

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265810	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Adams Street		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure oxygen tubing and/or nebulizer mask and tubing were changed at least weekly for four residents (Resident #1, #2, #3, and #4) out of four sampled residents and failed to provide orders for oxygen therapy for one resident (Resident #4). The facility's census was 58. 1. Review of the facility's Oxygen Concentrator policy, revised 01/2018, showed: -Oxygen is administered under orders of the attending physician, except in the case of an emergency;-Keep delivery devices covered in plastic bag when not in use;-Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated;-Change humidifier bottle when empty, every 72 hours, or as recommended by the manufacturer;-If applicable, change nebulizer tubing and delivery devices every 72 hours. 2. Review of the facility's policy on Cleaning and Disinfecting Nebulizer equipment, dated 2017, showed staff were directed to replace nebulizer mask and tubing weekly. 3. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/17/25, showed staff assessed the resident as cognitively intact, and received oxygen therapy. Review of the resident's care plan, revised 07/10/25, showed staff assessed the resident to wear oxygen as needed for oxygen saturation below 90%. Review of the resident's Physician Order Sheet (POS), dated 08/22/25, showed an order for oxygen one liter per minute (LPM) via nasal cannula for oxygen saturation for shortness of breath, and to change and date oxygen tubing/nasal cannula and nebulizer mask and tubing every Sunday night shift related to COPD. Review of the resident's TAR, dated 08/01/25 through 08/22/25, showed staff were directed to change and date oxygen tubing/nebulizer mask and tubing every Sunday night shift related to COPD. Observation on 08/22 at 9:05 A.M., showed an oxygen concentrator next to the resident's bed, the nasal cannula unbagged, and tube dated 07/28/25. Observation showed a nebulizer mask on the bed, unbagged, and the tube dated 07/28/25. During an interview on 08/22/25 at 9:05 A.M., the resident said staff administers breathing treatments to him/her via the nebulizer mask, and he/she uses oxygen sometimes. Observation on 08/22/25 at 1:55 P.M., showed a nebulizer mask hung from the nebulizer machine, and the tubing dated 07/28/25. 4. Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact, received oxygen therapy, and uses a non-invasive mechanical ventilator (Bilevel Positive Airway Pressure (BiPAP)- a machine to help a person breathe). Review of the resident's care plan, revised 08/22/25, showed staff documented the resident to wear oxygen as needed, and to change oxygen tubing and cannister weekly. Review of the resident's POS, dated 08/22/25, showed an order for BiPAP at bedtime, and Ipratropium-Albuterol Inhalation Solution 0.5-2.5, three milligrams (mg)/three milliliters (ml) vial, inhale orally every six hours as needed for shortness of breath. Review of the resident's TAR, dated 08/01/25 through 08/22/25, showed the TAR did not contain documentation to direct staff on when to change the BiPAP and nebulizer masks and tubing. Observation on 08/22/25 at 9:12 A.M., showed a BiPAP mask and a nebulizer mask on the resident's nightstand, unbagged, and the masks and tubing dated 07/29/25. During an interview on 08/22/25 at 9:13 A.M., the resident said he/she wears oxygen via his/her BiPAP at nights. 5. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and received oxygen therapy. Review of the resident's care plan, revised 07/10/25, showed staff documented the resident should wear oxygen at two LPM continuously via nasal cannula, and to change oxygen tubing and water cannister weekly. Review of the resident's POS, dated 08/22/25, showed physician orders as followed: -Oxygen two LPM via nasal cannula for oxygen saturation below 90% or shortness of breath every shift;-Change oxygen tubing/nebulizer mask and tubing every Sunday night shift for prevention of infection;-Ipratropium-Albuterol Inhalation Solution 0.5-2.5, three mg/three ml vial, inhale orally every six hours for productive cough. Review of the resident's TAR, dated 08/01/25 through 08/22/25, showed staff were directed to change oxygen tubing/nebulizer mask and tubing every Sunday night shift for prevention of infection. Observation on 08/22/25 at 9:32 A.M., showed the resident wore his/her oxygen via nasal cannula. Observation showed the oxygen tubing undated, and the humidifier bottle, dated 07/29/25. Observation showed a nebulizer mask on the floor, unbagged, and the tube dated 07/29/25. During an interview on 08/22/25 at 9:32 A.M., the resident said he/she wears oxygen all the time, and staff administers a breathing treatment to him/her a few times per day. 6. Review of Resident #4's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and received oxygen therapy. Review of the resident's care plan, revised 06/12/25, showed staff were directed</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and record review, facility staff failed to ensure prepared food items were served at a safe and appetizing temperature when facility staff failed to serve meals in a timely manner to residents and failed to maintain the internal temperatures of hot food to at least 120 degrees Fahrenheit (F) upon service to residents who resided on the 300 and 400 halls. The facility census was 58.1. Review of the facility's Food Preparation and Service policy, dated July 2014, showed the danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. 2. Review of the facility's Food Safety Requirements policy, dated 09/2022, showed foods and beverages shall be distributed and served to resident in a manner to prevent contamination and maintain food at the proper temperature and out of the danger zone. This includes timely distribution of all meals and snacks. 3. Observation on 08/22/25 at 12:29 P.M., showed an un-enclosed cart in the dining room with meals served on warm plates, covered with insulated dome plate covers. Observation on 08/22/25 at 12:31 P.M., showed a staff member took the un-enclosed cart with meals and placed the cart across from the nurses' station against the wall between the 300 and 400 halls. Observation on 08/22/25 at 12:35 P.M., showed a staff member delivered a meal tray from the un-enclosed cart to a room on the 300 hall. Observation on 08/22/25 at 12:41 P.M., showed several lunch trays remained on the un-enclosed cart across from the nurses' station. During an interview on 08/22/25 at 1:2 P.M., Certified Nursing Assistant (CNA) B said the nursing staff usually serve the residents in the dining room first, then deliver meal trays to the residents who eat in their rooms. During an interview on 08/22/25 at 2:04 P.M., the resident said his/her breakfast was cold when he/she got it and is often served that way to him/her. He/She said lunch was a bit warmer than breakfast, but not hot. During an interview on 08/22/25 at 2:26 P.M., the Director of Nursing (DON) said the nursing staff is responsible to deliver meals to residents who eat in their rooms, and he/she ensures staff delivers the meals timely, so they are not served cold to the residents. The DON said he/she had not been able to monitor meal service for the past few weeks. During an interview on 08/22/25 at 2:08 P. M., [NAME] C said dietary staff plates the trays, then nursing staff places the drinks and condiments on the trays and serve to the residents. 4. Observation on 08/22/25 at 12:50 P.M., showed the administrator took the temperature of the foods on Resident #8's tray. Observation showed the internal temperature of the fish measured 91.5 F and the internal temperature of the rice measured 98 F. The administrator directed staff to serve the resident his/her tray and take the cart to the 300 hall and serve the remaining lunch trays to the residents who ate in their rooms, after he/she checked the food temperatures. 5. During an interview on 08/22/25 at 1:10 P.M., Resident #8 said by the time he/she got his/her lunch, the food was not hot. During an interview on 08/22/25 at 3:00 P.M., the administrator said hot foods should be above 120 F when served to the residents and he/she should not have directed staff to serve the residents the meals with the food temperatures below 98 F. 9. During an interview on 08/22/25 at 2:08 P.M., [NAME] C said the temperature of hot foods served to the residents should be about 145 F. He/She said if staff notifies dietary staff a resident's meal is below temperature or cold, dietary staff will either serve a new plate from the steamtable or offer an alternative if requested. During an interview on 08/22/25 at 2:26 P.M., the DON said hot foods should be served hot to the residents. The DON said when staff deliver meals to residents in their rooms, staff should check with the residents before leaving the room that the food temperature is ok for them, and if not, offer to get a new plate, or reheat if requested. During an interview on 08/22/25 at 3:00 P.M., the administrator said the nursing staff is responsible to deliver meals to residents' rooms quickly after they are served from the kitchen to ensure appropriate temperatures, and the DON to monitor the nursing staff during meals.</p> <p>Complaint# 2587511 and 2587447</p>		