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	03/13/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49999 Based on observation, interview, and record review, the facility failed to provide access to survey results. This had the potential to affect all residents. The facility census is 46. Review of the facility's policy titled, Examination of Survey Results, dated April 2007, showed: - A copy of the most recent standard survey along with state approved plans of correction of noted deficiencies, is maintained in a three-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room. Observations from 03/10/25 through 03/13/25 showed: - On 03/10/25 at 11:35 A.M., no survey binder was found at the nurses' station or activities room; - On 03/13/25 at 2:15 P.M., no survey binder was found at the nurses' station or activities room. During an interview on 03/13/25 at 10:10 A.M., Resident #25 said he/she was not aware the survey results could be read or where to find them. During an interview on 03/13/25 at 10:10 A.M., Resident #4 said he/she did not know where to find the survey results. During an interview on 03/13/25 at 10:10 A.M., Resident #35 said he/she did not know where to find the survey results. During an interview on 03/13/25 at 8:45 P.M., the Administrator said she would expect the survey results to be available for the residents to read without asking.

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: 265772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Desoto		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Villas Drive DE Soto, MO 63020	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49999 Based on observation, interview, and record review, the facility failed to ensure a physician's order for bilevel positive airway pressure (BIPAP - a noninvasive ventilation device that helps people breathe by delivering pressurized air into the airways) included settings. This affected one resident (Resident #32) out of one sampled resident. The facility's census was 46. Review of the facility's policy titled, CPAP/BiPAP Support, dated March 2015, showed: - Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the machine. Review of Resident #32's medical record showed: - admitted [DATE]; - Diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that causes restricted airflow and breathing problems), obstructive sleep apnea (a sleep disorder that occurs when the upper airway becomes blocked during sleep), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), diastolic heart failure (a condition where the heart muscle becomes stiff and cannot relax properly between heartbeats), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of the resident's Physician's Order Sheet (POS), dated 03/13/25, showed: - An order for trilogy (a device that delivers both invasive and non-invasive ventilation modes) on at bedtime and off in the morning with four liters (L) per minute of oxygen (O2) bled in, dated 07/15/24; - No order for BiPAP settings. During an interview on 03/12/25 at 11:45 A.M., the resident said he/she uses BiPAP at night and needs some assistance with reaching the mask and machine. Observation on 03/13/25 at 11:35 A.M. showed the resident turned on the machine and started BiPAP. During an interview on 03/13/25 at 11:35 A.M., Licensed Practical Nurse (LPN) A said he/she does not know what the settings are for the resident's BiPAP. During an interview on 03/13/25 at 8:45 P.M., the Director of Nursing (DON) and the Administrator both said they would expect the settings for BiPAP to be listed in the order.

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49879 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. This had the potential to affect all residents. The facility's census was 46. Review of the facility's policy titled, Sanitization, dated October 2008, showed: - The food service area shall be maintained in a clean and sanitary manner; - All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects; - All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, and cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair; - If a sink is used for washing utensils, cooking equipment, or dishes, and also used to wash produce or thaw food, it will be cleaned between uses with an approved cleaning and sanitizing agent; - High-Temperature Dishwashing machines must be operated using wash temperatures between 150 and 165 degrees Fahrenheit (F) for at least 45 seconds and rinse temperatures between 165 and 180 degrees F for at least 12 seconds; - Food Service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. 1. Observations on 03/10/25 at 10:49 A.M. of the kitchen showed: - Dirt and debris on the floor under the main food prep table; - Dirt, grime and old food debris along the top of the dishwasher; - Floors dingy and sticky; - Numerous dirty and dingy ceiling tiles; - The deep fryer grease dark brown with left over food residue; - Grease down the sides of the fryer and on the floor below the fryer; - One ten ounce (oz) dented can of crushed pineapple; - One four pound (lb) dented can of chunk light tuna in water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 03/13/25 at 10:57 A.M. of the kitchen showed: - The deep fryer grease dark brown with left over food residue; - Grease down the sides of the fryer and on the floor below the fryer; - No thermometer inside the walk in refrigerator or freezer; - Stove top with old food debris on it; - Two frying pans on the shelf above the stove with black buildup on the bottoms. 3. Observation on 03/13/25 at 11:45 A.M. of the upstairs kitchen serving area showed: - Food crumbs, dirt and debris over the entire floor; - The warming station covered with food debris; - The plate storage rack with dried food debris and dried liquid spills down all sides of it; - One container of cereal not dated; - The toaster with crumbs on it and on the counter below; - The walls, cabinet doors, blinds, and windows covered in dirt, grime, spilled liquid run marks, and dried food. Review of the cleaning schedule for the upstairs kitchen, starting on 03/09/25, showed: - Cleaning was completed on 03/09/25, 03/10/25, and 03/11/25; - No documentation that cleaning had been completed on 03/12/25 or 03/13/25. Review of temperature logs for the upstairs kitchen refrigerator showed: - Temperatures logged from 10/16/24 to 10/24/24 and from 01/01/25 to 01/21/25; - No temperatures logged for the month of February 2025; - No temperatures logged for the month of March 2025. No record of temperature logs for the upstairs kitchen freezer. Review of food temperature logs showed: - Food temperatures logged for 03/11/25 and 03/12/25; - No food temperatures recorded prior to 03/11/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Observation on 03/13/25 at 2:15 P.M. of the kitchen showed Dietary Aide K prepped hamburger patties without wearing a hair restraint. Review of temperature log for high temperature dish machine from 12/01/24 through 03/13/25 showed: - On 01/15/25, day shift recorded a rinse temperature of 140 degrees F; - On 01/22/25, day shift recorded a rinse temperature of 130 degrees F; - On 01/22/25, evening shift recorded a rinse temperature of 160 degrees F; - On 01/23/25, day shift recorded a rinse temperature of 160 degrees F; - On 01/24/25, day shift recorded a wash temperature of 130 degrees F; - On 01/26/25, day shift recorded a wash temperature of 145 degrees F and a rinse temperature of 160 degrees F; - On 01/26/25, evening shift recorded a rinse temperature of 163 degrees F; - On 01/27/25, day shift recorded a wash temperature of 142 degrees F and a rinse temperature of 143 degrees F; - On 01/27/25, evening shift recorded a rinse temperature of 151 degrees F; - On 01/28/25, day shift recorded a rinse temperature of 150 degrees F; - On 01/29/25, day shift recorded a rinse temperature of 150 degrees F; - On 01/31/25, day shift recorded a wash temperature of 147 degrees F; - On 01/31/25, evening shift recorded a wash temperature of 148 degrees F; - On 02/03/25, day shift recorded a rinse temperature of 150 degrees F; - On 02/03/25, evening shift recorded a rinse temperature of 154 degrees F; - On 02/04/25, evening shift recorded a wash temperature of 148 degrees F; - On 02/05/25, day shift recorded a wash temperature of 130 degrees F; - On 02/06/25, evening shift recorded a wash temperature of 148 degrees F and a rinse temperature of 160 degrees F; - On 02/07/25, day shift recorded a rinse temperature of 155 degrees F; - On 02/07/25, evening shift recorded a rinse temperature of 156 degrees F; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/08/25, day shift recorded a rinse temperature of 155 degrees F; - On 02/08/25, evening shift recorded a rinse temperature of 161 degrees F; - On 02/09/25, day shift recorded a rinse temperature of 163 degrees F; - On 02/09/25, evening shift recorded a wash temperature of 148 degrees F and a rinse temperature of 160 degrees F; - On 02/10/25, day shift recorded a wash temperature of 130 degrees F; - On 02/10/25, evening shift recorded a wash temperature of 149 degrees F; - On 02/11/25, day shift recorded a wash temperature of 148 degrees F; - On 02/11/25, evening shift recorded a wash temperature of 130 degrees F; - On 02/12/25, day shift recorded a wash temperature of 130 degrees F; - On 02/12/25, evening shift recorded a wash temperature of 136 degrees F; - On 02/15/25, day shift recorded a wash temperature of 148 degrees F; - On 02/16/25, evening shift recorded a wash temperature of 132 degrees F; - On 02/17/25, day shift recorded a wash temperature of 130 degrees F and a rinse temperature of 110 degrees F; - On 02/17/25, evening shift recorded a wash temperature of 130 degrees F; - On 02/18/25, day shift recorded a wash temperature of 130 degrees F and a rinse temperature of 110 degrees F; - On 02/18/25, evening shift recorded a wash temperature of 130 degrees F and a rinse temperature of 140 degrees F; - On 02/19/25, day shift recorded a rinse temperature of 158 degrees F; - On 02/19/25, evening shift recorded a wash temperature of 138 degrees F and a rinse temperature of 157 degrees F; - On 02/20/25, evening shift recorded a wash temperature of 140 degrees F and a rinse temperature of 158 degrees F; - On 02/23/25, day shift recorded a wash temperature of 130 degrees F; - On 02/23/25, evening shift recorded a wash temperature of 130 degrees F; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/24/25, day shift recorded a wash temperature of 140 degrees F; - On 02/24/25, evening shift recorded a wash temperature of 140 degrees F; - On 02/25/25, day shift recorded a wash temperature of 135 degrees F; - On 02/25/25, evening shift recorded a wash temperature of 145 degrees F; - On 02/26/25, day shift recorded a wash temperature of 135 degrees F; - On 02/26/25, evening shift recorded a wash temperature of 140 degrees F; - On 02/27/25, day shift recorded a wash temperature of 137 degrees F; - On 02/27/25, evening shift recorded a wash temperature of 145 degrees F; - On 02/28/25, day shift recorded a wash temperature of 138 degrees F; - On 02/28/25, evening shift recorded a wash temperature of 145 degrees F; - On 03/01/25, day shift recorded a wash temperature of 130 degrees F; - On 03/01/25, evening shift recorded a wash temperature of 140 degrees F; - On 03/02/25, day shift recorded a wash temperature of 145 degrees F; - On 03/03/25, day shift recorded a wash temperature of 136 degrees F; - On 03/04/25, day shift recorded a wash temperature of 140 degrees F; - On 03/05/25, day shift recorded a wash temperature of 136 degrees F; - On 03/05/25, evening shift recorded a wash temperature of 140 degrees F; - On 03/06/25, evening shift recorded a wash temperature of 145 degrees F; - On 03/07/25, evening shift recorded a wash temperature of 140 degrees F; - On 03/08/25, evening shift recorded a wash temperature of 140 degrees F; - On 03/09/25, evening shift recorded a wash temperature of 140 degrees F. During an interview on 03/13/25 at 12:00 P.M., the Dietary Manager (DM) said the floors needed to be rewaxed and they were looking for a company who could do that for them. The DM was unaware of the type of dishwasher in the kitchen. During an interview on 03/13/25 at 8:45 P.M., the Administrator said she would expect the kitchen to be free from dirt, debris and grime.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47678 Based on observation, interview, and record review, facility staff failed to maintain appropriate infection control practices by not following enhanced barrier precautions (EBP) for one resident (Resident #20) out of three sampled residents and by not performing proper hand hygiene and glove changing techniques during incontinent care, transfer, and wound care for three residents (Resident #20, #22 and #23) out of 16 sampled residents. The facility's census was 46. Review of the facility's policy titled Enhanced Barrier Precautions, last updated 04/04/24, showed: - All staff receive training on enhanced barrier precautions upon hire and at least annually and expected to comply with all designated precautions; - All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions; - The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; - High-contact resident care activities include dressing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care; - Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals. Review of the facility's policy titled, Wound Care, revised September 2018, showed: - The purpose of this procedure is to provide guidelines for the care of wounds to promote healing; - Verify that there is a physician's order for this procedure; - Review the resident's care plan to assess for any special needs of the resident; - Assemble the equipment and supplies as needed; - Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field; - Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier; - Put on gloves. Loosen tape and remove dressing, discard dressing appropriately, wash and dry hands thoroughly; - Put on gloves. Gowns will only be necessary if soiling your skin or clothing, masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wear sterile gloves when physically touching the wound or holding a moist surface over the wound; - Place one gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water; - Remove dry gauze. Apply treatments as indicated; - Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time and date and apply dressing; - Remove the disposable items and discard appropriately, remove gloves and discard; - Wash and dry hands thoroughly. Review of the facility's policy titled, Hand Hygiene, dated May 2021, showed: - The use of gloves does not replace hand hygiene; - If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's policy titled, Negative Pressure Wound Therapy, dated February 2014, showed: - Identify and size wound to be treated; - Wash hands and apply gloves; - Clean wound according to facility protocol, or as ordered; - Remove gloves; - Wash hands and apply new gloves; - Cut sponge dressing to size; - Create barrier dressing to protect healthy skin as needed: - Estimate the size of barrier dressing that will need to be cut. There should be at least a 1-inch barrier around the margins of the wound; - Cut the dressing with clean scissors; - Apply skin prep to the peri-wound skin; - Apply barrier dressing over the top of the wound; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Carefully trim a hole in the dressing to expose the wound and allow insertion of the sponge/gauze dressing; - Alternatively, the drape may be cut and placed in strips surrounding the wound and leaving the wound cavity open; - Apply secondary layer of barrier adhesive (drape); - Apply adhesive pad with tubing to the wound; - Assemble pump and disposable canister; - Connect device (canister) tubing to wound tubing, turn to lock into place; - Unclamp both sides of tubing; - Turn on pump, initiate negative pressure setting on pump as ordered. 1. Review of Resident #20's medical record showed: - An order to cleanse wound with wound cleanser, apply folded alginate calcium (an absorbent material used for dressing), collagen powder (a substance used to promote wound healing), skin prep peri wound and apply superabsorbent gelling fiber with silicone border and faced (a cover dressing with silicone) every day shift and as needed for stage three (full-thickness skin loss, exposing fat tissue) pressure wound, dated 03/10/25. Review of the resident's Plan of Care, last revised 10/10/24, showed: - Requires Enhanced Barrier Precautions (EBP) related to wound. Observation on 03/10/25 at 11:35 A.M. of the resident's mechanical lift transfer showed: - Signage for EBP on the resident's door; - Personal Protective Equipment outside the room door; - Without donning gloves and gown, Certified Nurse Aide (CNA) B and CNA C entered the room; - CNA C moved the mechanical lift over the resident, attached the sling straps to the lift on the resident's right side while touching the right side of the bed with his/her clothes; - CNA B attached the sling straps to the left side of the mechanical lift, touching the bed with his/her clothes; - CNA B and CNA C transferred the resident from the bed to the wheelchair using the mechanical lift; - CNA B brushed the resident's hair; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA C made the resident's bed; - CNA B and CNA C performed hand hygiene and left the room. Observation on 03/12/25 at 9:10 A.M. of the resident's incontinent care showed: - Without donning gowns, CNA B and CNA D entered the room; - CNA B and CNA D donned gloves without performing hand hygiene; - CNA B wet wash cloths; - CNA B and CNA D positioned the resident onto his/her left side, touching the bed with their clothes; - CNA B and CNA D removed the mechanical lift sling from under the resident; - CNA B wiped the resident's front peri area with a wet cloth; - CNA D reached into CNA B's pocket and obtained a roll of trash bags, removed a bag, laid the roll onto the bed, and opened the trash bag; - CNA B placed the dirty cloth into the trash bag; - CNA D positioned the resident onto his/her left side; - CNA B wiped the resident's buttocks with a clean, wet, cloth; - Without performing hand hygiene, CNA B changed gloves; - CNA B placed a clean brief on the resident; - CNA B and CNA D repositioned the resident in the bed, placed blanket and call light; - CNA B and CNA D removed gloves and performed hand hygiene; - CNA B placed the roll of trash bags back into his/her pocket; - CNA B and D left the room. During an interview on 03/12/25 at 10:15 A.M., CNA B said he/she knows who requires EBP by the sign on the door, should have worn a gown and gloves during care of the resident who required EBP and should have not placed the roll of trash bags back into his/her pocket after the roll was laid on the resident's bed. During an interview on 03/12/25 at 11:15 A.M., CNA D said he/she should have worn a gown during the care of the resident who required EBP. (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 - Few	Observation on 03/12/25 at 9:45 A.M. of the resident's wound care, showed: - Licensed Practical Nurse (LPN) A donned a gown, gathered a cover dressing, opened gauze and opened calcium alginate from the treatment cart with his/her bare hands, contaminating dressing supplies; - LPN A placed contaminated gauze and calcium alginate in hand, placed the cover dressing, opened gauze, opened calcium alginate, bottle of wound cleanser, bottle of liquid vitamin E, and tube of collagen powder onto a newspaper on the resident's bedside table, without using a barrier; - LPN A washed hands and donned gloves; - LPN A positioned the resident on his/her left side; - LPN A removed gloves and donned new gloves without performing hand hygiene; - LPN A applied calcium alginate to cover dressing, applied collagen powder to the calcium alginate, laid the dressing on the bed pad, without using a barrier; - LPN A cleansed wound with contaminated gauze and dermal wound cleanser; - LPN A changed gloves, did not perform hand hygiene; - LPN A applied skin prep to peri wound; - LPN A applied dressing to wound; - LPN A changes gloves, did not perform hand hygiene; - LPN A applied vitamin E to the resident's upper arms; - LPN A removed gloves, did not perform hand hygiene, positioned resident's blanket and call light; - LPN A placed wound cleanser, bottle of vitamin E, tube of collagen powder on top of treatment cart, contaminating cart, performed hand hygiene with hand sanitizer, and then placed the supplies into the treatment cart drawer, contaminating other supplies. During an interview on 03/12/25 at 9:58 A.M., LPN A said he/she should have worn clean gloves when gathering supplies, used a barrier, should have sanitized the multi-use supplies before placing them back in the cart, and should have at least used hand sanitizer with each glove change. 2. Review of Resident #22's Physician's Order Sheet showed: - An order for right inner shin dressing change, apply two Xeroform (a non-adherent gauze that minimizes pain during dressing changes and promotes healing) and cover with dressing to be changed once daily and as needed for stage three pressure wound (a full-thickness skin loss where fat is visible), dated 02/24/25. Observation of Resident #22's wound care on 03/13/25 at 8:55 A.M. showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Desoto		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident's dressing already removed; - Registered Nurse (RN) I entered the resident's room with supplies in hand; - Without a barrier, RN I laid supplies on the resident's bedside table; - Without performing hand hygiene, RN I donned gloves; - RN I picked up supplies and walked to the resident sitting in his/her wheelchair; - RN I squatted down in front of the resident, took saturated gauze out of cup and wiped wound and surrounding skin; - Without establishing a clean field, RN I set dressing supplies on the overbed table; - RN I removed gloves and threw the gloves and gauze into the waste can; - Without performing hand hygiene, RN I donned new gloves; - RN I removed Xeroform from package; - RN I opened Mepilex (self-adherent, soft silicone bordered foam dressing that is used to protect wounds from infection and further damage) while holding Xeroform between fingers; - RN I placed the Xeroform on the center of the Mepilex and placed it over the wound; - RN I removed gloves, disposed of trash in waste can; - Without performing hand hygiene, RN I left the resident's room. During an interview on 03/19/2025 at 10:52 A.M., RN I said hand hygiene should be performed upon entry to the resident's room, between glove changes, and when exiting the room. RN I said he/she only uses a barrier for supplies when it is a sterile procedure. He/She said the overbed table is to be wiped with a disinfectant prior to putting supplies on the table. 3. Review of Resident #23's Physician's Order Sheet, dated 03/20/25, showed: - An order for wound vac to right foot: clean wound and surrounding skin with wound cleanser and pat dry, apply skin prep (a protective wipes or liquid film-forming dressing to create a barrier between the skin and adhesives, tapes, or films) and drape (transparent material that creates a seal while acting as a barrier to external contaminants) to peri wound (the area of skin surrounding a wound) to prevent foam from touching healthy skin, apply black foam to wound bed and secure with drape, bridge foam to non-weight bearing surface if needed and apply vac at negative pressure 125mmHG continuous suction, change every Tuesday, Thursday, and Saturday, dated 03/07/25. Observation on 03/10/25 at 4:05 P.M. of the resident's wound care showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Desoto		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Villas Drive DE Soto, MO 63020	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Registered Nurse (RN) S said he/she had already wiped down the bedside table. Without placing a barrier on the table, RN S placed the dressing supplies on the table; - RN J donned gown, sanitized hands, and donned gloves; - RN J opened dressings and cut drape into strips; - RN J opened the sterile packing; - RN J removed gloves and placed into trash, sanitized hands, and donned new gloves; - RN J clamped tubing, removed dressing and wound vac from the resident's right foot; - The skin around the wound red and macerated (a condition where the skin becomes soft, soggy, and breaks down due to prolonged exposure to moisture); - RN J removed gloves and placed in trash; - Without performing hand hygiene, RN J donned new gloves; - RN J discarded old wound vac dressing and canister into trash; - RN J removed gloves and placed in trash; - Without performing hand hygiene, RN J donned new gloves; - RN J cleansed the wound with a wet gauze, removed gloves and placed gloves and gauze in trash; - Without performing hand hygiene, RN J donned new gloves; - RN J cleansed the wound with a wet gauze, removed gloves and placed gloves and gauze in trash; - RN J sanitized hands and donned new gloves; - RN J cleansed the wound with a wet gauze, removed gloves and placed gloves and gauze in trash; - RN J sanitized hands and donned new gloves; - RN J failed to apply skin prep and drape to peri wound; - RN J measured wound, cut black foam to fit wound bed, and placed black foam onto wound bed; - Without covering foam with drape, RN J applied wound vac [NAME] pad (a specialized tubing that is placed on top of the sponge and is connected to the device) to top of black foam; - RN J removed gloves and placed in trash; - RN J sanitized hands; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Desoto		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Villas Drive DE Soto, MO 63020	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The [NAME] pad and black foam started separating from the wound; - Without donning gloves, RN J placed finger onto the dressing to hold in place; - RN J donned gloves; - The open end of [NAME] pad tubing fell on to the floor. RN J picked up the tubing and laid it across the resident's legs; - RN J applied drape cut into strips over the [NAME] Pad and around black foam; - RN J removed gloves and placed in trash; - RN J sanitized hands and donned new gloves; - RN J wiped off the end of the open wound vac tubing that fell on the floor with wound cleaning solution and gauze; - RN J connected [NAME] pad tubing to canister tubing, plugged wound vac device into the wall and turned it on. During an interview on 03/10/25 at 4:55 P.M., RN J said he/she cleaned the tubing that fell on the floor because there were no more wound vac supplies and that is the only option he/she had. RN J said he/she should have applied skin prep and allowed it to dry before applying the dressing. During an interview on 03/13/25 at 08:45 A.M., RN I said Resident #23 had wound vac supplies in his/her room all week. During an interview on 03/13/25 at 8:45 P.M., the Administrator and Director of Nursing (DON) both said they would expect the dressing to be changed if the open tubing fell on to the floor. During an interview on 03/13/25 at 8:50 P.M., the Administrator and the DON said they expect staff to wear a gown and gloves during high contact activities for residents who require EBP, to perform hand hygiene prior to donning gloves, use a barrier for wound care supplies, and to sanitize multi use supplies after use. 49879 49999