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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265819	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Oak Tree	3108 West Truman Boulevard Jefferson City, MO 65109

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 - 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. 43024 Based on interview and record review, facility staff failed to notify one resident's (Resident #1's) out of one sampled residents family and physician when a resident leg fell from the wheelchair pedal which resulted in a fracture to the residents leg. The facility census was 26. 1. Review of the facility Change in a Resident's Condition or Status policy, revised May 2017, showed the facility shall promptly notify the residents attending physician and representative of changes in the resident medical/mental condition and/or status. Review showed the nurse will notify the resident's attending physician or physician on call when there is an accident or incident involving the resident. Review showed a significant change of condition is a major decline that will not normally resolve itself without intervention by staff. Review showed prior to notifying the physician, the nurse will make detailed observations and gather relevant and pertinent information. Review showed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/12/24, showed staff assessed the resident as: -Cognitively intact; -Active diagnoses of Osteoporosis (bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes); -Used a wheelchair; -Required full dependence on staff for all transfers. Review of the resident's plan of care, dated 5/15/23, showed staff documented the resident had impaired mobility. Review showed staff are instructed to assist resident with ambulation and transfers. Review showed staff documented the resident had osteoporosis. Review showed staff are instructed to monitor, document and report to physician as needed for any signs, symptoms or complications due to osteoporosis. (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 - Actual harm Residents Affected - Few	Review of the facility watch note (a system to alert staff of a concern with a resident) ,dated 4/10/24 at 6:04 P. M., showed Certified Nursing Assistant (CNA) C documented he/she propelled the resident back from dinner with pedals, left foot fell off pedal and leg bent under his/her wheelchair. Resident reported his/her leg hurt when lifted. He/She reported to the nurse at 6:00 P.M. Review of the facility's incident report, dated 4/11/24, showed Licensed Practical Nurse (LPN) A documented on 4/10/24 approximately 5:55 P.M., While at nurses station, noted resident being pushed from the dining room when his/her foot pedal on the wheelchair swung out causing his/her foot to fall off onto the floor and bending his/her left lower leg back. Foot pedal was locked back into place and left lower extremity was placed back onto the pedal. Documented no injuries were observed at time of incident. Review showed the physician and emergency contact was not notified of the incident until 4/11/24. During an interview on 4/16/24 at 2:14 P.M., LPN B said he/she was approached on 4/11/24 by CNA C with the Social Services Director (SSD) because of the incident with the resident and concerned he/she had not been assessed and had a high level of pain. He/She went and assessed the resident and noted the resident's leg to be bruised and swollen, and any movement of the leg or toes was painful for the resident. He/She said the resident one hundred percent needed additional assessment to see if anything was broken or torn. He/She said LPN A had reported the incident to him/her, said the resident was fine, and had not documented anything in the resident's chart about the incident, the injury, or contacting the physician or emergency contact until the administrator was informed and corrected the issue. The resident did require tylenol on his/her shift but it was effective because when he/she followed up the resident was asleep. During an interview on 4/16/24 at 2:43 P.M., LPN A said the administrator called him/her the day after the incident and made him/her document the incident, call the physician and family member and order an X-Ray. He/She said no one was notified after the incident because he/she was busy with an upset family member and he/she did not think it was that bad. LPN A said CNA did not report pain and swelling of the residents leg. During an interview on 4/16/24 at 2:59 P.M., the administrator said his/her expectation is the resident would be assessed, and physician and emergency contacts notified. During an interview on 4/16/24 at 4:30 P.M, LPN E said LPN A told him/her about the incident with the resident at off-going report. LPN E said LPN A said he/she looked the resident over and he/she was fine. LPN E said the resident's leg was swollen and bruised but not double in size, requested tylenol sometime after midnight for pain, and he/she administered it. He/She did not contact the resident's physician. LPN E said since the tylenol was effective he/she felt that was an assessment and he/she did not need to contact the physician. He/She said he/she assumed LPN A called the physician since it occured on his/her shift. During an interview on 4/17/24 at 10:57 A.M., the physician said he/she would expect to be notified promptly after an injury if the resident was experiencing swelling, pain or bruising for a stat X-Ray to be ordered or for the resident to be sent out for assessment. He/She said the resident is frail so the sooner he/she is contacted, the better. MO00234731