STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265670	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to prevent misappropriation of one residents (Resident #1's) out of four sampled residents when Licensed Practical Nurse (LPN) A misappropriated the resident's Oxycodone (an Opioid analgesic) and Lorazepam (an antianxiety medication). The facility census was 83. The administrator was notified on 04/08/25 of past Non-Compliance which occurred on 03/07/25. Staff immediately suspended LPN A, conducted an investigation, and notified the required parties and agencies. The administrator immediately in-serviced all staff on facility's policy regarding counting narcotics and accounting for medications upon a resident's discharge, and abuse, neglect and misappropriation. The deficiency was corrected on 03/11/25. 1. Review of the facility's Abuse, Neglect, and Exploitation Program Responsibilities Policy, dated 9/2022, showed staff are directed as follows: -Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation, including the freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms, injury of unknown origin, or theft of belongings; -Residents must not be subject to abuse by anyone, including, but not limited to: facility staff, other residents, consultant contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. -Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 2. Review of Resident #1's Discharge Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/07/25, showed staff assessed the resident as cognitively intact. Review showed staff documented the resident with occasional pain with an intensity level of seven, and received opioid and antianxiety medications. Review of the resident's physician order sheet (POS), dated 2/01/25, showed an order for Oxycodone-Acetaminophen (Apap) 10-325 mg, one tablet every six hours for chronic pain. Review showed the resident's POS did not contain an order for Lorazepam. (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
	265670	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy Packing Slip Proof of Delivery, dated 2/28/25, showed the pharmacy delivered four Oxycodone filled bubble cards of 30 tablets each for a total of 120 tablets. Review of the resident's Medication Release Form, dated 3/07/25, showed staff documented the staff released to the resident 49 tablets of Oxycodone-APAP 10-325 mg and 25 tablets of Lorazepam .5 mg. Review of the facility's investigation, dated 3/11/25, showed staff documented on 3/11/25, staff reported the resident medications from his/her discharge on [DATE] missing to the Director of Nursing (DON). Staff documented the pharmacy delivered 120 tablets of Oxycodone on 2/28/25. Review showed staff discharged the resident with 19 tablets of Oxycodone and three cards of 30 tablets of Oxycodone, which the resident reported missing. Upon review of video footage, staff observed LPN A in the medication room pull three medication cards from the locked narcotic box, and place the three cards into the top drawer of the medication cart. LPN A took one of the cards from the locked narcotic box, placed the three cards in the top of the medication cart, and took one of the cards and the medication sign out sheet from the top of the cart, and left the medication room, and walked down the hallway. Upon returning into the video screen he/she disposed of something in the shred bin and something in the trash. Review of the local police department's incident report, dated 3/20/25, showed on 3/11/25 the investigator documented video from the facility showed LPN A handling the missing medications for the resident. The three cards, according to the administrator were one full card of 30 Oxycodone (Percocet), one partial card of 20 tablets of Oxycodone (Percocet), and a card containing 25 tablets of Lorazepam. In the video, LPN A is seen pulling the three cards from a locked box, only to place two cards back and leave the medication room with a full card and medication sign-out sheet. After less than five minutes LPN A is seen coming back up to the office where he/she is seen disposing of something in a shred bin and something else into the trash. The administrator watched the video, went through the shred bin, and located the top of the medication card, matching the resident's missing prescription. The administrator said there would have been no reason at that time for the resident to even have used up a full card, suggesting that LPN A was seen in the video leaving with a full card of Oxycodone only to dispose of the packaging without accounting for the medication. During an interview on 3/25/25, at 11:09 A.M., the DON said the resident's spouse notified the facility on 3/11/25, to inform them resident was missing medications from his/her discharged medications on 3/07/25. The DON said during the investigation, staff reviewed video of the medication room and nurse's station, and observed LPN A pull three cards from the locked box, take a card and sign out sheet down the hall, and discard something in the trash, and something in the shred bin. During an interview, on 3/25/25 at 11:50 A.M,. the Administrator said he/she reviewed the video footage of LPN A pulling three cards from the locked box in the medication room, walking down the hall with a card and sign out sheet, then returning to the nurse's station, and discarding something in the trash, and something in the shred bin. The Administrator said she and the DON found the top of the resident's medication card in the shred bin, and empty medication card in the trash. The administrator said he/she notified the local police department and state agency. MO00250892

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265670	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review facility staff failed to ensure one resident (Resident #1) remained free from accidents when staff failed to prevent Resident #1 from ingesting Resident #2's medications. The facility census was 83. The administrator was notified on 04/08/25 of past Non-Compliance which occurred on 03/29/25. when Resident #1 ingested Resident #2's medications. Staff assessed the resident, and notified the required parties and agencies. The administrator immediately in-serviced all nursing staff in-serviced nursing staff on medication administration. Staff corrected the deficient practice on 4/02/25. 1. Review of the facility's Administering Medications Policy, updated 12/2012, showed staff are to verify the resident's identity three times before administering the medication. Review showed staff are to check the medication label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review showed, during medication administration, no medications are kept on top of the cart, the cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Review of the facility's Adverse Consequences and Medication Errors policy, updated 4/2017, showed in the event of a significant medication related error, staff are to notify the attending Physician, implement the Physician's orders, monitor the resident closely for 24 to 72 hours or as directed, describe the incident on shift change to alert staff for the need to monitor the resident, document the incident, and forward the report to the Director of Nursing (DON), Quality Assurance Nurse, Medical Director, and Consultant Pharmacist. 2. Review of the facility's investigation, dated 3/29/25, showed staff documented Resident #1 approached the medication cart requested his/her night medications. Certified Medication Technician (CMT) C set aside the cup of medications he/she had prepared for Resident #2, and prepared Resident #1's Atorvastatin (a cholesterol reducing medication) 40 milligrams (mg), along with a cup of water, and handed the medication to Resident #1. Licensed Practical Nurse (LPN) D stood to the right of the medication cart, and requested CMT C check his/her blood glucose level. CMT C performed the blood glucose level on LPN D, after taking his/her own medication, Resident #1 reached in front of CMT C, picked up the cup containing Resident #2's medications, and ingested the medications. Review showed Resident #1 ingested one 5mg tablet of Haloperidol (an antipsychotic medication), one 20 mg tablet of Atorvastatin Calcium, and one 400 mg tablet of Clozaril (an antipsychotic). 3. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/07/25, showed staff assessed the resident as cognitively intact and independent with ambulation. Review of the resident's plan of care plan, dated 3/14/25, showed staff were directed to give medications as ordered. Review of the resident's Physician's Order Sheet (POS), dated March 2025, showed the POS did not contain an order for Haloperidol, Atorvastatin Calcium 20 mg, or Clozaril 400 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265670	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Owensville	1016 W Highway 28 Owensville, MO 65066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's nurses' note, dated 3/29/25 at 6:49 P.M., showed LPN D documented he/she stood at the medication cart when CMT C handed Resident #1 his/her medications, turned to check LPN D's blood glucose level, and when he/she looked down, Resident #1 had taken his/her own medication, then set the cup down and took Resident #2's medication. Staff assessed Resident #1 and notified the on-call Nurse Practitioner. Staff obtained an order to monitor Resident #1's vitals signs every shift. Review of the resident's nurses' note, dated 3/30/25 at 4:58 A.M., showed Registered Nurse (RN) E documented at 4:50 A.M., resident's oxygen saturation level measured 89 percent with a heart rate in the 40's. RN E documented the resident's family member gave permission to send the resident to the Emergency Department. RN E documented, Audible wheezing could be heard down the hall two doors down. Skin greyish in color at this time and gurgling is clearly heard with only the ears. During an interview on 4/07/25 at 2:50 P.M., the DON said staff are directed to administer medications, or lock medications in the medication cart if they are unable to administer the medications immediately. The DON said he/she in-serviced staff regarding completing one task before performing another task, and to not interrupt staff if they are administering medications. He/She said the on-call Nurse Practitioner directed staff to monitor the resident every shift. He/She said staff were monitoring the resident at least every two hours. During an interview on 4/07/25 at 11:36 A.M., the physician said staff contacted his/her office and notified him/her about the medication error. The physician said he/she could not say for sure if the medication error led to the resident's death, but he/she had been notified. During an interview on 4/07/25 at 3:29 P.M., LPN D said he/she approached CMT C as CMT C was giving Resident #1 his/her medications, and requested CMT C check LPN D's blood glucose level. LPN D said as Resident #1 was finishing his/her cup of water, CMT C pivoted his/her body to perform a fingerstick on LPN D. LPN D said while CMT C was performing the fingerstick on LPN D, Resident #1 reached in front of CMT C, picked up the cup containing Resident #2's medications, and ingested the medications. LPN D said he/she and CMT C immediately assessed the resident's vital signs, took the resident to his/her room, and notified the on-call Nurse Practitioner, DON, and Administrator. During an interview on 4/07/25 at 3:40 P.M., CMT C said as he/she was preparing Resident #2's medications, Resident #1 approached him/her and requested his/her medication. CMT C said he/she placed Resident #2's cup of medications on top of the medication cart, and prepared Resident #1's medication.CMT C said he/she handed Resident #1 his/her medication and a cup of water. He/She said as the resident finished the water, LPN D approached him/her and requested he/she check LPN D's blood glucose level. While CMT C was performing the fingerstick on LPN D, Resident #1 reached in front of CMT C, picked up the cup containing Resident #2's medications, and ingested the medications. CMT C said he/she and LPN D immediately assessed the resident's vital signs, took the resident to his/her room, and notified the on-call Nurse Practitioner, DON, and Administrator. MO00251947 and MO00252178