STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265772	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Desoto	1550 Villas Drive DE Soto, MO 63020

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the safety of one resident (Resident #1) out of three sampled residents when staff failed to place a fall mat next to the resident's bed as directed by the care plan. The resident fell out of bed onto the floor resulting in injury. The facility census was 52. The administration was notified on 07/24/25 of the Past Non-Compliance which occurred on 07/18/25. On 07/18/25, upon notification, the facility administration started an investigation and notified the Department of Health and Senior Services of the fall which resulted in a fracture. The non-compliance was corrected on 07/18/25, as the facility in-serviced all staff on the facility's policy and procedures on Falls and Fall Risk, Managing, High Fall Risk Patient Interventions, and on the Abuse and Neglect Policy. Review of the facility policy titled, Falls and Fall Risk, Managing, revised on December 2019, showed:The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once);In conjunction with the Attending Physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis (a disease that weakens the bones), as applicable) to try to minimize serious consequences of falling. Review of Resident #1's medical record showed:admission date of 11/27/24;Diagnoses of Alzheimer's disease (a brain condition that gradually affects memory, thinking, and behavior, leading to difficulties in daily tasks), bipolar disorder (episodes of mood swings, from depressive lows to manic highs), chronic kidney disease stage 4 (kidneys are severely damaged and can only filter a small amount of waste), osteopenia (brittle bones), and adult failure to thrive (condition characterized by significant weight loss, decreased appetite, and reduced physical activity). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff), dated 05/23/25, showed:Cognition moderately impaired with inattention, disorganized thinking, poor decision making; Had one to three falls. Review of the Resident's Care Plan, last revised on 06/06/25, showed:A bolstered low air loss mattress (a type of low air loss mattress that incorporates raised side perimeters to provide additional safety and support);Ensure bed in the low position;A fall mat next to the bed. Review of the resident's Fall Assessments showed:On 06/25/25, a history of falls in last the last three months with one - two falls and a moderate fall risk;On 07/01/25, a history of falls in the last three months with three or more falls and a high fall risk;On 07/17/25, a history of falls in the last three with three more falls and a high fall risk;On 07/18/25, a history of falls in the last three months with three more falls and a high fall risk. Review of the resident's Progress Notes, dated 07/01/25 - 07/18/25, showed:A fall note on 07/01/25 at 6:00 P.M., the resident was on a fall mat in front of the bed. The resident climbed out of the bed before staff help. Upon entering the room, the resident sat on the fall mat in front of the bed on his/her knees. No apparent injuries;A fall note on 07/17/25 at 4:29 A.M., the resident was on the floor mat at the bedside with his/her head facing the foot of the bed and his/her feet faced the head of bed. No apparent injuries;A fall note on 07/18/25 at 4:00 P.M., the resident was found next to the bed bleeding from an active head laceration. A large hematoma noted to left side of the head. The resident was yelling out for help to his/her leg. The resident screamed out when the nurse palpated his/her left hip and left leg. Pressure was applied to the head wound to control the bleeding. Hospice, the resident's family, and the physician were notified of the fall with an injury. Resident was sent to the emergency room (ER) for evaluation. He/She was admitted to the hospital for surgical intervention. The resident's family declined surgery and instead chose conservative treatment. Review of the resident's X-ray Report, dated 07/18/25, showed:An intertrochanteric left hip fracture with varus angulation (a break in the upper part of the left thigh bone, near the hip, with the broken pieces angled inward towards the body). During an interview on 07/24/25 at 11:30 A.M., Nurse Assistant (NA) #C said he/she was one of the aides assigned to Resident #1 on 07/18/25. NA C said he/she got complacent. NA C and another staff went in the resident's room, transferred the resident with a Hoyer lift (a mechanical lift), removed the Hoyer sling, changed the resident, covered him/her up with a blanket, put the call light in reach, lowered the bed, and left the room. NA C went to tell the nurse the resident had cramping stomach pain. NA C went across the hall to help another resident when he/she heard Resident #1 call out for help and that he/she was in pain. NA C looked over and saw the resident's leg on the floor. NA C called for help and went to the resident's room to wait for the nurse to get there. During an interview on 07/24/25 at 1:00 P.M., the Administrator and the Director of Nursing (DON) said they would expect staff to replace all safety devices