

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 08/02/2024
NAME OF PROVIDER OR SUPPLIER Stonebridge Lake Ozark		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131</p> <p>Based on interview and record review, facility staff failed to review the code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) and failed to obtain physician orders for their preferred code status for two residents (Resident #42 and #159) out of 22 sampled residents. The facility census was 52.</p> <p>1. Review of the facility's Advance Directives policy, dated [DATE], showed upon admission, the resident will be provided with written information in a manner easily understood by the resident or resident representative concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Prior to or upon admission of a resident, the facility will inquire of the resident, his/her family members about the existence of any written advance directives. the resident's Advance Directives must be easily accessible by staff in order for staff to make appropriate clinical decisions during emergency and routine situations.</p> <p>Review of the facility's Do Not Resuscitate Order (DNR) policy, dated [DATE], showed a DNR form must be completed and signed by the attending physician and resident and placed in the front of the resident's medical record.</p> <p>2. Review of Resident's 42's face sheet, undated, showed the resident admitted to the facility on [DATE]. The face sheet did not contain an Advance Directive for the resident.</p> <p>Review of the resident's medical record did not contain a completed Advance Directive form, dated and sign by the resident, or the resident's representative.</p> <p>Review of the the facility's Advance Directive Folder, kept at the nurse's station, showed it did not contain a completed Advance Directive form for the resident.</p> <p>Review of the resident's care plan, dated [DATE], showed the resident has an Advance Directive for a DNR code status.</p> <p>Review of the resident's Physician Order Sheet (POS), dated [DATE], showed it did not contain an order for Advance Directive.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:21 A.M., the resident's representative said he/she has not filled out any paperwork and has not been asked about the resident's Advance Directive, since his/her admission.</p> <p>During an interview on [DATE] at 1:46 P.M., Registered Nurse (RN) B said the resident is Hospice so he/she should have an advance directive/code status. The RN said he/she did not know the resident did not have an order for his/her code status. The RN said since the resident received hospice services and does not have a code status order it puts the resident at an increased risk of staff potentially performing Cardiopulmonary resuscitation (CPR), an emergency treatment that's done when someone's breathing or heartbeat has stopped. The RN said the Social Services Director (SSD) or charge nurse who is in the facility when the resident is admitted , should get a code status order. The RN said the resident admitted on [DATE], and should have a code status order by now.</p> <p>During an interview on [DATE] at 4:07 P.M., the SSD said he/she doesn't know why the resident doesn't have an order for his/her code status, the nurse should get the order. The SSD said he/she does not have access to the POS. The SSD said without an order, staff will code the resident and the resident is not a full code. The SSD said staff would have to perform CPR if there is not a DNR order. The SSD said he/she didn't ask the resident's family, the nurse should have asked his/her family, Advance Directives is in the nurse's admission paperwork.</p> <p>During an interview on [DATE] at 11:00 A.M., RN C said he/she admitted the resident and he/she had no paperwork to fill out with the resident when he/she admitted . The RN said he/she could not fill out the code status, because he/she did not have access to the paperwork he/she needed, to have the resident or family sign.</p> <p>During an interview on [DATE] at 1:51 P.M., RN C said he/she forgot to put the code status in when he/she admitted the resident. The RN said he/she got busy and did not get it done.</p> <p>3. Review of Resident 159's face sheet, undated, showed the resident admitted to the facility on [DATE]. Review showed the face sheet did not contain an Advance Directive for the resident.</p> <p>Review of the resident's care plan, dated [DATE], showed the resident Advance Directive as a DNR code status.</p> <p>Review of the resident's Physician Order Sheet (POS), dated [DATE], did not contain an order for an Advance Directive.</p> <p>Review of the the facility's Advance Directive Folder, kept at the nurse's station, did not contain a completed Advance Directive Form for the resident.</p> <p>During an interview on [DATE] at 4:43 P.M., RN B said the SSD does not get orders, the SSD fills out the paperwork and gives it to the nursing staff and the nursing staff clarify the paperwork with the doctor and add the order to the POS. The RN said the nurses never received any paper work for the resident.</p> <p>During an interview on [DATE] at 4:01 P.M., the SSD said he/she doesn't know why the resident's POS doesn't have a code status order, typically the nurses call the doctor. The SSD said there should be a doctors order for the code status on the POS.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on [DATE] at 4:53 P.M., the Director of Nursing (DON) said typically the nurse who admits the resident should put admission orders in, if the nurse is overwhelmed, the assisting DON and DON can help. The DON said a code status should be added to the POS by the admitting nurse. The DON said code status and consent to treat is a part of the admission paperwork, but should be completed by the charge nurse when admitted. The DON said every resident should have a code status on their POS, when they are admitted to the facility. The DON said he/she does not know why the two residents don't have one. The DON said if staff don't have a code status for the resident, staff would perform CPR. The DON said paramedics would have to do the same without a DNR, they would have to provide life saving measures. The DON said the facility has a code status book at the nurse's station. The DON doesn't know why the two resident's code status is not in the code status book. The DON said it should be put in the book by the admitting nurse. The DON said he/she is sure somebody is supposed to review the code status book, he/she just doesn't know who. The DON said he/she does not think there is admission packets at the nurse's station.</p> <p>During an interview on [DATE] at 2:06 P.M., the administrator said the nurse who admits the resident, should fill out the code status paperwork and get a telephone order from the physician. The administrator said the DON is responsible to ensure the nurses get the code status orders.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45489</p> <p>Based on observation, interview and record review, facility staff failed to develop and implement a comprehensive person-centered care plan addressing code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) for three residents (Resident #11, #20, and #25) out of a sample of 22 residents. The facility census was 52.</p> <p>1. Review of the facility's policy titled, Comprehensive Care Plans, dated [DATE], 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 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; all care area assessments (CAAs) triggered by the MDS will be considered in developing the plan of care. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, the resident's goals for admission, desired outcomes, and preferences for future discharge.</p> <p>2. Review of Resident #11's Admission MDS, dated [DATE], showed staff the resident admitted to the facility on [DATE].</p> <p>Review of the resident's Physician Order Sheet (POS), dated [DATE], showed an order for Full Code (a medical order that indicates a patient's medical team should take all possible measures to maintain and resuscitate their life if they experience cardiac or respiratory arrest) status with a start date of [DATE].</p> <p>Review of the resident's comprehensive care plan, dated [DATE], showed it did not contain the resident's code status or preferences.</p> <p>3. Review of Resident #20's Admission MDS, dated [DATE], showed staff assessed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's medical record showed staff documented the resident's code status as Do Not Resuscitate ((DNR), an order than informs medical staff that cardiopulmonary resuscitation (CPR) should not be attempted).</p> <p>Review of resident's care plan, dated [DATE], showed it did not contain the resident's code status or preferences.</p> <p>4. Review of Resident #25's Admission MDS, dated [DATE], showed staff assessed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's medical record showed staff documented the resident's code status as DNR.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated [DATE], showed it did not contain the resident's code status or preferences.</p> <p>5. During an interview on [DATE] at 9:37 A.M., Certified Nurse Aide (CNA) K said the residents' code status can be found on the care plans. If the code status is not on the care plan the CNA would go to the nurse and ask. The CNA said if a resident is unresponsive, and he/she is unable to find the code status it would delay the residents care. The CNA said if he/she did not know a residents' code status, he/she would initiate CPR and this could be against the residents' wishes.</p> <p>During an interview on [DATE] at 9:39 A.M., Licensed practical nurse (LPN) J said a residents' code status should be on their care plan. The LPN said if the code status is not on the care plan a resident who wishes to be a DNR could receive CPR in an emergency situation.</p> <p>During an interview on [DATE] at 9:46 A.M., the Director of nursing (DON) said a residents' code status should be on their care plan. The DON said if a code status is not on a residents care plan there is potential staff would not follow the resident's wishes in an emergency. The DON said when a resident is admitted the nurse is responsible for obtaining the orders for code status preference. Once the nurse has the order it should be entered into the electronic Medication Administration Record (eMAR) system and the MDS coordinator is responsible for putting the code status on the care plan.</p> <p>During an interview on [DATE] at 10:50 A.M., the MDS coordinator said a residents' code status should be on the care plan. The MDS coordinator said he/she believes all residents have a code status on their care plan. The MDS coordinator said there could be a detrimental outcome if staff are needing to look for a code status and it is not there.</p> <p>During an interview on [DATE] at 11:25 A.M., the MDS Coordinator said code status should go on the care plan on admission, and the care plans should be reviewed quarterly or if there are any changes, including daily changes. He/she said he/she was responsible for making those changes and it was missed.</p> <p>During an interview on [DATE] at 1:00 P.M., the administrator said code status should be on the care plan and the MDS Coordinator is responsible to update, and he/she did not know some of the resident's did not have a code status on their care plan.</p> <p>50361</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45489</p> <p>Based on observation, interview, and record review, facility staff failed to review and revise the care plan for one resident (Resident #20) who started dialysis and for a change in code status for one resident (Resident #33) out of a sample of 22 residents. The facility census was 52.</p> <p>1. Review of the facility's policy titled, Comprehensive Care Plans, dated [DATE], showed 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) assessment. All care area assessments (CAAs) triggered by the MDS will be considered in developing the plan of care. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and the resident's goals for admission, desired outcomes, and preferences for future discharge. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.</p> <p>2. Review of Resident #20's Admission MDS, dated [DATE], showed the resident admitted to the facility on [DATE] with diagnoses of anemia and End Stage Renal Disease (ESRD).</p> <p>Review of the resident's medical record showed staff documented the resident went to the hospital on [DATE] and returned to the facility on [DATE]. The resident returned with new orders to begin dialysis treatment three times a week.</p> <p>Review of the resident's care plan, dated [DATE], showed the care plan did not contain direction for staff in regard to the resident's dialysis treatments.</p> <p>During an interview on [DATE] at 9:40 A.M., Licensed Practical Nurse (LPN) J said a care plan should be updated right away when resident returns from the hospital because there was clearly a change in condition. LPN said if a resident has a new order for dialysis it should be updated on the care plan immediately to prevent lapse in care.</p> <p>During an interview on [DATE] at 9:48 A.M., the Director of nursing (DON) said care plans should be updated as soon as there is a change in condition with a resident. The DON said if a resident has returned from the hospital with a new order for dialysis, he/she would expect the care plan to be updated immediately. He/she said the MDS coordinator is responsible for updating the care plan.</p> <p>During an interview on [DATE] at 10:51 A.M., The MDS coordinator said care plans should be updated with any resident changes, which could be daily. The MDS coordinator said care plans are reviewed quarterly with the whole care team. The MDS coordinator said new orders for dialysis should be translated to the care plan in real time. He/she said he/she thought the resident's care plan was updated.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:49 P.M., the administrator said he/she would expect staff to complete a care plan review when a resident returns from the hospital. The administrator said they would expect to see new orders for dialysis on the resident's care plan. The MDS coordinator is responsible for ensuring care plans are completed and updated.</p> <p>3. Review of Resident #33's Annual MDS, dated [DATE], showed staff assessed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's Physician Order Set (POS), dated [DATE], showed an order for Do Not Resuscitate ((DNR), an order that informs medical staff that cardiopulmonary resuscitation (CPR) should not be attempted). Review showed a previous order for Full Code status changed to DNR on [DATE].</p> <p>Review of the resident's care plan, dated [DATE], showed it did not contain the resident's code status or change in code status or preferences.</p> <p>During an interview on [DATE] at 9:37 A.M., Certified nurse aide (CNA) K said he/she would look for a residents' code status on their care plan. If the code status is not on the care plan the CNA would go to the nurse and ask. The CNA said if a resident is unresponsive, and he/she is unable to find the code status this could delay care. The CNA also said if he/she did not know a residents' code status, he/she would initiate CPR and this could be against the resident's wishes.</p> <p>During an interview on [DATE] at 9:39 A.M., Licensed Practical Nurse (LPN) J said a residents' code status should be on their care plan. The LPN said if the code status is not on the care plan a resident who wishes to be DNR could receive CPR in an emergency situation.</p> <p>During an interview on [DATE] at 9:46 A.M., the Director of Nursing (DON) said a residents' code status should be on their care plan. The DON said if a code status is not on the resident's care plan there is a potential staff would not follow the resident's wishes in an emergency. He/she said when a resident is admitted the nurse is responsible for obtaining the orders for code status preference. Once the nurse enters the orders into the electronic Medication Administration Record (eMAR) system the MDS coordinator is responsible for putting the code status on the care plan.</p> <p>During an interview on [DATE] at 11:25 A.M., the MDS Coordinator said code status should go on the care plan on admission, and the care plans should be reviewed quarterly or if there are any changes, including daily changes. He/she said he/she is responsible for making those changes and it was just missed, it was a lapse.</p> <p>During an interview on [DATE] at 1:00 P.M., the Administrator said code status should be on the care plan and the MDS Coordinator is responsible to update, and he/she did not know they were missing.</p> <p>50361</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>37131</p> <p>Based on observation, interview, and record review, staff failed to ensure medications were monitored and stored in a safe and effective manner. Licensed staff failed to maintain the control logs for three controlled medications in the facility's destruction cabinet. The facility census was 52.</p> <p>1. Review of the facility's Controlled Substances policy, dated December 2016, showed nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing (DON).</p> <p>Review of the facility's Discarding and Destroying Medications policy, dated October 2016, showed disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by resident.</p> <p>2. Review of Resident #98's Control Log, undated, showed staff documented a count of 20 tablets of Hydrocodone/APAP(Tylenol) (a narcotic medication used to treat pain) 5-325 milligrams (mg) on 07/27/24.</p> <p>Review of the resident control log showed staff did not document a count of the residents Hydrocodone/APAP 5-325 mg on 07/28/24, 07/29/24, 07/30/24, 07/31/24 and 08/01/24, with the off going and on going nurses.</p> <p>Observation on 08/01/24 at 2:54 P.M., showed the destruction cabinet in the medication room contained a bubble pack of Hydrocodone/APAP 5-325 mg with 20 tablets left in the bubble pack.</p> <p>3. Review of Resident #99's Control Log, undated, showed staff documented on 07/26/24 a count 19 tablets of Lorazepam (a narcotic medication used to treat anxiety) 0.5 mg and 30 milliliters (ml) of Morphine Solution (a narcotic medication used to treat pain) 100 mg/5 ml.</p> <p>Review of the resident control log showed staff did not document a count of the residents Lorazepam 0.5mg and Morphine Solution 100 mg/5 ml on 07/27/24, 07/28/24, 07/29/24, 07/30/24, 07/31/24 and 08/01/24, with the off going and on going nurses.</p> <p>Observation on 08/01/24 at 02:54 PM, showed the destruction cabinet in the medication room contained an open bottle of Morphine Solution with 30 ml left in the bottle.</p> <p>4. During and interview on 08/01/24 at 2:54 P.M., the Assistant Director of Nursing (ADON) said the nurses who pull the controlled medication for destruction, put the medications in the destruction cabinet. The ADON said the nurse's usually bring the medications for destruction to him/her, but he/she should have checked the destruction cabinet. The ADON said he/she had not checked the destruction cabinet, because the DON had just quit and he/she had been trying to run everything and work the floor. The ADON said staff should always sign, when they have access to the controlled medications. The ADON said he/she does not know why the nursing staff had not been signing the controlled logs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/01/24 at 3:12 P.M., Licensed Practical Nurse (LPN) J said the nurse who signs off on controlled narcotics should be the only staff with access to the controlled medications. The LPN said staff should sign the controlled log at the beginning and end of their shift. The LPN said the nurse coming on shift should count the controlled medications with the nurse who is leaving. The LPN said to be honest, he/she did not realize the medications were in the cabinet.</p> <p>During an interview on 08/01/24 at 3:18 P.M., Registered Nurse (RN) B said nurses should count controlled medications every time they take the keys. The RN said he/she did not sign for the controlled medications, because he/she did not know there was any controlled medications in the cabinet. The RN said he/she should have signed for the medications.</p> <p>During an interview on 08/01/24 at 5:22 P.M., the DON said staff have to sign the controlled log when they have access to controlled medications. The DON said staff should count and sign controlled logs at shift change. The DON said if controlled medications are in the destruction cabinet, they still have to count and document the count on a controlled log. The DON said the controlled medications should have never come out of the the medication cart, unless they were being destroyed. The DON said he/she does not know why staff weren't signing the control sheets. The DON said the ADON is responsible for monitoring for medications that need to be destroyed.</p> <p>During an interview on 08/02/24 at 2:06 P.M., the administrator said on-coming and off-going staff should count all controlled medications every shift. The administrator said controlled medications scheduled for destruction should be counted at shift change by staff. The administrator said he/she does not know why staff did not count the controlled medications in the destruction cabinet. The administrator said he/she does not know who is responsible to check the destruction cabinet. The administrator said he/she did not know there was a destruction cabinet.</p>		