STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265810	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Adams Street	1024 Adams Street Jefferson City, MO 65101

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43010 Based on interview and record review, facility staff failed to contact one resident's (Resident #3) responsible party and physician when the resident had an unwitnessed fall. The facility census 54. 1. Review of the facility's Change in a Resident's Condition or Status Policy, dated 5/2017, showed staff are directed to promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and or status. The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident. Unless otherwise instructed by the resident a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source. 2. Review of Resident #3's Minimum Data Set (MDS), a federally mandated assessment tool, dated, showed: -Severe cognitive impairment; -Diagnosis of right sided paralysis and vascular dementia; -Dependant on two staff for transfers; -Two falls since prior assessment, one without injury and one with injury. Review of the resident's care plan, dated 10/7/24, showed staff assessed at risk for falls due to poor safety awareness and impulsiveness. Staff are directed to keep the bed in low position, keep the call light within reach, and not to leave the resident alone in his/her room in his/her wheelchair due to impulsivity and attempt to place himself/herself in bed. Review of the resident's nurses notes, dated 10/4/24, showed the staff documented the resident slid from his/her wheelchair and on the floor in front of his/her sink. Staff documented they assessed the resident and helped him/her back into his/her wheelchair off of the floor. Staff did not document they notified the physician and family. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/24 at 9:53 A.M., Licensed Practical Nurse (LPN) A said when a resident has a fall the physician and family should be contacted. He/She said the resident slid from his/her wheelchair to the floor. The LPN said the resident said he/she put himself/herself on the floor. He/She said it is care planned for the resident to put himself/herself on the floor. The LPN said he/she did not notify the doctor or family because he/she did not consider the resident to have had a fall. During an interview on 10/11/24 at 1:52 P.M., LPN D said if a resident has an unwitnessed fall the physician and family should be notified as part of their fall policy. He/She said it is documented in point click care under the resident's post fall report. During an interview on 10/17/24 at 12:00 P.M., the resident's family member said he/she was not contacted on 10/4/24 regarding the resident's unwitnessed fall. During an interview on 10/17/24 at 1:40 P.M., the Director of Nursing (DON) said nurses are expected to notify the physician and family if a resident has a witnessed or unwitnessed fall. If a resident put themselves in the floor it is considered an unwitnessed fall. During an interview on 10/17/24 at 1:48 P.M., the administrator said staff are expected to notify the physician and family if the resident has a fall. MO00243183 and MO00243145

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43010 Based on interview and record review, facility staff failed to complete neurological checks for three residents (Resident #1, #2, and #3) out of three sampled residents who had unwitnessed falls. The facility census was 54. 1. Review of the facility's Fall Clinical Protocol Policy, dated 09/2012, showed falls should be categorized as those that occur while trying to rise from a sitting or lying to an upright position, those that occur while upright and attempting to ambulate, and other circumstances such a sliding out of a chair or rolling from a low bed to the floor. Review of the facility's Post Fall Step by Step Policy, undated, showed staff are to complete post fall initial clinical assessment completed one time directly after each fall. Post fall 72- hour monitoring is completed after a no head injury fall once per shift for three days Post fall 72-hour monitoring with head injury is completed on a tapering scale for 72 hours. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 8/21/24, showed staff assessed the resident as: -Modified cognition; -Diagnosis of right sided paralysis; -No falls since prior assessment. Review of the resident's care plan, dated 10/2024, showed staff assessed the resident with falls and staff are instructed to remind the resident to use his/her call light for assistance, have non slip footwear, and not to leave the resident unattended in his/her wheelchair while in his/her room. Review of the facility's fall report, dated 9/11/24 to 10/11/24, showed staff documented the resident had a fall with injury on 9/22/24. Review of the residents medical did not contain documentation staff completed neurological checks for 72 hours after the residents fall on 09/22/24. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Diagnosis of Vascular dementia, stroke, and contracture of right knee; -Three falls since prior assessment, two without injury and one with injury. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 9/18/24, showed staff assessed the resident at risk for falls related to dementia, poor safety awareness, and contracture's to bilateral knees. Staff are instructed if fall occurs, initiate frequent neurological checks and bleeding evaluation per facility protocol. Review of the facility's fall report, dated 9/11/24 to 10/11/24, showed staff documented the resident had a fall with injury on 9/11/24. Review of the residents medical did not contain documentation staff completed neurological checks for 72 hours after the residents fall on 09/11/24. 4. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severe cognitive impairment; -Diagnosis of right sided paralysis and vascular dementia; -Two falls since prior assessment, one without injury and one with injury. Review of the resident's care plan, dated 10/7/24, showed staff assessed the resident at risk for falls related to poor safety awareness and impulsiveness. Staff are instructed to use slip resistant footwear, floor matt at bedside, and complete neurological checks for the next 72 hours. Staff documented puts self on the floor in his/her careplan. Review of the facility's fall report, dated 9/11/24 to 10/11/24, showed staff documented the resident had an unwitnessed fall on 10/4/24. Review of the residents medical did not contain documentation staff completed neurological checks for 72 hours after the residents fall on 10/04/24. During an interview on 10/11/24 at 9:53 A.M., Licensed Practical Nurse (LPN) A said neurological checks are to be complete for 72 hours post fall. He/She said the resident slid from his/her wheelchair to the floor. The LPN said the resident said he/she put himself/herself on the floor. He/She said it is care planned for the resident to put himself/herself on the floor. This is why he/she did not initiate neurological checks. 5. During an interview on 10/11/24 at 1:52 P.M., LPN D said if a resident has an unwitnessed fall or they hit their head, neurological checks should be completed for 72 hours in point click care. If a resident is unable to tell what happened neurological checks would be initiated. During an interview on 10/16/24 at 8:02 A.M., LPN F said if a resident has a fall and hits their head, has an injury, or the fall is unwitnessed nurses are expected to perform neurological checks for 72 hours. If a resident placed themselves in the floor unwitnessed it is still considered an unwitnessed fall. During an interview on 10/17/24 at 1:40 P.M., the Director of Nursing (DON) said nurses are expected to start neurological checks for residents who have fallen and hit their head, found on the floor, or had an unwitnessed fall. The neurological checks are done for a period of 72 hours. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 1:48 P.M., the administrator said staff are expected to start neurological checks and complete them for 72 hours on residents who have had an unwitnessed fall or hit their head. MO00243183 and MO00243145