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	08/29/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45489 Based on record review and interview, facility staff failed to complete a baseline care plan within 48 hours of admission for five residents (Resident #1, #2, #6, #28, and #65) out of a sample of 25 residents. The facility census was 71. 1. Review of the facility's policy titled Care plans - Baseline, dated December 2016, showed staff were directed: -A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission; -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan; -The resident and their representative will be provided a summary of the baseline care plan. 2. Review of Resident #1's medical record showed staff documented the resident admitted to the facility on [DATE]. The record did not contain a baseline care plan. 3. Review of Resident #2's medical record showed staff documented the resident admitted to the facility on [DATE]. The record did not contain a baseline care plan. 4. Review of Resident #6's medical record showed staff documented the resident admitted to the facility on [DATE]. The record did not contain a baseline care plan. 5. Review of Resident #28's medical record showed staff documented the resident admitted to the facility on [DATE]. The record did not contain a baseline care plan. 6. Review of Resident #65's medical record showed staff documented the resident admitted to the facility on [DATE]. The record did not contain a baseline care plan. (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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 08/29/24 at 1:30 P.M., the Director of Nursing (DON) said baseline care plans should be completed within 48 hours of admission by the nursing staff as part of the admission process. The DON said the Assistant Director of Nursing (ADON) complete chart reviews but has been unable to recently. The admitting nurse should complete the baseline care plan, and he/she does not know the care plans are not complete. During an interview on 08/29/24 at 2:00 P.M., Licensed Practical Nurse (LPN) S said baseline care plans are completed on a routine basis, and reviewed with the medical chart or primary care and family. LPN S said the care plan should address how the resident participates with care, their preferences, and should be completed within 24 hours of admission. LPN S said he/she does not know who is responsible. The LPN said the admitting nurse tries to get most of it completed, and he/she did not know the baseline care plans were not done. During an interview on 08/29/24 at 2:10 P.M., the administrator said baseline care plans should be completed on admission and within 48 hours by the admitting nurse. The admitting nurse is responsible for completing the care plan, and then nursing leadership should ensure the care plans are complete. The administrator said he/she did not know the baseline care plans were missing and has only been at the facility for five months. 50361

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview and record review, facility staff failed to develop and implement a comprehensive person-centered care plan addressing oxygen use for one resident (Resident #14), limited range of motion for one resident (Resident #64), Post Traumatic Stress Disorder (PTSD), a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event, for four residents (Resident #66, #71, #1, and #17), urinary catheter (tube placed directly in the bladder) care for one resident (Resident #2), and Activities of Daily Living (ADL)/transfer needs for one resident (Resident #65) out of 25 sampled residents. The facility census was 71. 1. Review of the facility's policy titled, Comprehensive Care Plans, dated October 2022, showed staff were directed to do the following: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment; -The comprehensive care plan will be developed within seven days after the completion of the comprehensive Minimum Data Set (MDS), a federally mandated assessment tool to be completed by staff, assessment; -The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma; trigger specific interventions will be used to identify ways to decrease a resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident; -The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment; -Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 2. Review of Resident #14's Annual MDS, dated [DATE], showed staff assessed resident as follows: -Cognitively intact; -Did not receive oxygen; -Diagnoses of Respiratory Failure and Chronic Obstructive Pulmonary Disease (COPD), a lung disease that restricts airflow. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Physician Order Sheet (POS), dated 08/24, showed an order dated 09/17/22 for Oxygen two Liters Per Minute (LPM), as needed with the goal to maintain oxygen saturation at 88% or higher and for shortness of air. Review of the resident's care plan, dated 06/10/24, showed it did not address the resident's respiratory failure, or the intervention of oxygen use. Observation on 08/27/24 at 11:21 A.M., showed the resident in bed with an oxygen concentrator at his/her bedside. The oxygen concentrator is on and the nasal cannula is on the floor. Observation on 08/28/24 at 8:58 A.M., showed the resident in bed with an oxygen concentrator at his/her bedside. The oxygen concentrator is on and the nasal cannula is hung over the concentrator. During an interview on 08/28/24 at 8:58 A.M., the resident said he/she mainly uses the oxygen at night when he/she sleeps. During an interview on 08/29/24 at 11:25 A.M., Certified Nurse Aide (CNA) M said the resident is supposed to wear oxygen at all times, but he/she wears it off and on during the day and most of the night. The CNA said oxygen should be addressed on the care plan and he/she has no idea why it is not on the care plan. During an interview on 08/29/24 at 11:37 A.M., Licensed Practical Nurse (LPN) K said oxygen therapy should be on a resident's care plan. During an interview on 08/29/24 at 1:24 P.M., the Director of Nursing (DON) said Respiratory Failure with Hypoxia and oxygen therapy should be on a resident's care plan. The DON said he/she does not know why it is not. During an interview on 08/29/24 at 2:10 P.M., The MDS Coordinator said oxygen should be on a resident's care plan, if the resident wears it during the look back period. Staff are not documenting that the resident is wearing oxygen on the Treatment Administration Record (TAR). The MDS Coordinator said he/she is responsible for ensuring the care plans reflect the care the resident wants and requires. During and interview on 08/29/24 at 2:39 P.M., LPN I said the resident wears oxygen when he/she wants to. The LPN said the resident takes the oxygen off and throws it on the floor. The LPN said the resident does wear the oxygen every day. The LPN said he/she is pretty sure the oxygen is on the resident's care plan. 3. Review of the Resident #64's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Moderately impaired cognition; -ROM impairment of upper extremities; -ROM impairment of lower extremities; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of Stroke and paralysis of one side of the body. Review of the resident's care plan, dated 07/26/24, showed staff did not document the resident's contractures, goals or interventions. Observation on 08/26/24 at 2:52 P.M., showed the resident in bed. The resident's left hand is contracted closed. Observation on 08/27/24 at 2:22 P.M., showed the resident in bed. The resident's left hand is contracted closed. The resident attempted to open his/her left hand with his/her right hand. The resident grimaced and could not open his/her left hand. During an interview on 08/27/24 at 2:22 P.M., the resident said it hurts when he/she tries to open his/her left hand. During an interview on 08/29/24 at 11:25 A.M., CNA M said if a resident has a contracture it should be on the care plan. During an interview on 08/29/24 at 11:37 A.M., LPN K said care plans should direct resident care. The LPN said the resident's contracture should be in his/her care plan. During an interview on 08/29/24 at 1:24 P.M., the DON said he/she would imagine the contracture should be care planned, he/she doesn't know why it is not. During an interview on 08/29/24 at 2:10 P.M., The MDS Coordinator said the resident's contracture should be in the care plan. The MDS Coordinator said he/she did not see the contracture on the resident's hospital discharge paperwork and it is not on the resident's diagnosis list. 4. Review of Resident #66's Quarterly MDS, dated [DATE], showed the staff assessed the resident as follows: -Moderate cognitive impairment; -Mood interview showed the resident feels down, depressed or hopeless, has trouble falling asleep/staying asleep; feels bad about self; moves, or speaks slowly and has trouble concentrating on things nearly everyday; Was this addressed? Yes -Diagnosis of PTSD. Review of the resident's care plan, dated 08/13/24, showed it did not address the resident's PTSD diagnosis with interventions. 5. Review of Resident #71's Quarterly MDS, dated [DATE], showed the staff assessed the resident as follows: -Moderate cognitive impairment; -Diagnosis of PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 06/18/24, showed it did not address the resident's PTSD diagnosis with interventions. During an interview on 08/26/24 at 11:21 A.M., the resident cried as he/she talked. The resident said he/she does not want to be at the facility. During an interview on 08/26/24 at 11:28 A.M., The DON said the resident sometimes has crying spells. 6. Review of Resident #1's Admission MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Mood interview showed little interest/pleasure in doing things; feels down, depressed or hopeless; had trouble falling asleep/staying asleep; feels tired/has little energy; poor appetite or overeats; and has trouble concentrating on things nearly everyday; -Social isolation often; -Diagnosis of PTSD. Review of the resident's care plan, dated 06/07/24, showed it did not address the resident's PTSD diagnosis with interventions. During an interview on 08/27/24 at 8:53 A.M., the resident said the SSD knows about his/her PTSD. The resident said he/she does like to be in large crowds, and said certain pictures or sounds can trigger him/her. During an interview on 08/29/24 at 10:10 A.M., CNA M said he/she has not noticed any certain behaviors from Resident #1, but would not know what to look for specifically. During an interview on 08/29/24 at 11:28 A.M., the SSD said said Resident #1 has refused outside treatment, and has asked if she has a flare up if she can talk to the SSD. He/she said the only trigger he/she is aware of is the resident does not like to be in large group settings or activities like going to Wal-Mart. During an interview on 08/29/24 at 2:00 P.M., LPN S said he/she does know Resident #1 has PTSD but is not aware of any specific triggers. LPN S said triggers should be found in the care plan, and signs of the resident's PTSD such as abnormal behaviors, or increased anxiety. He/she did not know PTSD is not on the care plan. 7. Review of Resident #17's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mood interview showed little interest/pleasure in doing things; fees down, depressed or hopeless; trouble falling asleep/staying asleep; feels tired/has little energy; poor appetite or overeats; and trouble concentrating on things nearly everyday; -Social isolation often; -Diagnosis of PTSD. Review of the resident's care plan, dated 07/26/24, showed it did not address the resident's PTSD diagnosis with interventions. During an interview on 08/29/24 at 10:10 A.M., CNA M said Resident #17 does have some behaviors and does not come out of his/her room a lot. During an interview on 08/29/24 at 11:28 A.M., the SSD said Resident #17 is seeing his/her own psychiatrist and refuses to discuss his/her triggers with staff. The SSD said PTSD should be on the care plan to identify any triggers or behaviors that would indicate a flare up of the PTSD. During an interview on 08/29/24 at 2:00 P.M., LPN S said she is aware that resident #17 has some mental health diagnoses but did not know if he/she had PTSD. 8. During an interview on 08/29/24 at 10:10 A.M., CNA M said he/she not did not know of any residents on his/her with PTSD, but he/she had not asked. CNA M said it is very important to know what the resident's triggers are because they could shut down or have behaviors, and it would be good to know what the triggers are so we can treat them how they need to be treated. He/she said it should be found in the care plan or computer system, and he/she would expect to see PTSD on the care plan. During an interview on 08/29/24 at 10:17 A.M., CMT/CNA T said he/she does not now if any residents on his/her hall have PTSD. He/she said it would be important to watch for behaviors, as some can get violent, and it would be helpful to know what their triggers are, to know what to look for. CMT/CNA T said he/she would expect to find that information in the care plan. During an interview on 08/29/24 at 1:30 P.M., the DON said the SSD works with each resident to figure out their PTSD triggers, and psychiatry comes to the building for residents who agree to be seen. The DON said the SSD relays the information regarding the resident's PTSD to the rest of the team. He/she said PTSD needs to be on the care plan, and he/she does not know why it is not care planned. The DON said the triggers and potential behaviors to look for should be on the care plan, and if triggers are unknown then behaviors to watch for should be on the care plan. During an interview on 08/29/24 at 2:00 P.M., LPN S said PTSD triggers should be found in the care plan, and signs of the residents' PTSD such as abnormal behaviors, or increased anxiety. He/she did not know that PTSD is not on the care plan. He/she said if staff does not know what the triggers are the resident could be triggered and it could make the situation worse, with behaviors such as exit seeking, erratic behaviors, or anything off the resident's baseline behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 2:10 P.M., The MDS Coordinator said PTSD should be identified on the care plans. The MDS Coordinator said he/she gets PTSD information from the resident's diagnosis list. The MDS Coordinator said he/she did not know it had not been care planned. The MDS Coordinator said there is four residents with PTSD and he/she added it to all four of their care plans this morning. During an interview on 08/29/24 at 2:10 P.M., the Administrator said PTSD should be on the care plan with known triggers and behaviors to watch for. He/she does not know why PTSD is not on the care plan for the residents, and if staff does not know what the triggers for a resident are then the resident could be triggered or have an exacerbation of their PTSD. The Administrator said he/she has only been at the facility for five months. 9. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident had an indwelling urinary catheter. Review of the resident's care plan showed staff documented: -Resident has a urinary catheter; -Check tubing for kinks with cares, monitor/document for pain/discomfort due to catheter, and monitor/record/report to medical doctor (MD) for signs or symptoms of Urinary Tract Infection (UTI), an infection of the urinary tract system; -Resident has an ADL self-care performance deficit with interventions to provide supervision with toileting hygiene. -The care plan did not address the resident's urinary catheter care. During an interview on 08/27/24 at 9:54 A.M., the resident said staff does not clean his/her catheter. The resident said he/she needs assistance from staff to clean his/her perineal area. During an interview on 08/29/24 at 10:22 A.M., CNA M said staff provide perineal and catheter care for the resident. The CNA said the resident uses his/her call light when he/she needs to use the bathroom, and staff provides the care at this time. Usually, it is once or twice a day. The CNA said the resident's care plan should contain instruction for catheter care so staff are aware it should be completed on a regular basis. During an interview on 08/29/24 at 10:45 A.M., RN (Registered Nurse) W said CNAs sometimes provide perineal care for the resident. RN M said the resident will sometimes toilet himself/herself. RN M said there should be a task in the charting system to prompt CNAs to perform catheter care. RN M said the tasks are assigned in the chart by the MDS coordinator and there is a task in his/her chart to perform catheter care. RN M said there is not care plan documentation for catheter care for resident. During an interview on 08/29/24 at 12:49 P.M., the DON said catheter care should be on listed on the resident's care plan. The DON said CNA tasks should be generated from the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 2:10 P.M., the Administrator said catheters and the required care should be on the care plans. He/she did not know catheter care is not on the care plan for the resident. 10. Review of Resident #65's Admission MDS, dated [DATE], showed staff assessed the resident is at risk for developing pressure ulcers. Review of resident's Discharge MDS, dated [DATE], showed staff assessed the resident as: -Has one unhealed, unstageable pressure injury; -Dependent on staff for sit to stand transfer and chair-bed-to-chair transfer; -Toilet transfer, tub/chair transfer, and car transfer not attempted due to medical condition/safety concern; -Walk 10 feet not attempted due to medical condition/ safety concern; -Resident is dependent on staff to wheel 50 feet. Review of the resident's care plan, 07/11/24 showed resident has a potential for pressure ulcer development related to immobility. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of the care plan showed it did not address pressure relief interventions, transfer/weight bearing status, or use of an external fixator to the right knee. Observation on 08/27/2024 at 8:36 A.M., showed the resident in bed with an external fixator on his/her right leg. Observation on 08/27/2024 at 12:22 P.M., showed the resident in his/her recliner with legs propped up and an external fixator on the right leg. During an interview on 08/29/24 at 10:19 A.M., CNA M said the resident is toe touch weight bearing on one leg and is a pivot transfer with a gait belt. The CNA said this is documented through the therapy department and he/she knows this information from going to therapy to ask them to transfer the resident with him/her, so he/she knows how to do it properly. The CNA said this information should be on the resident's care plan. The CNA said he/she also receives this information through shift report. The CNA said there should be documentation in the residents care plan about the external fixator to ensure they knew how to properly care for the resident in regard to the medical device. During an interview on 08/29/24 at 10:38 A.M., RN W said therapy usually meets with staff to go through the residents' transfer needs, abilities, and weight bearing statuses. RN W said this should be documented in the resident's therapy notes and weight bearing status and restrictions should be pulled over in the orders. The RN said he/she would expect the resident's transfer needs to be in their care plan and be updated as their needs and capabilities change with therapy progression. The RN said most care plans are not specific about resident wounds and related interventions. The RN said the facility policies and procedures cover floating heels and off loading as well as standing orders. The RN said if this is not in the care plan it would have to be verbally communicated to the care staff from a nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 12:40 P.M., the DON said transfer needs should be in the resident's care plan. The DON said he/she did not think the resident's external fixator was mentioned in the care plan. The DON said the physician orders has the residents weight bearing status, device use, and pin sights. The DON said there should be person centered interventions in resident care plans about wound care needs. The DON said there should be more detail and clarification about the residents wound and their specific needs. During an interview on 08/29/24 at 2:10 P.M., the Administrator said pressure ulcer prevention and interventions should be on the care plan, as well as any assistance and cares needed for Resident #65's external fixator (a device used to keep fractured bones stabilized and in alignment). The Administrator said the care plan should address how staff are to take care of the external fixator and how the resident should transfer with the external fixator. 45489 50361

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on interview and record review, facility staff failed to document the administration of medications for five residents (Residents #2, #12, #23, #64 and #65) of 25 sampled residents, on the residents Medication Administration Record (MAR). The facility census was 71. 1. Review of the facility's Documentation of Medication Administration policy, dated April 2007, showed the facility shall maintain a medication administration record to document all medications administered. A Nurse or Medication Medication Aide shall document all medications administered to each resident on the resident's MAR. Administration of medication must be documented immediately after it is given. The documentation must include signature and title of the person administering the medication. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/16/24 showed staff documented the resident has a diagnosis of osteomyelitis (an infection of the bone). Review of the resident's Physician Order Sheet (POS) showed an order for Ceftazidime (an antibiotic) Intravenous Solution two grams (gm) intravenously (IV) three time a day for osteomyelitis for six weeks with a start date of 07/05/24 and stop date of 08/16/24. Review of the resident's MAR, dated August 2024, showed staff did not document they administered the resident's Ceftazidime on: -08/02/24 at 6:30 A.M., -08/10/24 at 2:30 P.M., -08/11/24 at 6:30 A.M. 3. Review of Resident #12's Annual MDS, dated [DATE], showed staff assessed the resident as: -Frequent pain; -Pain frequently disrupts sleep; -Pain occasionally interferes with day-to-day activities; -Diagnosis of arthritis. Review of the resident's POS, dated 05/13/24, showed an order for Norco (a narcotic medication used for pain relief) 7.5-325 milligrams (mg) three times a day for pain. Review of the resident's MAR, dated August 2024, showed staff did not document they administered the resident's Norco on: (continued on next page)

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	265670	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/03/24 at 2:23 P.M., -08/04/24 at 2:30 P.M., -08/09/24 at 6:30 A.M., -08/09/24 at 2:30 P.M., -08/13/24 at 2:30 P.M., -08/16/24 at 6:30 A.M., -08/20/24 at 6:30 A.M., -08/23/24 at 2:30 P.M. 4. Review of the Resident #23's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Received scheduled pain medication; -Received opioid medication seven out of the seven days in the look back period. Review of the resident's POS, dated August 2024, showed an order for Norco Oral Tablet 5-325 MG before meals and at bedtime for pain. Review of the resident's MAR, dated August 2024, showed staff did not document they administered the resident's Norco on: -08/03/24 before lunch; -08/03/24 before dinner; -08/13/24 before lunch; -08/13/24 before dinner; -08/23/24 before dinner; -08/25/24 before dinner. 5. Review of the Resident #64's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderate cognitive impairment; -Had a feeding tube; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Received a mechanically altered diet; -Diagnoses of Stroke and Hemiplegia (paralysis of of one side of the body). Review of the resident's POS, dated August 2024, showed an order for Glucerna 1.5 Cal 240 milliliters (ml) with a 60 ml water flush four times a day. Review of the resident's MAR, dated August 2024, showed showed staff did not document they administered the resident's Glucerna or water flush on: -08/04/24 at 6:30 A.M.; -08/10/24 at 6:30 A.M.; -08/13/24 at 4:30 P.M.; -08/23/24 at 6:30 A.M.; -08/25/24 at 4:30 P.M. 6. Review of Resident #65's POS, dated August 2024, showed an order for Piperacillin Sod-Tazobactam (a antibiotic) 3-0.375 gm IV every six hours for infection of the knee for 42 days with a start date of 07/29/24 and a stop date of 08/26/24 and Piperacillin Sod-Tazobactam 3-0.375 gm IV every six hours with a start date of 08/26/24 and stop date of 09/7/24. Review of the resident's MAR dated August 2024showed staff did not document they administered the resident's Pipercillin Sod-Tazobactam on: -08/05/24 at 6:00 P.M., -08/19/24 at 6:00 P.M., -08/25/24 at 6:00 P.M. -08/26/24 at 6:00 P.M., -08/28/24 at 6:00 P.M. 7. During an interview on 08/29/24 at 11:34 A.M., Certified Medication Technician (CMT) P said staff should sign the MAR after they give the medication to the resident. The CMT said if the MAR is not signed it was probably was not given. During an interview on 08/29/24 at 11:37 A.M., Licensed Practical Nurse (LPN) K said staff should sign the MAR when they give the medication or treatment. The LPN said if the MAR is not signed, it means it was not given, or staff did not sign it out. The LPN said if staff give the medication and do not sign the MAR, the resident could get a double dose of the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 1:24 P.M., the Director of Nursing (DON) said staff should sign the MAR after the medication or treatment is administered. The DON said no signature means it's not administered, and this could lead to the resident receiving the wrong dose of medication. 50361

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 37131 Based on observation, interview, and record review, facility staff failed to provide appropriate treatment and services to prevent further decrease in range of motion (ROM), movement of a joint, for one resident (Resident #64), with a contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to the left hand out of 25 sampled residents. The facility census was 71. 1. Review of the facility's Resident Mobility and ROM policy, dated July 2017, showed residents with limited ROM will receive treatment and services to increase and/or prevent further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. As part of the resident's comprehensive assessment, the nurse will identify the resident's current ROM of his/her joints and current mobility status. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility to include contractures. The care plan will be developed by the interdisciplinary team based on comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. Review of the facility's Functional Impairment-Clinical Protocol policy, dated September 2012, showed the physician and staff will evaluate the resident for complications secondary to functional decline and/or immobility, such as contractures. The physician and staff will review the results and implications of these evaluations and use them to guide subsequent care planning. 2. Review of Resident #64's hospital discharge documentation, dated 03/29/24, given to the facility upon admission, showed hospital staff documented, anticipate ongoing Occupational Therapy (OT) with the the specific focus to include the use of left upper extremity and contracture prevention. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/18/24, showed: -Moderately impaired cognition; -ROM impairment of upper extremities; -ROM impairment of lower extremities; -Diagnosis of Stroke and paralysis of one side of the body. Review of the resident's care plan, dated 07/26/24, did not contain documention of the resident's contractures, goals or interventions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/26/24 at 2:52 P.M. showed the resident in bed and his/her left hand contracted close. Observation on 08/27/24 at 2:22 P.M., showed the resident in bed and his/her left hand contracted close. The resident attempted to open his/her left hand with his/her right hand. The resident grimaced and could not open his/her left hand. During an interview on 08/27/24 at 2:22 P.M., the resident said it hurts when he/she tries to open his/her left hand. The resident said he/she does not have any braces. The resident said staff put a rolled up wash cloth in his/her hand, but there is not one now. The resident said his/her hand feels better when staff put the rolled up wash cloth in it. The resident said he/she could not remember if he/she told staff the wash cloth helped. The resident said hopefully, he/she will start physical therapy. Observation on 08/27/24 at 4:25 P.M., showed Licensed Practical Nurse (LPN) I entered the resident's room to provide care. The resident's left hand contracted and did not have anything in it. The LPN left the room after he/she provided care and did not provide an intervention to the resident's contracted left hand. Observation on 08/28/24 at 9:51 A.M., showed the resident in bed and his/her left hand contracted close. Certified Nurse Aide (CNA) J entered the resident's room. The CNA provided care, and repositioned the resident. The CNA left the room and did not provide an intervention for the resident's contracted left hand. Observation on 08/29/24 at 8:44 A.M., showed CNA J provided care and repositioned the resident. The CNA left the resident's room and did not provide an intervention for the resident's contracted left hand. During an interview on 08/29/24 at 8:47 A.M., CNA J said the resident's left hand is contracted and staff have to work hard to get his/her left hand open to clean it. The CNA said he/she is not aware of anything staff do for the resident's contracted hand, and the resident is not receiving therapy. The CNA said he/she does not perform ROM with the resident. The CNA said the facility has two Restorative Aides (RA). During an interview on 08/29/24 at 9:00 A.M., LPN K said he/she the resident's left hand is contracted. The LPN said he/she is not sure if physical therapy had seen the resident for his/her hand contracture. The LPN said staff were putting folded washcloths in the resident's hand and he/she does not know why staff have not put the washcloth in the resident's hand this week. The LPN said care plans should direct the resident's care. The LPN said the contracture should be on the resident's care plan. During an interview on 08/29/24 at 10:06 A.M., RA L said he/she provides restorative therapy after an order is received and the Director of Nursing (DON) puts it on the Medication Administration Record (MAR). The RA said he/she had not noticed the resident's contracted hand. The RA said he/she had not received an order for passive ROM with the resident. The RA said he/she has not done restorative therapy with the resident's hand. The RA said he/she doesn't think he/she had looked at the resident's care plan. The RA said if the resident had a contracture he/she would think the contracture would be care planned. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/24 at 11:25 A.M., CNA M he/she is aware the resident has a contracture of his/her left hand. The CNA said when he/she is on the resident's hall, he/she puts a washcloth in the resident's hand, but he/she is not on the resident's hall all the time. The CNA said if a resident has a contracture it should be on the care plan. The CNA said he/she has some experience, so he/she puts a washcloth in the resident's hand, but some of these aides are new and don't have the experience. During an interview on 08/29/24 at 1:24 P.M., the DON said he/she is aware of the resident's left hand contracture. The DON said the contracture should be care planned and he/she does not know why it is not. The DON said he/she does not know why staff is not putting a washcloth in the resident's hand anymore. He/She said it should be communicated with the nurse and in the resident's care plan. The DON said it is the charge nurses responsibility to document the resident contracture and ensure information is communicated to the MDS Coordinator so it can be put in the care plan. The DON said physical therapy determines who receives restorative services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37131 Based on observation, interview, and record review, facility staff failed to remove and destroy expired medications and biologicals in two of four sampled medication carts, and one of two medication rooms. The facility census was 71. 1. Review of the facility's policy titled Storage of Medications, dated April 2007, showed the facility staff shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 2. Observation on 08/27/24 at 8:45 A.M., showed the charge nurse's medication cart contained liquid pain relief acetaminophen 160 milligrams (mg)/5 milliliters (ml), 16 fluid (fl) ounces (oz), 473 (ml), expired 04/24. 3. Observation on 08/27/24 at 9:03 A.M., showed the 400 hall medication cart contained the following expired medications: -Refresh lubricant eye gel 0.5 fl oz bottle, expired 04/24; -Bottle of Nitroglycerin 0.4 MG, expired 08/14/24; -10 ml bottle of fecal occult blood test developing solution, expired 04/30/24; -5 MG box of laxative tablet, expired 02/24; -One dressing change kit with statlock, expired 01/14/24. 3. Observation on 08/27/24 at 9:53 A.M., showed the medication storage room contained the following expired medications: -Novolog (insulin)Flex Pen, expired 12/18/23; -28 doses of 0.7 mL prefilled syringes of Influenza Vaccine, Fluzone High-Dose Quadrivalent, expired 06/2024; -25 doses of prefilled syringes 0.5 mL influenza vaccine, Flulaval Quadrivalent, expired 6/30/24. 4. During an interview on 08/27/24 at 9:03 A.M., Certified Medication Technician (CMT) R said someone from the pharmacy used to come in and check the medication carts and medication room for expired medications, but they don't come anymore. The CMT said if he/she sees an expired medication he/she removes it from the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/29/24 at 11:37 A.M., Licensed Practical Nurse (LPN) K said the nurses and CMT's look through the medication carts and medication room weekly for expired medications. The LPN said he/she did not know of any expired medications in the medication carts or the medication room. The LPN said he/she believes he/she checks the nurse's medication cart and the CMTs check their medication carts. During an interview on 08/29/24 at 1:24 P.M., the Director of Nursing (DON) said the pharmacist comes monthly and completes cart audits. The DON said he/she normally checks the medication storage rooms for expired medications. The DON said any nurse that sees expired medications, can throw it away. The DON said he/she did not there were expired medications in the medications in the medication carts and medication rooms. The DON said she checked the medication storage room last week and he/she did not know why the expired vaccines were in the medication room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33477 Based on observation, interview, and record review, facility staff failed to provide a clean barrier for wound supplies during wound care for two residents (Resident #2 and #3) and failed to perform approved hand hygiene during incontinence care for two residents (Resident #3 and #64) out of 25 sampled residents. Facility staff failed to ensure dietary staff performed hand hygiene as often as necessary using approved techniques to prevent cross-contamination during food preparation and service. The facility census was 71. 1. Review of the facility's policy titled, Dressings, Dry/Clean, dated September 2013, showed staff are directed to do: -Clean bedside stand; -Establish a clean field; -Place clean equipment on the clean field. 2. Observation on 08/29/24 at 9:20 A.M., showed LPN (Licensed Practical Nurse) S entered Resident #2's room with wound care supplies and placed the supplies directly on the end of the resident's bed. The LPN did not provide a clean field for the wound care supplies prior to wound care. 3. Observation on 08/29/24 at 8:20 A.M., showed LPN S entered Resident #3's room with wound care supplies and placed the supplies directly on the resident's urine soaked bed. The LPN did not provide a clean field for the wound care supplies prior to wound care. During an interview on 08/29/24 at 9:21 A.M., LPN S said wound care supplies should be placed on a clean surface such as the bed or bedside table. LPN S said the residents' bedside tables are preferred but are usually in use and cluttered. He/She said the bed is the easiest accessible location for supplies to be placed. During an interview on 08/29/24 at 12:45 P.M., The Director of Nursing (DON) said wound care supplies should always be placed on a clean barrier, such as a towel, when taken into a residents' room. During an interview on 08/29/24 at 2:10 P.M., the administrator said staff should always place care supplies on a clean barrier when in a residents' room. 4. Review of the facility's policy titled, Infection Control- Preventing Spread of Infection- Hand Hygiene, undated, showed staff are directed: -Hand hygiene should be completed before and after direct resident contact; -Before and after changing a dressing; -Before and after assisting resident with toileting; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-After coming in contact with a residents body fluids. Review of the facility's policy titled Perineal Care Procedure, undated, showed the policy directed staff to perform hand hygiene after providing perineal care. 5. Observation on 08/29/24 at 8:20 A.M., showed LPN S entered Resident #3's room to provide wound care to the resident's sacral (near the lower back) wound. Observation showed the LPN did not wash his/her hands or change his/her gloves and provided perineal care. With the same soiled gloves on, the LPN put a clean brief on the resident and turned the resident. During an interview on 08/29/24 at 9:21 A.M., LPN S said staff should perform hand hygiene before and after they touch a resident, any time gloves are visibly soiled, and when moving from dirty to clean tasks. During an interview on 08/29/24 at 12:45 P.M., the DON said staff should perform hand hygiene at the start of their shift, before and after cares, and from dirty to cleans tasks. The DON said if staff fail to perform proper hand hygiene it could result in infections or the spread of infections. 6. Observation on 08/28/24 at 9:45 A.M., showed Certified Nurse Aide (CNA) J entered Resident #64's room, washed his/her hands and applied gloves. Observation showed the CNA removed the resident's soiled brief, moved the resident to his/her right side, and wiped the resident's urine soaked back and perineal area. With the same soiled gloves, the CNA rolled the resident to his/her left side, removed the soiled sheets from the bed, and then touched the resident's clean sheets, and clean brief. Observation showed the CNA removed his/her gloves, did not wash his/her hands, touched three pillows in the resident's room and repositioned the resident. During an interview on 08/28/24 at 9:55 A.M., CNA J said he/she is supposed to change gloves and wash hands when moving from dirty to clean tasks. The CNA said he/she should have changed gloves and washed hands between touching soiled linens and clean linens. The CNA said he/she should have change his/her gloves, he/she just tried to get the resident back where he/she should be, quickly. During an interview on 08/29/24 at 1:24 P.M., the DON said staff should wash their hands and put gloves on before providing care, and should remove their soiled gloves and wash their hands before they touch anything clean. The DON said he/she did not know why the staff did not change their gloves and wash their hands during care. During an interview on 08/28/24 at 2:10 P.M., the administrator said staff should wash their hands between gloves changes, from dirty to clean tasks, and before and after care. The administrator said staff should not wear the same gloves during the whole process. 7. Review of the facility's policy titled Hand Hygiene, undated, showed: -Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also know as alcohol-based hand rub (ABHR); -Hand hygiene technique when using soap and water: a. Wet hands with water. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Apply enough soap to cover all hand surfaces. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers; d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use towel to turn off the faucet. -The use of gloves does not replace hand washing. Wash hands after removing gloves. Review showed the policy did not include any additional direction to staff on when hand hygiene should be performed. Observation on 08/26/24 at 11:27 A.M., showed, Dietary Aide (DA) C washed his/her hands at the sink in the dining room food service station. The DA scrubbed his/her hands with soap for two seconds, rinsed his/her hands and turned the faucet off with his/her wet bare hand. Observation showed the DA then served plates of food to residents. Observation on 08/26/24 at 11:49 A.M., [NAME] A served food to residents in the dining room food service station with gloved hands. Observation showed the cook removed his/her soiled gloves and washed his/her hands at the sink in the station by scrubbing his/her hands with soap for five seconds. Observation showed, after the cook washed his/her hands, he/she donned new gloves and continued to serve food to the residents. Observation on 08/26/24 at 11:53 A.M., showed, when DA C washed his/her hands at the sink in the dining room food service station, the DA scrubbed his/her hands with soap for two seconds, rinsed his/her hands and turned the faucet off with his/her wet bare hand. Observation showed, after the DA washed his/her hands, he/she then entered the kitchen, obtained cartons of milk from the refrigerator, placed the cartons of milk on a tray, brought the tray of milk to the dining room and put the tray on top of a food cart that contained trays of food for service to the residents. Observation showed the DA delivered the food cart to the unit for the lunch meal service. Observation on 08/26/24 at 12:04 P.M. showed, when DA B washed his/her hands at the sink in the dining room food service station, the DA scrubbed his/hands with soap for five seconds, rinsed his/her hands and turned the faucet off with his/her wet bare hands. Observation showed the DA then served drinks to the residents in dining room. During an interview on 08/26/24 at 12:06 P.M., DA B said he/she had worked at the facility about a month and he/she got trained on how to wash his/her hands upon hire. The DA said he/she was trained to scrub his/her hands with soap for 20 seconds and to turn the faucet off with a towel. The DA said he/she just got in a hurry and did not think about how he/she washed his/her hands. (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	08/29/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/26/24 at 12:08 P.M., showed, when [NAME] A washed his/her hands at the sink in dining room food service station, the cook scrubbed his/her hands with soap for one second out of the water and then scrubbed his/her hands in the running water. Observation showed, after the cook washed his/her hands, he/she donned gloves and continued to serve food to residents. During an interview on 08/26/24 at 12:09 P.M., [NAME] A said he/she had worked at the facility since October 2023 and he/she got trained on how to wash his/her hands. The DA said he/she was not sure how long he/she should scrub his/her hands with soap and he/she should probably wash his/her hands longer that he/she had, but at least he/she washes his/her hands often. The DA said hands should be scrubbed with soap out of the water, not under running water, during handwashing. Observation on 08/26/24 at 1:26 P.M., showed [NAME] A used his/her cell phone, put the phone back in his/her pocket and, without performing hand hygiene, obtained two sanitized metal food preparation/service pans from the storage shelf and set the pans on the countertop. Observation showed the cook then obtained two cans of sliced apples from the pantry and placed the cans on the countertop next to the pans. Observation showed the cook used his/her bare hand to wipe his/her mouth, used the can opener on the countertop to open the cans of sliced apples and pour the apples in to the pans. During an interview on 08/28/24 at 12:11 P.M., the Certified Dietary Manager (CDM) said staff should wash their hands when they change gloves, between tasks and anytime their hands become contaminated. The CDM said when staff wash their hands, they should scrub their hands with soap for 20 seconds out of the water, not under running water, and turn the faucet off with a paper towel. The CDM said staff are trained on hand hygiene upon hire and routinely during the year. During an interview on 08/28/24 at 12:22 P.M., the administrator said staff should perform hand hygiene when they after they enter and before they exit the kitchen, between tasks, after glove use and after they touch anything dirty. The administrator said when staff wash their hands, they should scrub their hands with soap for 30 seconds out of the water, not under running water, and turn the faucet off with a towel. The administrator said staff are trained on hand hygiene upon hire and as needed. 37131 50361