STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265553	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Marble Hill	702 Highway 34 West Marble Hill, MO 63764

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on interview and record review, the facility failed to allow one resident (Resident #1) to return to the facility after being sent out to the hospital for an evaluation. The facility census was 76 residents. Review of the facility's policy titled, Bed Holds, dated March 2022, showed: - When emergency transfers are necessary, the facility will provide the resident or representative with information concerning our bed-hold policy within 24 hours of such transfer; - If the facility determines that a resident who was transferred cannot return to the facility, the facility will comply with the facility's Discharge Policy. Review of the facility's policy titled, Transfers and Discharges (Including Against Medical Advice (AMA), dated September 2022, showed: - If a Notice of Discharge is given the facility will send a copy of transfer or discharge notice to the Ombudsman. The facility will also provide to the resident and/or resident representative additional information in the notice regarding the process for appealing transfer or discharge; - If the facility has made the decision that a resident cannot return to the facility following a hospital discharge the facility must discharge the resident according to the policy. The medical record should show documentation of the reason the resident cannot return to the facility. A discharge notice must be presented to the resident or resident's representative in the case that a resident is not returning to the facility as decided by the facility; - Provide the resident with a statement of the right to appeal the action to the state agency designated for such appeals, along with the name, address and phone number of the State long term care ombudsman; - For developmentally disabled individuals the appeal rights notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled; - The physician should document medical reasons for transfer or discharge in the medical record. A copy of the physician's order for discharge should be attached to the discharge notice. (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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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's medical record showed: - admitted [DATE]; - Diagnoses of spina bifida occulta (a gap formed in the spine at birth), pressure ulcer of the sacral region (a wound caused from limited mobility to the spine that connects to the pelvis), colostomy (when the colon is diverted through the abdomen), dysphagia (difficulty swallowing), schizophrenia (a chronic mental illness that affects a person's thoughts, feelings and behaviors), bipolar disorder (extreme mood swings, along with changes in thinking and behavior), type 2 diabetes mellitus (a chronic disease when the body doesn't produce enough insulin or use it properly), attention-deficit hyperactivity disorder (a chronic mental disorder that affects a person's behavior and ability to focus and control impulses), anxiety (excessive fear, dread, or uneasiness), and depression (persistent low mood and loss of interest); - Resident is his/her own responsible party; - An entry on the resident's Electric Medical Record (EMR) assessments page, dated 09/26/24, for the completion of a transfer form for discharge to the hospital; - No official discharge notice to the resident or resident's representative. Review of the resident's Preadmission Screening and Resident Review (PASARR - an evaluation guided by federal regulations that require all individuals being considered for admission to a Medicaid-certified nursing facility (NF) be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition) Level I screening, dated 11/15/23, showed: - The resident with a diagnosis of spina bifida and schizophrenia that would qualify as a related condition; - A PASRR Level II screening was indicated for intellectual disability or related condition. Review of resident's Level II PASARR dated, 11-21-23, showed resident had auditory hallucinations, schizophrenia, psychotic disorder, anxiety disorder, MDD, personality disorder, adjustment disorder, bi-polar disorder, obsessive-compulsive disorder, spina bifida, hydrocephalus, paraplegia, suicidal ideations; - The PASRR Level II Evaluation, dated 11/30/23, showed the residents' needs could be met in a nursing facility. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 09/26/24, showed: -Resident was discharged with return anticipated; - Able to make consistent and reliable decisions independently. Review of the resident's nurse's note, dated 09/26/24, at 4:07 A.M., showed: (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident was returned from the hospital at approximately 9:00 P.M., on 09/25/24, via ambulance; - The resident complained of chest pain. Vital signs obtained; - The resident was able to answer questions appropriately but then began to switch the conversation to family deaths and his/her role in them; - The resident said he/she was going to do something stupid and requested to go to the hospital; - The on-call provider was contacted and order obtained to send the resident to the hospital for a thorough psychiatric evaluation and treatment; - Emergency Medical Services (EMS) arrived and departed facility with resident en route to the emergency room (ER). Review of the resident's hospital records, dated 09/26/24, showed: - On 09/26/24, the resident was seen by a telepsychiatry physician; - On 09/26/24, the psychiatrist recommendations were for medication adjustments and supportive psychotherapy (a variety of treatments that aim to help a person identify and change troubling emotions, thoughts, and behaviors); - On 09/26/24, the resident was cleared by psychiatry to return to the facility. The resident wanted to return to the facility; - On 09/26/24, the facility reported to the hospital staff they would not take the resident back until he/she has had an inpatient psychiatric stay with medication adjustments; - On 09/26/24, the hospital continued to search for placement. The resident was never admitted to the hospital, but remained in the ER; - On 10/08/224, the resident continued to be stable for discharge from the ER back to the facility; - On 10/09/24, the resident was accepted for admission to another skilled nursing facility from the ER; - The resident remained in the ER from 09/26/24 - 10/09/24, without admission to the hospital. During an interview on 10/08/24, at 10:20 A.M., the Director of Nursing (DON) said: - On the morning of 09/26/24, the resident complained of chest pain. The resident said he/she was going to do something stupid. The on-call provider was notified and the staff received an order to send the resident out for a psychiatric evaluation; - The facility did not discharge the resident, they were waiting for the resident to receive in-patient psychiatric services; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The medical director said the resident was not safe at the facility and the staff were not able to provide care to the resident. Therefore, they could not accept the resident back to the facility. Review of a letter from the facility's Medial Director, dated, 10/08/24, showed: - Based on the psychiatric evaluation, the staff at the facility would need to do 1:1 suicidal watch care for Resident #1, which the facility is not equipped or staffed to provide. After speaking with the DON and the Psychiatric Nurse Practitioner, the decision to not readmit the resident at this time was made for the resident's safety. It was advised that the resident be admitted to a behavioral psychiatric unit for acute care. During an interview on 10/08/24 at 11:35 A.M., the Registered Nurse Case Manager (RN CM) at the ER said: - The resident was brought into theER on the morning on 09/26/24; - The resident underwent a psychiatric evaluation on 09/26/24. The resident was deemed able to return to the facility with medication modifications; - The facility medical director refused to accept the resident back to the facility until the resident had an inpatient psychiatric stay with medication adjustments; - He/She sent over 50 referrals to other long-term care facilities and received 25 denials. Due to the medical complexities of the resident, in-patient psychiatric facilities were not equipped to manage the resident's medical needs; - The facility did not issue the resident a discharge notice and did not assist with finding placement; - The resident was not admitted to the hospital due to being medically stable. The resident had been in the ER for two weeks. During an interview on 10/15/24 at 2:21 P.M., the DON said she went to the ER and interviewed the resident. The resident said he/she didn't want to live in a facility anymore. The resident wanted to live on his/her own in an apartment. She said the resident still had a 1:1 sitter at the ER. She went to the ER to do an assessment, not to discharge the resident, but the resident was not better. The resident was still hearing voices. The DON said the facility did not issue a discharge notice at that time. During an interview on 10/15/24 at 2:30 P.M., the Administrator said the DON went to the ER and saw the resident on 10/09/24. The hospital found placement for the resident at another long-term care facility. The Administrator said the facility did not begin the discharge process at any time for Resident #1. No discharge process had been started, but the resident would not be allowed back to the facility without an in-patient psychiatric stay. MO00242905