STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 43327 Based on interview and record review, the facility staff failed to ensure six Nurse Aide's ((NA) NA A, NA B, NA C, NA D, NA E, and NA F) of eight completed the nurse aide training program within four months of his/her employment in the facility. The census was 56. 1. Review of the facility's policies showed the facility did not provide a policy for NA qualifications. 2. Review of NA D's personnel file showed a hire date of 04/06/22. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said this employee is 96% done with his/her classes. He/She said he/she is behind because he/she tried out another unit for three and half weeks before returning to nursing care. 3. Review of NA F's personnel file showed a hire date of 06/12/23. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said the employee is on step 93 of 120 steps of the on-line program. He/She said he/she is not sure why it has taken the NA over the required 120 day times frame to complete the classes. 4. Review of NA E's personnel file showed a hire date of 11/20/23. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said the employee is behind because he/she wanted to try out a different area for two weeks before returning to nursing work. 5. Review of NA C's personnel file showed a hire date of 01/18/24. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said the NA is done with the on-line classes and is waiting for his/her test to be scheduled. He/She said he/she had just finished the classes on-line. (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
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of NA A's personnel file showed a hire date of 02/21/24. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said the NA was hired as a NA then wasn't sure if he/she wanted to be in nursing and tried out a different area. He/She said they have since decided they do want to do nursing and are currently on step 85 of 120 on their on-line classes. 7. Review of NA B's personnel file showed a hire date of 04/05/24. Review showed the NA file did not contain documentation the NA completed the required nurse aide training program. During an interview on 09/17/24 at 1:04 P.M., the administrator said he/she is not sure where this employee is at in the program, but they are enrolled in it. He/She said he/she sets the employees up with the on-line program upon hire and he/she gets weekly reports for where they are at in the program. He/She is reponsible for monitoring where they are at in the program and responsible for ensuring they complete the program on time. He/She said the employees work at their own pace and that is sometimes harder to mange compared to when emploees were taught in the class room. He/She does not know why this employee has not completed the program. 8. During an interview on 09/17/24 at 10:26 A.M., the clinical supervisor said the administrator signs them up for the classes, ensures they have completed the program in the four months and keeps track of where they are in the program. During an interview on 09/17/24 at 1:04 P.M., the administrator said he/she is responsible for ensuring the new hires nurse aides complete the nurse aide training. He/She is aware new hires need to complete the nurse aide training within the 120 days from hire. He/She said they were having issues with the online classes not recognizing them as a site for the nurse aide hours. He/She said it is harder to ensure they complete the required hours through the on-line program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on observation, interview and record review, facility staff failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease (LD- a serious type of pneumonia (lung infection) caused by Legionella bacteria, which places all residents of the facility at risk of exposure which could lead to illness. Facility staff failed to implement an enhanced barrier precautions (EBP) system for one (Resident #33) of two sampled residents with wounds when facility staff failed to wear appropriate personal protective equipment (PPE) during high-contact care activities and place PPE in close proximity. The facility census was 56. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed: -The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains; -Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water; -CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the Centers for Disease Control and Prevention (CDC) and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html). Environmental, clinical, and epidemiological considerations for healthcare facilities are described in this toolkit; -Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities: -Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; -Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's Water Management Program, showed the program did not contain policies related to water management. Review showed the program did not contain control measures or corrective actions. Review of the facility's water management documentation showed four water heaters were identified as temperature permissive areas where Legionella could grow. Review showed two of the four water heaters were identified as not having recirculating pumps. Review showed the monitoring procedure for water heaters was weekly temperature checks. Review showed weekly water temperature check log sheets did not contain an acceptable range for water temperatures. Review showed the plan did not include a temperature range or corrective actions to address out of range water temperatures. During an interview on 09/19/24 at 9:30 A.M., the maintenance director said he/she and housekeeping staff are responsible for cleaning water fixtures and running water faucets weekly. The maintenance director said he/she checks water temperatures weekly. The maintenance director said he/she did not flush the four large water heaters. The maintenance director said he/she was not aware of any water management policies. During an interview on 09/19/24 at 1:15 P.M., the administrator said he/she and the maintenance director were responsible for the water management program. The administrator said there were not policies or an overall plan related to water management. The administrator said he/she did not know two of four water heaters did not have recirculating pumps. The administrator said if water temperatures were not high enough, water should not be used until the issue was corrected. The administrator said there was no policy to identify correct water temperature range, but water should be between 105 and 120 degrees Fahrneheit. 2. Review of the facility's EBP policy, dated September 2022, showed: -EBP refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO (Multi-drug resistant organism, bacteria resistant to antibiotics) as well as those that increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices); -Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require use of gown and gloves; -An order for EBP will be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; -Make gowns and gloves available immediately outside the resident's room; -High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheters), and wound care (any skin opening that requires a dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of Resident #33's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/19/24, showed staff assessed the resident as: -Impaired Cognition; -One unhealed stage III pressure (full-thickness tissue loss) wound; -Received pressure ulcer care to include a non-surgical dressing to the feet; -Diagnosis of diabetes, anemia (low iron) and dementia. Review of the Physician Order Sheet (POS), dated September 2024, showed an order on 08/22/24 to cleanse the left heel wound with wound cleanser, cover with a petroleum dressing, and followed by a border gauze pad daily. Observation on 09/16/24 at 11:29 A.M., showed a sign on the resident's door said EBP, wear gloves and gown for the following high-contact resident care activities: dressing, bathing, transferring, changing linens, personal hygiene, changing briefs and assisting with toileting, device care, urinary catheter care, wound care - any skin opening requires a dressing. PPE was not located outside the resident room. Observation on 09/16/24 at 1:30 P.M., showed Nurse Aide (NA) I and NA E transfered the resident to the bed from the wheelchair. NA I and NA E did not wear a gown during the transfer. A sign was located on the resident's door EBP, wear gloves and gown for the following high-contact resident care activities: dressing, bathing, transferring, changing linens, personal hygiene, changing briefs and assisting with toileting, device care, urinary catheter care, wound care - any skin opening that requires a dressing. PPE not located outside the resident room. Observation on 09/17/24 at 09:41 A.M., showed Registered Nurse (RN) L and Licensed Practical Nurse (LPN) K provided wound care to the resident and did not wear a gown. A sign was located on the resident's door, EBP, wear gloves and gown for the following high-contact resident care activities: dressing, bathing, transferring, changing linens, personal hygiene, changing briefs and assisting with toileting, device care, urinary catheter care, wound care - any skin opening that requires a dressing. PPE not located outside the resident room. Observation on 09/18/24 at 08:11 A.M., showed a sign on the resident's door read: EBP, wear gloves and gown for the following high-contact resident care activities dressing, bathing, transferring, changing linens, personal hygiene, changing briefs and assisting with toileting, device care, urinary catheter care, wound care - any skin opening that requires a dressing. PPE not located outside the resident room. 4. During an interview on 09/16/24 at 1:30 P.M., NA E said he/she does not use a gown when transferring this resident because he/she does not have an infection. NA E said the resident recently had Coronavirus disease (COVID-19) (a contagious disease caused by the SARS-Cov-2 virus) and the sign just wasn't removed yet. He/She said he/she was educated on EBP but they only have to use a gown when a resident has a catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265651	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Hermann	1800 Wein Street, Hermann, MO 65041

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/17/24 at 8:48 A.M., Nurse Aide (NA) I said staff do not use extra PPE when just transferring this resident. He/She said the resident does not need the extra PPE and there are not any residents in that room that require it. He/She said he/she was educated on EBP. During an interview on 09/17/24 at 9:41 A.M., RN L said EBP have not been implemented for all wounds yet, just residents with catheters. He/She said that if the resident has a draining wound, EBP would be implemented. The resident does not have a draining wound and does not need EBP at this time. During an interview on 09/18/24 at 8:21 A.M., the Infection Preventionist (IP) said he/she was aware the regulation was in effect but wanted to start slowly to get the staff used to it before implementing fully. An in-service has been conducted by the facility, the health department and the Quality Improvement Program of Missouri (QIPMO) nurse regarding EBP and should include the use of signs and PPE outside of the resident rooms. During an interview on 09/19/24 at 8:30 A.M., LPN K said residents with wounds and catheters should have EBP used during care because they are higher risk of having bacteria introduced through the staff. Staff are instructed to use gowns and gloves. He/She said the process was started last month and was just using the extra precautions on those with catheters and not wounds until this week. He/She said PPE should be located outside the resident rooms for easier access. During an interview on 09/19/24 at 10:31 A.M., the DON said EBP has been fully implemented now and should be performed, as the sign says, during high-contact care activities. During an interview on 09/19/24 at 10:57 A.M., the Administrator said there should be a sign on the door and PPE outside the door for residents on EBP. He/She said EBP was put into place for residents with MDRO and anyone with catheters and should include the use of gown and gloves. He/She said that the Infection Control Assessment and Research (ICAR) team came to the facility and did an infection control survey and education and was instructed it was ok to start the process slowly. The administrator said the facility then had a COVID outbreak which delayed everything. He/She said he/she knew the regulation was in effect and had no other good reason it was not implemented. He/She said he/she just read the regulation at the end of July.