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	05/01/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility staff failed to maintain an air gap (a safety feature which prevents sewage from backing up into ice machines) for two of two ice machine drains. This failure has the potential to affect all residents. The facility census was 34. 1. Review of the facility's policies provided showed they did not contain a policy related to ice machine air gaps. Observation on 04/29/26 during the Life Safety Code tour showed the black drain hose from the kitchen ice machine on the floor in a small puddle of water near the floor drain which did not have a cover and had an accumulation of black material. Observation also showed the white plastic drain from the dining room ice machine passed through a hole in the wall to an adjacent mechanical room and set directly on a rusted floor drain cover. During an interview on 04/29/26 at 2:53 P.M., the Plant Supervisor said he/she and the facility's contracted vendor are responsible for maintaining the ice machines. The supervisor said the vendor checks and cleans the drain hoses and maintenance staff verify the vendor's work. The supervisor said he/she did not know air gaps were required for the ice machine drains so he/she never thought about the drains setting on the floor. During an interview on 04/29/26 at 3:57 P.M., the administrator said maintenance staff are responsible for the maintenance of the ice machines. The administrator said he/she never heard of an air gap and did not know the ice machine drains were on the floor. The administrator said the dining room ice machine was just installed and he/she expected the vendor to have installed it correctly.

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

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	05/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 transfer two residents (Residents #21 and #17) out of two sampled residents by mechanical lift in a manner to prevent accidents. The facility census was 34.1. Review of the facility's policy titled Lifting Machine, Using a Mechanical Lift, dated July 2017, showed the purpose of the procedure is to establish the general principle of safe lifting using a mechanical lifting device. Review showed:-At least two nursing assistants are needed to safely move a resident with a mechanical lift;-Gently support the resident as he or she is moved, but do not support any weight. Review of the Mechanical Lift operating manual, REV2.7.13.20, undated, showed there are circumstances that may require two people to safely operate the lift. It is the responsibility of each facility or caregiver to determine if more than one person is required to safely operate the lift at the time of transfer.2. Review of Resident #21's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/11/26, showed staff assessed the resident as:-Cognitively impaired;-Dependent on staff for transfers.Observation on 04/29/26 at 9:50 A.M., showed Nursing Assistant (NA) C and the Director of Nursing (DON) used a mechanical lift to transfer the resident from the wheelchair to the bed. Once attached to the lift sling, the DON used the remote to lift the resident from the wheelchair. NA C moved the wheelchair and stood next to the bed. The DON moved the lift over to the bed as the resident hung in the lift sling over the tile floor without hands on guidance or support. During an interview on 04/29/26 at 10:02 A.M., NA C said two people should be used for all mechanical lift transfers for safety. One should work the lift, and the other should hold on to the resident during the transfer. He/She said he/she had been trained on lift transfers. During an interview on 05/01/26 at 9:55 A.M., the DON said he/she expects staff to use two people during mechanical lift transfers for safety. One staff member should operate the lift, and the other should guide the resident. He/She said the second staff member should be nearby in case something happens or move the wheelchair but did not think the policy stated to have a hand hold onto the resident when they are suspended in the air. Observation on 04/29/26 at 10:20 A.M., showed Certified Nursing Assistant (CNA) A operated the lift and while transfer of the resident he/she was suspended in air without hands-on stabilization by CNA B. During an Interview on 05/5/26 at 9:45 A.M., CNA B said he/she has received training on mechanical lift transfers. He/She said two people should perform the lift. One person operates the equipment, and the second person is on standby to help the resident into the chair. CNA B said the second person watches to make sure the resident doesn't tip, or the sling doesn't break. He/She said the second person should hold onto the resident while suspended in air. The CNA said he/she did not hold the resident because he/she was not paying attention or thinking about it at the time. 3. Review of Resident #17's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Dependent on staff for transfers.Observation on 04/29/26 at 1:34 P.M., showed CNA D and NA C enter the room to transfer the resident to his/her bed from wheelchair. NA C and CNA D attached the lift sling to the lift. CNA D used the remote to lift the resident in the air. NA C moved the wheelchair and stood by the bed while the resident remained suspended without staff guidance or support with hand touch. The sling and resident rocked back and forth over the tile floor when CNA D moved the lift over to the bed and lowered the resident. During an interview on 04/29/26 at 1:52 P.M., CNA D said two staff should be present for all lift transfers for safety. One staff member should work the lift, and the other should hold the resident while being moved to the bed and/or wheelchair, so the resident does not fall or tip the lift over. He/She said he/she should not have let the resident dangle without support or guidance, but he/she was nervous. During an interview on 04/29/26 at 10:02 A.M., NA C said two people should be used for all mechanical lift transfers for safety. One should work the lift, and the other should guide and support the residents during a transfer. He/She said he/she shouldn't have moved the (continued on next page)

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	05/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident from the raised position until the wheelchair was out of the way. 4. During an interview on 05/01/26 at 9:51 A.M., the administrator said two staff should complete all lift transfers for safety. One should operate the lift, and the other should hold the resident. The resident should not be suspended in the air without staff holding on.