

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Owensville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on interview and record review, facility staff failed to administer medications as ordered by the physician when Licensed Practical Nurse (LPN) D prepared insulin for Resident #2, and the Assistant Director of Nursing (ADON) administered the insulin to Resident #1 and facility staff failed to document a medication error in the resident's medical record. The facility census was 78.</p> <p>1. Review of the facility's medication administration policy, dated December 2024, showed 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> <p>2. Review of Resident #1's Minimum Data Set (MDS), a federal mandated assessment tool, dated 5/23/25, showed the staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-Diagnoses of Alzheimer's, hypothyroidism, congestive heart failure, schizophrenia, and diabetes mellitus type II.</p> <p>Review of the Physicians Order Sheet (POS), dated June 2025, showed the POS did not contain a physician order for insulin.</p> <p>Review of the resident's progress notes, dated June 2025, showed the nurses notes did not contain documentation the resident received another resident's insulin on 6/7/25.</p> <p>During an interview on 6/16/25 at 12:04 P.M., the physician's nurse said the doctor was notified on 6/10/25 when the resident received another resident's insulin on 6/7/25.</p> <p>During an interview on 6/16/25 at 12:10 P.M., the Director of Nursing (DON) said he/she was unaware of a medication error and the resident being given insulin. He/She said it is the expectation of the staff to document if there is a medication error in Point Click Care (PCC) (an electronic Medical Record system) in the progress notes. He/She said one staff should not prepare the medications while another one gives them.</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: 265670
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/16/25 at 12:15 P.M., the ADON said he/she had to come in to work because the medication technician went home. He/She said he/she was aware of the medication error which occurred on 6/7/25. He/She said Licensed Practical Nurse (LPN) D was more familiar with the residents to pass medications, so they prepped the insulin and gave it to him/her to administer to the resident. He/She said he/she checked the resident's blood glucose and administered the insulin in conjunction with the insulin sliding scale. He/She said the family was with the resident asked when the resident started taking insulin. He/She said this is when they discovered the medication error and LPN D called the on-call doctor. He/She said staff are not to prepare medication and another staff administer. He/she said staff should document errors in PCC. He/She said he/she just went along with this system of LPN D preparing the insulin and he/she administering it because they have been short of staff, and he/she came in halfway through the medication pass.</p> <p>During an interview on 6/16/25 at 12:23 P.M., LPN D said they had a medication technician go home early during medication pass. He/She said he/she prepared insulin and the glucometer for Resident #2 when the ADON came up and said he/she would take care of it. He/She said the ADON realized his/her mistake after the insulin had been given to Resident #1 and said he/she would take care of notification and charting of the medication error.</p> <p>During an interview on 6/16/25 at 12:31 P.M., the administrator said he/she was made aware of the medication error and started an investigation. He/She said the ADON had to come in on 6/7/25 due to a medication technician going home. The ADON said LPN D handed him/her the insulin pen and glucometer. He/She said staff are expected to notify the doctor, the family and himself/herself if an error occurs with medications, and all of this should be documented in PCC. Staff are not expected to prepare medication and another staff administer the medication.</p> <p>MO00255687</p> <p>MO00256185</p>		