> <p>Opened package of hot dogs with no date. The package was opened and left uncovered.</p> <p>An opened gallon of milk with no open or use by date</p> <p>One bag of thawed Harvest blend mixed vegetable with no date.</p> <p>One bag of Oriental blend mixed vegetables with no date.</p> <p>A bag of six hard boiled eggs with no date.</p> <p>A whole ham in plastic bag with no date.</p> <p>A plastic bag of sliced ham with no date.</p> <p>A gallon jar of sweet pickle relish with no open date or use by date.</p> <p>A plastic bag of lunch meat with no date.</p> <p>Twenty-three cartons of milk with an expiration date of 01/23/25.</p> <p>An observation of the kitchen walk-in refrigerator revealed 32 cartons of milk with an expiration date of 01/26/25.</p> <p>(continued on next page)</p>		

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	During an interview with the DM on 01/27/25 at 10:33 AM she stated that the weekend staff should have been responsible for labeling and making sure there were no outdated items in the refrigerators. The DM stated she expects all dietary staff to be aware of the food storage policy and follow it.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Stonebridge Maryland Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on observation, record review, and interview, the facility failed to follow infection control guidelines during a wound care observation for one of three residents (Resident (R)1) reviewed for wounds out of 33 sampled residents. This failure had the potential for infections to be spread to vulnerable residents in a high-risk population.</p> <p>Findings include:</p> <p>Review of R1's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus, and congestive heart failure.</p> <p>Review of R1's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 12/01/24 revealed one stage four and one unstageable pressure ulcer.</p> <p>Review of R1's Care Plan located under the Care Plan tab in the EMR and dated 09/04/24 with a focus of wound management. Interventions were If drainage present, obtain order for a culture. Measure ulcer on at regular intervals [sic]. Provide wound care per [by] treatment order. [Name of Wound Care Company] physician eval [evaluate] and treat.</p> <p>Review of R1's Physician Orders located under the Orders tab in the EMR revealed orders dated 01/29/25 which stated, Calcium Alginate .Apply to left heel topically every day shift for pressure ulcer [sic] cleanse left heel with wound cleanser, allow to dry, apply calcium alginate [sic], cover with gauze, wrap with Kerlix, secure tape daily and as needed [sic] . and Calcium Alginate .Apply to right hip topically every day shift for pressure ulcer Cleanse right hip with wound cleanser, apply calcium alginate, cover with a bordered gauze daily and as needed [sic] .</p> <p>During a wound care observation on 01/29/25 at 3:00 PM, the following failures were observed while the Wound Care Nurse (WCN) was performing the wound care to R1: 1) The WCN cleaned the scissors and the overbed table without using gloves. 2) The resident was on Enhanced Barrier Precautions and the WCN did not wear a gown while performing wound care to R1. 3) The left heel bandage was removed, and the heel was placed directly on the bed without using a barrier to place the heel on. 4) The WCN sprayed wound cleanser to the left heel and then patted the wound with a clean 4x4 gauze then folded the gauze and patted the wound bed again with the same 4x4 gauze.</p> <p>During an interview on 01/29/25 at 3:20 PM, the WCN was asked about the above documented failures during the wound care observation, and the WCN became denied the infection control breaches that the surveyor observed during the wound care observation.</p> <p>During an interview on 01/29/25 at 3:25 PM, the Director of Nursing stated, The nurse is to wear a gown when performing wound care because the resident is on Enhanced Barrier Precautions. The nurse wears gloves when cleaning the over bed table and her scissors. The nurse is to clean the wound bed with one 4x4 then discard and repeat with a new clean gauze. And a barrier is to be used on the bed to place the resident's heel on while performing the wound care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265486	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Stonebridge Maryland Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 2963 Doddridge Avenue Maryland Heights, MO 63043	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>36917</p> <p>Based on interview, record review, and policy review, the facility failed to monitor the use of antibiotics for three of three residents (Resident (R)86, R81, and R102) reviewed for antibiotic stewardship of a total sample of 33 residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Infection Prevention and Control Program [IPCP], revised 11/2024, revealed . Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program .</p> <p>During an interview on 01/29/25 at 3:55 PM, the Infection Preventionist (IP) was asked to provide the facility's documentation of the antibiotic stewardship program from 01/01/24 through 12/31/24. The IP provided documentation dated 07/01/24 through 12/31/24. The IP confirmed that when she began as the IP, she was provided the facility's Infection Control Log and confirmed the log did not contain the required start and end date of the administered antibiotics, or the met/not met criteria for administration. The IP confirmed antibiotic usage should be tracked with use and outcome criteria applied. She also stated she was aware that numerous residents did not meet the criteria for antibiotic usage and that she had discussed the issue with the facility medical director. She could not provide documentation of her report of discussion with the medical director.</p> <p>During an interview on 01/29/25 at 4:40 PM, the Corporate Nurse stated she could not provide documentation that supported adherence to their antibiotic stewardship policy for Resident (R)81, R86, and R102. Infection surveillance checklists (MGeers Criteria) were provided for R86, R81, and R102 but were incomplete.</p>		