STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265779	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Lake Ozark	872 College Boulevard Osage Beach, MO 65065

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse when Resident #2 touched Resident #1's chest inappropriately. The facility census was 57. 1. Review of the Facility's Abuse, Neglect, and Exploitation Program Responsibilities policy, dated September 2022, showed: -Each resident has the right to remain free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies; -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish; -Sexual abuse is defined as non-consensual contact of any type with a resident. 2. Review of the facility incident note, dated 03/26/25, showed staff documented the nurse found Resident #2's hand down Resident #1's shirt touching his/her chest. 3. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/10/25, showed staff assessed the resident as: -Severe cognitive impairment; -Used [NAME] and wheelchair; -Takes antipsychotic medications; -Diagnosis of dementia. Review of the resident's care plan, dated 03/21/25, showed it did not contain interventions related to the sexual altercation by Resident #2. Review of the resident's progress notes, dated 03/26/25, showed staff documented the resident was touched inappropriately by Resident #2. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/25 at 12:05 P.M., Licensed Practical Nurse (LPN) C said he/she was told the resident was on 15-minute checks for the resident to resident sexual altercation. He/She said the resident is on the 15 minute checks because he/she wanders the facility and he/she wandered over to Resident #2 and Resident #2 to touch him/her inappropriately in the chest. During an interview on 03/27/25 at 12:07 P.M., the Director of Nursing (DON) said Resident #1 wandered over to Resident #2, and Resident #2 touched Resident #1 inappropriately. He/She said after the incident the residents were placed on 15 minute checks. 4. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Verbal behavioral symptoms of yelling out; -No physical or sexual behaviors; -Diagnosis of stroke and anxiety. Review of care plan, dated 12/24/24, showed it did not contain documentation or interventions related to the inappropriate touching. During an interview on 03/27/25 at 12:05 P.M., LPN C said he/she was told the resident was on 15-minute checks for the resident to resident sexual altercation. Resident #2 inappropriately touched Resident #1's chest. During an interview on 03/27/25 at 12:07 P.M., the DON said was made aware of the incident by the Assistant Director of Nursing. He/She said Resident #2 touched Resident #1's chest inappropriately. He/She said Resident #2 is immobile. He/She said after the incident they were placed on 15 minute checks. MO00251734

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, facility staff failed to revise a comprehensive person-centered care plan for two residents (Resident #1 and #2) out of two sampled residents who had behaviors. The facility census was 57. 1. Review of the facility's policy titled, Comprehensive Care Plans, dated February 2025, showed: -It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality; -The comprehensive care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physician, mental, and psychosocial well-being. 2. Review of the Facility's Resident to Resident Altercations policy, revised October 2022, showed staff should make any necessary changes in the care plan approaches to any or all of the involved individuals. 3. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/10/25, showed staff assessed the resident as: -Severe cognitive impairment; -Wanderer behavior occurred one to three days; -Behavioral symptoms of physical, verbal, and other did not occur; -Diagnosis of Dementia. Review of resident's elopement evaluation, dated 03/10/25, showed: -Moderate Risk to wander; -Wanderer behavior with a pattern; -Wanders aimlessly; -Wanderer behavior likely to affect others. Review of resident's behavioral chart showed staff documented: -On 09/12/24 wandered/paced hallways during shift; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/08/24 wandered facility the whole shift, restless and anxious; -On 10/10/24 exhibited exit seeking behaviors; -On 10/15/24 attempted to get into bed with/another female resident; -On 10/26/24 wandered facility and other resident rooms confused and agitated; -On 02/14/25 wore shirt and a skirt and refused assistance and pants; -On 03/04/15 ambulated without assistance in hallway with just a shirt and brief on. He/She yelled pinched, and kicked at staff when they attempted to intervene. Review of resident's care plan, dated 03/21/25, showed the care plan did not contain documentation or interventions to direct staff for the resident's behaviors of wandering, elopement, physical behaviors towards others, verbal behaviors towards others, or after a resident to resident sexual altercation. Observation on 03/27/25 at 10:35 A.M., showed the resident propelled his/her self around the nurse station. Observation on 03/27/25 at 10:42 A.M., showed the resident propelled down the 200 hall. Observation on 03/27/25 at 10:50 A.M., showed the resident propelled down 200 hall and was looking in other resident rooms. During an interview on 03/27/25 at 10:30 A.M., Certified Nurse Aide (CNA) A said the resident wanders frequently and exit seeks. CNA A said he/she was made aware that the resident was touched inappropriately by another resident. He/She said the resident is now on 15 minute checks because he/she is mobile and wanders the halls frequently. He/She said he/she was unaware of interventions for the resident before the 15 minute checks. During an interview on 03/27/25 at 10:38 A.M., Certified Medication Technician (CMT) B said he/she was not made aware of any new interventions for the resident. CMT B said he/she knows the resident wanders but is not aware of any other behaviors. During an interview on 03/27/25 at 11:57 A.M., the MDS nurse said the resident does wander/exit seek. He/She said he/she was made aware of the resident being touched by another resident in appropriately that morning but did not update the care plan because he/she was not told it was witnessed and he/she thought it was just an allegation. He/she said residents who wander or are an elopement risk should have it care planed. He/She said he/she was not aware the resident was missing the wandering and elopement from his/her care plan and said it must have been an oversight. During an interview on 03/31/25 at 10:45 A.M., the resident's family member said the resident is known to exit seek and wander the facility. He/She said the resident uses a wander guard bracelet to prevent him/her from exiting the building. He/She said the resident is known to refuse care and be non-cooperative. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/25 at 12:05 P.M., Licensed Practical Nurse (LPN) C said he/she was told the resident was on 15-minute checks for a resident-to-resident altercation. He/She said the resident likes to wander and exit seek but has a wander guard on. He/She said he/she was not made aware of any other behaviors and had not witnessed any that day. He/She said wandering, elopement and any behaviors should be care planned. He/She would expect the incident to be care planed with interventions. During an interview on 03/27/25 at 12:07 P.M., Director of Nursing (DON) said the resident likes to exit seek and wander but does wear a wander guard. He/She said the resident can be verbally aggressive but not physically. He/She said he/she would expect the resident's behaviors, wandering/elopement risk, and the incident to be care planned. He/She said he/she is not sure why it wasn't. 4. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Verbal behavioral symptoms; -No physical or sexual behaviors; -Diagnosis of stroke and anxiety. Review of care plan, dated 12/24/24, showed it did not contain documentation to direct staff for sexually inappropriate behaviors. During an interview on 03/27/25 at 11:57 A.M., the MDS nurse said residents with behaviors that are sexually inappropriate should be care planned. He/She said he/she was made aware of the incident regarding the resident inappropriately touching another resident, but he/she thought it was just an allegation and did not know it was witnessed. He/she said he/she did not update the care plan to include the new behavior or interventions. During an interview on 03/27/25 at 12:05 P.M., LPN C said he/she was made aware of the incident regarding the resident inappropriately touching another resident, during shift report. He/She said he/she would expect there to be an updated care plan regarding the situation and detailed interventions. He/She said he/she was told in report that they are to keep eyes on the residents and keep them separated. During an interview on 03/27/25 at 12:07 P.M., DON said he/she was in the facility when staff witnessed the resident touching another resident inappropriately. He/She said staff were made aware of the incident and he/she said he/she would expect the acre plan to have been updated with the new behavior. MO00251734