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	09/13/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for transfer, for seven residents (Resident #8, #21, #31, #33, #35, #36, and #55) out of 10 sampled residents. The facility's census was 82. The facility did not provide a policy for transfer/discharge notification. 1. Review of Resident #8's medical record showed: - The resident transferred to the hospital on 03/06/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 03/16/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 03/27/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/18/24, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 03/06/24, 03/16/24, 03/27/24, and 07/18/24. 2. Review of Resident #21's medical record showed: - The resident transferred to the hospital on 03/14/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/08/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/22/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/27/24, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 03/14/24, 04/08/24, 04/22/24, and 05/27/24. 3. Review of Resident #31's medical record showed: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 08/30/24, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfer to the hospital on 08/30/24. 4. Review of Resident #33's medical record showed: - The resident transferred to the hospital on 10/03/23, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 10/26/23, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 11/14/23, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 10/03/23, 10/26/23, and 11/14/23. 5. Review of Resident #35's medical record showed: - The resident transferred to the hospital on 05/01/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/09/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/12/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/23/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/09/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 08/18/24, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 05/01/24, 05/09/24, 05/12/24, 05/23/24, 07/09/24, and 08/18/24. 6. Review of Resident #36's medical record showed: - The resident transferred to the hospital on 08/02/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 08/22/24, and readmitted to the facility on [DATE]; - No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 08/02/24 or 08/22/24. 7. Review of Resident #55's medical record showed: - The resident transferred to the hospital on 06/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/19/24, and readmitted to the facility on [DATE]; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of written notification provided to the resident and/or the resident's representative for the transfers to the hospital on 06/03/24 or 07/19/24. During an interview on 09/12/24 at 4:00 P.M., the Administrator said she would expect notice of a resident's transfer or discharge to the hospital to be given to the resident and/or the resident's representative in writing. She would also expect it to be documented in the resident's medical record that the notice was given to the resident or their representative. 49150 49152 49999

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of their bed hold policy at the time of transfer to the hospital for five residents (Resident #21, #31, #33, #36, and #55) out of 10 sampled residents. Facility census was 82. Review of the facility's policy titled, Bed Holds, dated March 2022, showed: - Upon admission and when a resident is transferred to hospitalization or for therapeutic leave, the facility will provide information regarding the bed-hold policy to the resident or representative in a written format that is understood by the resident or representative; - When emergency transfers are necessary, the facility will provide the resident or representative with information concerning the bed-hold policy within 24 hours of such transfer. 1. Review of Resident #21's medical record showed: - The resident transferred to the hospital on 03/14/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/08/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 04/22/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 05/27/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. 2. Review of Resident #31's medical record showed: - The resident transferred to the hospital on 08/30/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 3. Review of Resident #33's medical record showed: - The resident transferred to the hospital on 10/26/23, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfer. 4. Review of Resident #36's medical record showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident transferred to the hospital on 08/02/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 08/22/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. 5. Review of Resident #55's medical record showed: - The resident transferred to the hospital on 06/03/24, and readmitted to the facility on [DATE]; - The resident transferred to the hospital on 07/19/24, and readmitted to the facility on [DATE]; - No documentation the resident and/or the resident's representative was informed in writing of the facility's bed hold policy at the time of the transfers. During an interview on 09/12/24 at 4:00 P.M., the Administrator said she filled out the Bed Hold Notice form, mailed it to the resident's representative, and then made a note in the resident's chart. 49150 49152 49999

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49152 Based on interview and record review, the facility failed to develop and implement comprehensive care plans for two residents (Resident #33 and #35) out of 18 sampled residents. The facility's census was 82. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated October 2017, showed: - The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; - The care planning process will facilitate resident and/or representative involvement, include an assessment of the resident's strengths and needs, and incorporate the resident's personal and cultural preferences in developing the goals of care; - Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process; - Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change; - The IDT must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS - a federally mandated assessment to be completed by facility staff). 1. Review of Resident #33's medical record showed: - A diagnosis of Parkinsonism (a disease of the central nervous system that affects movement, often including tremors); - admitted to hospice for Parkinson's Disease on 11/08/23. Review of the resident's care plan, dated 09/09/24, showed Parkinsonism, including risks, goals, and interventions were not addressed. 2. Review of Resident #35's medical record showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A computed tomography (CT - a medical imaging scan used to obtain detailed internal images of the body) scan report, dated 06/02/22, showed a right-sided mediport (medical device put just below skin for access if blood needs drawn or intravenous medications need given) catheter; - No documentation for assessments of the mediport, an order to access the mediport, or and order/protocol to maintain the mediport. Review of resident's care plan, dated 08/04/24, showed the mediport, including risks, goals, and interventions were not addressed. Observation on 09/13/24 at 1:45 P.M. showed a right side upper chest mediport on Resident #35. The mediport had three small bumps for identification to access the mediport in the proper place. During an interview on 09/13/24 at 1:45 P.M., Resident #35 said he/she had a mediport because of poor veins and was a very hard person to stick for blood or intravenous (IV) access. He/She had the mediport for years. During an interview on 09/13/24 at 3:00 P.M., the DON and MDS Coordinator said the interdisciplinary team was in charge of developing the care plans. The DON and MDS Coordinator said that if a resident's condition changed, then the care plan would be revised. During an interview on 09/13/24 at 3:00 P.M., the Administrator said the interdisciplinary team was in charge of developing the care plans. The care plan should accurately reflect the resident's current condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47447 Based on observation, interview, and record review, the facility failed to have an order for and a process in place for accessing, maintaining, and assessing a mediport (medical device put just below skin for access if blood needs drawn or intravenous medications need given) for one resident (Resident #35) out of one sampled resident. The facility did not provide a policy on mediport care/maintenance. 1. Review of Resident #35's medical record showed: - A computed tomography (CT - a medical imaging scan used to obtain detailed internal images of the body) scan report, dated 06/02/22, showed a right-sided mediport catheter; - No order for the mediport; - No orders and/or protocols to access and maintain the mediport; - No documentation for assessments of the mediport. Review of resident's care plan, dated 08/04/24, showed the mediport, including risks, goals, and interventions, not addressed. Observation on 09/13/24 at 1:45 P.M. showed a right side upper chest mediport on Resident #35. The mediport had three small bumps for identification to access the mediport in the proper place. During an interview on 09/13/24 at 1:45 P.M., Resident #35 said staff accessed his/her mediport on 09/11/24, to draw lab work. He/She had the mediport for years because of poor veins and was a very hard person to stick for blood or intravenous (IV) access. Only one staff person knew how to access the mediport at the facility. During an interview on 09/13/24 at 2:00 P.M., the Director of Nursing (DON) said she was the only person in the facility who knew how to access and draw blood from Resident #35's mediport. She would expect there to be orders for the mediport and care/maintenance for the mediport. She would also expect assessments to be completed for the mediport.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47447 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent (%) or less. There were six errors out of 43 opportunities for errors, resulting in an error rate of 13.95%. This affected six residents (Resident #17, #20, #24, #33, #44 and #46), out of 10 sampled residents. The facility census was 82. The facility did not provide a policy for insulin pens. Review of Novolog (a rapid acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen (insulin in a pen-type device) manufacturer instructions, revised February 2023, showed: - Before each injection small amounts of air may collect in the cartridge during normal use, to avoid injecting air and to ensure proper dosing: remove the cap; attach the needle; prime the pen by turning the dose selector to select two units; press and hold the button and make sure a drop of insulin appears; select the dose; and give the injection. Review of Humalog (a fast acting insulin injected just below the skin) Kwik Pen (insulin in a pen-type device) manufacturer instructions, revised August 2023, showed: - Remove the cap; - Attach the needle; - Prime the pen before each injection. Priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin; - To prime the pen: turn the dose knob to select 2 units; push and hold the button and make sure a drop of insulin appears; - Select the dose; - Give the injection. Review of Fiasp (a rapid acting insulin injected just below the skin) Flextouch (insulin in a pen-type device) manufacturer instructions, dated July 2023, showed: - Remove the cap; - Check the liquid in the pen; - Attach the needle; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prime the pen. Prime the pen by turning the dose selector to select two units; press and hold the button and make sure a drop of insulin appears; - Select the dose; - Give the injection. 1. Review of Resident #17's Physician's Order Sheet (POS), dated September 2024, showed: - An order for Humalog Kwikpen inject six units subcutaneously ((an injection just beneath the skin) before meals, dated 09/04/24; - An order for Humalog Kwikpen inject per sliding scale (progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges) for a blood sugar of 351-400, give six units, dated 09/04/24. Observation of the resident on 09/12/24 at 10:45 A.M., showed: - The resident's blood sugar was 384; - Certified Medication Technician (CMT) A administered Humalog Kwikpen 12 units to the resident; - CMT A failed to prime the Humalog Kwikpen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 2. Review of Resident #46's POS, dated September 2024, showed an order for Novolog Flexpen inject per sliding scale for a blood sugar of 151-200, give two units, dated 05/01/24. Observation of the resident on 09/12/24 at 11:08 A.M., showed: - The resident's blood sugar was 162; - CMT A administered Novolog Flexpen two units to the resident; - CMT A failed to prime the Novolog Flexpen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 3. Review of Resident #20's Physician Order Sheet (POS), dated September 2024, showed: - An order for Novolog Flexpen inject 12 units subcutaneously before meals, dated 08/19/24; - An order for Novolog Flexpen inject per sliding scale for a blood sugar of 151-200, give two units, dated 08/19/24. Observation of the resident on 09/12/24 at 11:19 A.M., showed: - The resident's blood sugar was 185; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMT A administered Novolog Flexpen 14 units to the resident; - CMT A failed to prime the Novolog Flexpen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 4. Review of Resident #24's POS, dated September 2024, showed an order for Fiasp Flextouch Pen inject per sliding scale for a blood sugar of 181-220, give four units, dated 06/17/24. Observation of the resident on 09/12/24 at 11:27 A.M., showed: - The resident's blood sugar was 214; - CMT A administered Fiasp Flextouch Pen four units to the resident; - CMT A failed to prime the Fiasp Flextouch Pen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 5. Review of Resident #44's POS, dated September 2024, showed an order for Novolog Flexpen inject per sliding scale for a blood sugar of 150-199, give three units, dated 03/01/23. Observation of the resident on 09/12/24 at 11:41 A.M., showed: - The resident's blood sugar was 184; - CMT A administered Novolog Flexpen three units to the resident; - CMT A failed to prime the Novolog Flexpen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. 6. Review of Resident #33's POS dated, September 2024, showed an order for Novolog Flexpen inject per sliding scale for a blood sugar of 151-200, give two units, dated 10/31/23. Observation of the resident on 09/12/24 at 11:41 A.M., showed: - The resident's blood sugar was 155; - CMT A administered Novolog Flexpen two units to the resident; - CMT A failed to prime the Novolog Flexpen prior to the administration of the insulin to the resident per the manufacturer's instructions for use. During an interview on 09/12/24 at 11:50 A.M., CMT A said that he/she was not aware that insulin pens needed to be primed. During an interview on 09/12/24 at 4:30 P.M., the Administrator said she would expect the manufacturer's guidelines to be followed when administering insulin with an insulin pen.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 49999 Based on interview and record review, the facility failed to maintain an Infection Prevention and Control Program (IPCP) that included an antibiotic stewardship program. This deficient practice had the potential to affect all residents in the facility. The facility census was 82. Review of the facility's policy titled, Infection Prevention and Control Program, dated 2018, showed: - The facility's Infection Prevention and Control Program (IPCP) follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible; - The Infection Prevention and Control Program includes an antibiotic stewardship program. Review of the facility's policy titled, Infection Prevention and Control Manual Antibiotic Stewardship and Multidrug Resistant Organisms (MDROs), dated 2017, showed the Director of Nursing (DON) or designee will track antibiotic use and monitor adherence to evidence-based criteria. The facility did not provide documentation for the antibiotic stewardship program. During an interview on 09/10/24 at 9:30 A.M., the Administrator said the former DON/Infection Preventionist quit suddenly in August 2024, and he/she had been responsible for the antibiotic stewardship program. During an interview on 09/13/24 at 2:45 P.M., the DON said she was unable to find the antibiotic stewardship program documentation. The former DON quit suddenly and took all of the antibiotic stewardship program information.