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	03/19/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide safe mechanical transfer for one resident (Resident #1) and staff failed to transfer one resident (Resident #3) in a safe manner. Census was 47.1. Review of the facility's policy, Safe Lifting and Movement of Residents, dated 07/2017, showed in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.Review of the facility's policy, Hoyer Safety, undated, showed staff are directed to lock the wheels and widen the base to transfer. The policy did not provide direction for staff when to close the base of the lift.The facility did not provide a policy regarding safe transfers using a gait belt. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact and was dependent on staff with transferring to and from a bed to a chair or wheelchair. Dependent on staff for toileting hygiene.Review of the resident's care plan, dated 02/20/26, showed staff documented the resident required assistance from two staff for transfers.Observation on 03/19/26 at 9:31 A.M., showed Certified Nurse Aide (CNA) A and CNA B entered the resident's room to provide care. CNA A operated the mechanical lift, opened the legs during the tranters. Observation showed during the transfer the legs of the lift closed, and the resident was lowered into his/her wheelchair. During an interview on 03/19/26 at 2:25 P.M., CNA said he/she were educated to open the legs of the mechanical lift when transferring the resident. He/She said he/she open the legs of the mechanical lift, but there had been issues with the mechanical lift and the legs would open and close on their own.During an interview on 03/25/26 at 10:39 A.M., CNA B said the legs of the mechanical lift should be opened during a transfer. He/She said staff were directed to report issues with the mechanical lift to the nurse. He/She said he/she did not think CNA A locked the legs of the mechanical lift when transferring the resident. During an interview on 03/19/26 at 3:09 P.M., the administrator said staff are directed to open the legs of the mechanical lift during a transfer for stability. He/She said if the legs of the mechanical lift were not opened during the transfers, there was a possibility the lift could tip over and cause injury to the resident. He/She said he/she did not know any issues with the mechanical lifts, but staff are directed to report issues to the maintenance department. During an interview on 03/19/26 at 3:10 P.M., the Director of Nursing (DON) said staff are directed to open the legs of the mechanical lift during a transfer for stability. He/She said if the legs of the mechanical lift were not opened during the transfers, there was a possibility the lift could tip over and cause injury to the resident. He/She said he/she did not know any issues with the mechanical lifts, but staff should report issues to the maintenance department. During an interview on 03/25/26 at 10:56 A.M., Licensed Practical Nurse (LPN) E said staff are educated to open and lock the legs of the mechanical lift during tranters for stability.During an interview on 03/25/26 at 11:04 A.M., the ADON said staff are directed to lock the legs of the mechanical lift when in an open position. He/She recently watched staff completing transfers of residents with a mechanical lift and staff were unlocking the legs of the mechanical lift during the transfer process. 3. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed the resident as moderately cognitively impaired and was dependent on staff with transferring to and from a bed to a chair or wheelchair.Review of the resident's care plan, dated 02/06/26, showed staff documented the resident required assistance from two staff members with transfers.Observation on 03/19/26 at 1:37 P.M., showed CNA A entered the resident's room to provide transfer assistance. CNA A placed his/her arms around the resident's waist, lifted the resident out of the wheelchair, with the resident's feet in the air, and transferred the resident to the bed. The CNA A did not use a gait belt to transfer the resident. Observation showed the gait belt hung inside the resident's room by the door. During an interview on 03/19/26 at 1:37 P.M., the resident said staff did not use a gait belt when transferring him/her. He/She said there was a gait belt hanging by the door.During an interview on 03/19/26 at 2:25 P.M., CNA A said the resident required assistance from one staff member during transfers. He/She said he/she did not use the gait belt because it slipped his/her mind. He/She said the concern with not using a gait belt during a transfer was the potential for the resident to sustain injury.During an interview on 03/19/26 at 2:37 PM, LPN D said staff are required to use a gait belt anytime they are transferring a resident to prevent injury.During an interview on 03/19/26 at 3:09 P.M., the administrator said staff are directed to use a gait belt any time they are transferring a resident. He/She said staff utilized a gait belt to prevent potential injury to the resident.During an interview on 03/19/26 at 3:10 P.M., the DON said staff are required to use a gait belt any time a resident required transfer assistance from staff. He/She said the purpose of using the gait belt was to prevent potential injury to the resident. 2807774

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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** Based on observation, interview and record review, facility staff failed to use appropriate hand hygiene infection control practices during perineal care for one residents (Resident #1) out of two sampled residents, staff failed to follow Enhanced Barrier Precautions ((EBP) the wearing of gown and gloves during high contact patient care activities to prevent the spread of multi-resistant organisms), failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when facility staff failed change and/or store oxygen in a manner to prevent the spread of bacteria. The facility census was 47.1. Review of the facility's policy, Oxygen Concentrator, dated 01/2018, showed nursing staff were responsible to change oxygen tubing and mas/cannula weekly and as needed if it becomes soiled or contaminated.Review of the facility's policy, Enhanced Barrier Precautions, dated 04/04/24, showed:-it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms;- Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRA acquisition (e.g., residents with wounds or indwelling medical devices);-High-contact resident care activities include, dressing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care or use.Review of the facility's, Handwashing Training Packet, undated, showed staff involved in direct resident contact will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Wash hands before and after handling contaminated items, contact with blood and body fluid, secretions, excretions, mucous membranes, etc. and assisting with/providing personal care.Review of the facility's In-Service Training Guide, Infection Control- Preventing Spread of Infection- Hand Hygiene, undated showed:-The hand hygiene procedures to be followed by staff involved in direct resident contact;-Residents can be exposed to potentially pathogenic organisms in several ways, including but not limited to the following: improper hand hygiene and improper glove use (e.g., utilizing a single pair of gloves for multiple tasks or multiple residents);Contact precautions require the use of appropriate PPE (personal protective equipment), including a gown and gloves upon entering the contact precaution room. Prior to leaving the contact precaution room the PPE is removed and hand hygiene is performed;Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene when hands are visibly soiled, before and after direct resident contact, before and after assisting a resident with personal care, upon and after coming in contact with a resident's intact skin, after contact with a resident's mucous membranes and body fluids or excretions, and after handling soiled or used linens, dressings, bedpans, catheters and urinals. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as cognitively intact, dependent on staff for toileting hygiene assistance and did not contain documentation the resident used oxygen therapy.Review of the resident's care plan, dated 02/01/26, showed the resident required substantial assistance with toileting hygiene, incontinent of bowel and used a foley catheter.Observation on 03/19/26 at 9:31 A.M., showed a sign on the resident's door for EBP use. Observation on 03/19/26 at 9:31 A.M., showed Certified Nurse Aide (CNA) A and CNA B entered the resident room to provide care. CNA A and CNA B did not put on a gown prior to or upon entering the resident's room. CNA B provided perineal care, removed gloves, applied clean gloves from CNA's A pocket filled with gloves and did not perform hand hygiene. CNA B placed a clean brief under the resident and assisted CNA A with repositioning the resident, with the same soiled gloves placed clean pants on the resident. CNA B continued to wear the same soiled gloves and placed the mechanical lift sling under the CNA A continued to wear the same soiled gloves and removed the resident's nasal canula, placed the resident's nasal canula on the bedside table (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a protective barrier or in a storage bag and the tubing laid on the floor. CNA B continued to wear the same soiled gloves and removed the resident's shirt, put on a clean shirt, brushed the resident hair, washed his/her face, and brushed the resident tongue. CNA B left the room, did not perform hand hygiene, returned to the room without performing hand hygiene, did not wear a gown, and put on new gloves. CNA B cleaned the resident's dentures, applied denture adhesive to the dentures, and placed the dentures in his/her mouth. The resident did not want his/her dentures, CNA B cleaned the denture adhesive off the dentures without performing hand hygiene or glove change. CNA B picked up the oxygen tubing from the floor, attached the tubing on the portable tank and applied the nasal canula in the resident's nose.During an interview on 03/19/26 at 11:03 A.M., CNA B said staff are educated to use PPE when a resident is on EPB. He/She said he/she did see the signage on the door, but forgot to use the PPE, since the PPE cart was not directly outside the resident's door. CNA B said staff are directed to perform hand hygiene and glove change before care, during care when going from a dirty to clean area, and after providing care. He/She said he/she did miss a hand hygiene opportunity. He/She said he/she had no excuse why he/she did not perform hand hygiene or glove change during care.During an interview on 03/19/26 at 2:37 P.M., Licensed Practical Nurse (LPN) D said there was signage posted on a resident's door who were on EBP to let staff and visitors know what PPE was required to be used when there was physical contact. He/She said the concern with not using PPE when physical contact was involved, was the potential to transfer bacteria and germs. He/She said staff are directed to replace tubing when it touched the floor.During an interview on 03/19/26 at 3:09 P.M. the administrator said oxygen tubing should be changed if touch the floor due to contamination. He/She said there are EBP signage hung on the residents door and PPE carts located outside the resident's room. HE/She said gown and gloves should be using while providing care, due to an infection control issue and to protect residents and staff.During an interview on 03/19/26 at 3:09 P.M. the Director of Nursing (DON) said staff are directed to replace oxygen tubing if it touched the floor to prevent contamination. He/She said there are EBP signage hung on the resident's door and PPE carts located outside the resident's room. HE/She said gown and gloves should be using while providing care, due to an infection control issue and to protect residents and staff. 2807774