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	11/26/2025

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. (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	11/26/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to safely transfer one resident (Resident #1) out of two sampled residents in a manner to prevent accidents when staff failed to use a gait belt during a transfer which resulted in a fracture. The facility's census was 73. The administrator was notified on 11/26/25 of past Non-Compliance which occurred on 11/16/25 when the administrator implemented new policies and procedures to ensure the nursing staff safely transferred residents. Staff were in-serviced on 11/16/25 regarding how to safely transfer a resident.1. Review of the facility's Safe Lifting and Movement of Residents policy, dated 07/2017, showed to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. The policy did not contain direction for staff regarding when to use a gait belt.Review of the facility's Educational Guide for Caregivers for Safe Transfers policy, undated, showed staff are directed to always use a gait belt for staff and patient's safety. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 09/16/25, showed staff assessed the resident as moderately cognitively intact and required substantial to maximal assistance from staff with transferring to and from a bed to a chair (or wheelchair). Review of the resident's care plan, dated 11/24/25, showed staff documented the resident required substantial to maximum assistance from staff with transfers. The care plan did not contain documentation to direct staff on gait belt use with transfers. Review of the facility's fall incident report, dated 11/16/25, showed staff documented the resident had a fall with injury and was sent to the hospital. Staff documented Certified Nurse Aide (CNA) A and Nurse Aide (NA) D had attempted to lift the resident under his/her arms and heard a popping noise. Staff assessed the resident with a possible hip fracture after a fall. CNA A and NA D were counseled for n ot following fall protocol and resulted in a resident injury. Review of the resident's hospital discharge paperwork, dated 11/16/25, showed a diagnosis of a closed fracture of the left femur.During an interview on 11/26/25 at 10:42 A.M., CNA A said staff went into the resident's room and found the resident was partially on the bed with his/her upper half on the bed face down. He/She said NA D was trying to get the resident to an upright position on the floor. He/She said NA D had grabbed the resident under her arm pits and was beginning to move him/her on to the floor, when the resident turned, they heard a popping noise. He/She said neither staff member used a gait belt during the transfer. He/She said he/she did not know if staff were required to use a gait belt with the resident. He/She said the resident required a one person assist, but two staff members always transferred the resident. He/She said two staff would lift the resident with one hand under the arm on each side and another hand on the brief and pants. He/She said the concern with not using a gait belt when transferring the resident is the potential for injury. He/She said they should not have moved the resident without a gait belt, but they were worried about the resident safety and didn't think about it. He/She said he/she did not recall having an in-service on safely transferring residents, including during orientation.During an interview on 11/26/25 at 12:45 P M, Licensed Practical Nurse (LPN) B said to transfer a resident safely, staff are directed to use a gait belt and the appropriate number of staff. He/She said the resident was a two person assist. He/She said the concern with not using a gait belt while transferring the resident is the possibility of a fall. During an interview on 11/26/25 at 12:52 P.M., CNA C said staff were directed to use a gait belt when transferring a resident. He/She said the resident could potentially fall or hurt themselves if not safely holding on to the resident.During an interview on 11/26/25 at 1:16 P.M., the Director of Nursing (DON) [NAME] said staff are directed to use a gait belt or other type of transferring equipment. He/She said the resident was a one person assist with a gait belt. He/She said the concern with not using a gait belt while transferring a resident is the potential for injury due to fall. He/She said he/she did not think the staff used a gait belt during a transfer of the resident, which is why staff were in-serviced on safe transfers. 2669281