STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265365	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Florissant	6768 North Highway 67 Florissant, MO 63034

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document physician orders were verified for one resident (Resident #74) admitted for respite care. The sample was 17. The census was 66. Review of the facility's Admissions and admission Agreement Policy, dated February 2025, showed: Prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: medication orders, including (as necessary) a medical condition or problem associated with each medication; and routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary care plan. Review of the facility's Reconciliation of Medications on admission Policy, dated revised 2017, showed:-Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility;-Preparation: Gather the information needed to reconcile the medication list: approved medication reconciliation form; admission order sheet; all prescription and supplement information obtained from the resident/family during the medication history;-Steps in procedure: If a medication history has not been obtained from the resident or family, complete this first;-Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous Medication Administration Record (MAR) (if applicable), and the admitting orders (sources);-Review the list carefully to determine if there are discrepancies/conflicts;-If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy;-Document the medication discrepancy on the medication reconciliation form;-Document what actions were taken by the nurse to resolve the discrepancy;-If the discrepancy was unresolved, document how the discrepancy was communicated to the charge nurse, physician, pharmacy, and/or next shift;-If the discrepancy was resolved, document how the discrepancy was resolved. Review of Resident #74's medical record, showed:-Resident was alert with confusion;-admitted [DATE] and left against medical advice (AMA) on 6/15/25;-readmitted on [DATE] for respite care and discharged on 7/28/25;-Diagnoses included diabetes, anoxic brain injury (brain completely loses its oxygen supply, leading to potential brain cell death), polysubstance abuse, history of stroke, seizure disorder, high cholesterol, high blood pressure and chronic end stage renal failure (irreversible kidney disease). Review of the physician order sheet, dated active orders as of 8/22/25, showed: -A physician order for amlodipine besylate oral tablet 5 milligrams (mg), Give 5 mg by mouth one time a day for blood pressure, order date 7/24/25;-A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics, order date 6/13/25;-A physician order for atorvastatin calcium oral tablet (used to treat high cholesterol) 40 mg, give 1 tablet by mouth one time a day for prophylactic, order date 6/13/25;-A physician order for farxiga oral tablet (used to treat diabetes) 10 mg, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Stonebridge Florissant		STREET ADDRESS, CITY, STATE, ZIP CODE 6768 North Highway 67 Florissant, MO 63034	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give 1 tablet by mouth one time a day for give prior to breakfast, order date 6/13/25;-A physician order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety, order date 7/24/25;-A physician order for insulin glargine solution 100 unit/milliliter (ml), inject 14 unit subcutaneously (under the skin) one time a day for diabetes, order date 7/24/25;-A physician order for Keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant, order date 6/13/25;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure, order date 7/24/25;-A physician order for Novolog flex pen subcutaneous solution pen-injector 100 UNIT/ml, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia (blood glucose levels are elevated above normal), order date 7/24/25;-A physician order for oxycodone hcl oral tablet 5 mg, give 5 mg by mouth as needed for pain take one tablet by mouth as needed two times daily, order date 7/24/25;-A physician order for ramelteon tablet 8 mg, give 1 tablet by mouth at bedtime for insomnia, order date 7/24/25;-A physician order for trazodone hcl tablet 50 mg, give 50 mg by mouth at bedtime for insomnia, order date 7/24/25. Review of the progress notes, dated 7/24/25 at 7:30 P.M., showed no documentation the physician orders were verified with the physician. Review of the hospital records, dated 7/21/25, provided by the Administrator, after the surveyor asked for the information staff used for admitting the resident to the facility, showed there was no discharge summary or after care summary. During an interview on 8/20/25 at 6:34 A.M., Assistant Director of Nursing (ADON) A said if a resident was admitted on respite care, the admission process would be the same as any other admission. The floor nurse was responsible for completing the admission, which included completing the assessments and entering the medications into the computer. The physician orders were verified with the physician. The nurse should make a progress note showing the orders had been verified with the physician. ADON A looked through the hospital records packet, dated 7/21/25, and said there was no discharge summary or after visit summary. If a discharge summary or after care visit summary was not available, she would use the medication summary, medication outpatient medications as of 7/21/25 for the physician orders. ADON A said she did not enter the physician orders into the computer. Review of the Medication Summary, outpatient medication as of 7/21/25, showed:-A physician order for blood glucose sensor, use as directed to test blood sugar and change sensor every 10 days;-A physician order for hydroxyzine 10 mg four times daily;-A physician order for glucagon (glucagon emergency) 1 mg, inject 1 mg subcutaneous injection;-A physician order for hydrochlorothiazide 12.5 mg, no directions;-A physician order for lisinopril 40 mg (used for blood pressure) take 40 mg daily;-A physician order for insulin glargine 100 unit/ml, inject 14 units subcutaneous injection daily with breakfast;-A physician order for insulin Novolog flex pen, inject 5 units by subcutaneous injection three times daily with meals;-A physician order for MiraLAX 17 gram/dose powder (used for constipation), take 1 scoop (17 gm) twice daily, dissolve in 8 ounces of fluid and drink entire liquid;-A physician order for hydrophilic wound dressing (triad, paste that creates a moist wound healing environment, ideal for wounds with light to moderate exudate) apply to affected area twice daily;-A physician order for amlodipine 5 mg, take 5 mg daily;-A physician order for aspirin enteric coated (EC), take 81 mg daily;-A physician order for atorvastatin 40 mg daily;-A physician order for Plavix 75 mg (antiplatelet), take 75 mg daily;-A physician order for farxiga 10 mg, take 10 mg daily;-A physician order for Keppra 500 mg, take 500 mg twice daily;-A physician order for metoprolol tartrate 50 mg, take 50 mg twice daily;-A physician order for oxycodone 5 mg, take 5 mg every 12 hours as needed for pain; -A physician order for ramelteon 8 mg, take 8 mg daily at bedtime;-A physician order for senna (stool softener (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Stonebridge Florissant		STREET ADDRESS, CITY, STATE, ZIP CODE 6768 North Highway 67 Florissant, MO 63034	

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and laxative), take 2 tablets daily at bedtime;-A physician order for trazodone 50 mg, take 50 mg daily at bedtime. Review of the physician order sheet, dated active orders as of 8/22/25, showed the blood glucose sensor, glucagon, hydrochlorothiazide, lisinopril, Novolog insulin routine three times a day, MiraLAX, hydrophilic wound dressing, Plavix and senna were not on the physician order sheet. Review of the progress notes, dated 7/24/25 through 7/28/25, showed no documentation the physician orders were verified with the physician. During an interview on 8/20/25 at 2:00 P.M., Registered Nurse (RN) D said the floor nurse was responsible for completing the admission assessments and entering the orders into the computer. RN D looked at the hospital packet provided by the facility and dated 7/21/25, and said he/she used the medication list at end of the visit as of 7/10/25 for the physician orders. The family wrote the insulin instructions on a sheet of paper. RN D looked in the packet and said she thought the insulin orders were Novolog 3 units if eats small meal, 4 units if eats medium size meal and 5 units if eats large meal and Lantus insulin 14 units daily. RN D said he/she called the physician and verified the orders and documented it in the medical record. Review of the Medication List at the End of Visit, dated as of 7/10/25, showed:-A physician order for amlodipine 5 mg, take 5 mg daily;-A physician order for aspirin EC, take 1 tablet daily;-A physician order for atorvastatin 40 mg, take 40 mg at bedtime;-A physician order for Plavix 75 mg, take 75 mg daily;-A physician order for farxiga 10 mg, take 1 daily;-A physician order for glucagon .1 mg, inject 1 mg subcutaneous injection;-A physician order for hydrochlorothiazide 12.5 mg, no directions;-A physician order for hydrophilic wound dressing, apply to affected area twice daily;-A physician order for hydroxyzine 10 mg, take 10 mg four times daily;-A physician order for novolog flex pen u-100 insulin, inject 5 units by subcutaneous injection three times daily with meals;-A physician order for Lantus 100 unit/mL, inject 14 units by subcutaneous injection daily with breakfast;-A physician order for Keppra 500 mg, take 500 mg twice daily;-A physician order for lisinopril 40 mg, take 40 mg daily;-A physician order for metoprolol tartrate 50 mg, take 50 mg twice daily;-A physician order for oxycodone 5 mg, take 5 mg every 12 hours as needed;-A physician order MiraLAX 17 gram/dose, take 1 scoop (17 grams) twice daily. Dissolve in 8 ounces of fluid and drink entire liquid;-A physician order ramelteon 8 mg, take 8 mg daily at bedtime;-A physician order for senna-s, take 2 tablets daily at bedtime;-A physician order for trazodone 50 mg, take 50 mg daily at bedtime. Review of the physician order sheet, dated active orders as of 8/22/25, showed glucagon, hydrochlorothiazide, lisinopril, NovoLog insulin routine three times a day, MiraLAX, hydrophilic wound dressing, Plavix and senna s were not on the physician order sheet. During an interview on 8/21/25 at 10:53 A.M., ADON B said the hospital records packet, dated 7/21/25, is not what the facility would have used for the admission physician orders. The packet was the information sent over for the referral. During an interview on 8/21/25 at 12:18 P.M., ADON B said he/she was notified the resident was admitted on [DATE] with a bag that contained home medications and a list of the medications including insulin instructions. The facility did not keep a copy of the list. ADON B said the family may not comply and send the list if requested today since the resident has been discharged from the facility. Whoever the ADON assigned to the resident was expected to review and follow-up after the admitting nurse's admission process. ADON B said RN D and ADON A failed to obtain a copy of the resident's admission information for medical records. ADON B looked at the resident's electronic medical records and said RN D's admission assessment only showed two out eight assessments were completed. He/She said the admission process should be completed upon admission. During an interview on 8/22/25 at 11:35 A.M., the physician said the facility usually calls him when a resident is admitted to the facility to verify the orders. He did not recall if the facility called him to verify the orders. During an interview on 8/22/25 at 11:52 A.M., (continued on next page)

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	265365	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Florissant	6768 North Highway 67 Florissant, MO 63034

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator said if a resident is admitted for respite care, the family will bring in the orders or the facility will take the orders from the family. They also often bring the medications from home. The nurse should call the physician to verify orders and document it. During an interview on 8/22/25 at 3:13 P.M., the Administrator said the admission assessment should be completed upon admission. The Regional Nurse said any residents' documents should be part of the medical records. During an interview on 8/22/25 at 4:30 P.M., the Regional Nurse said the resident was here for a very short time. They talked with the staff and the resident did not bring in any paperwork with physician orders. He/She brought a bag with his/her medications in it. If the physician changed the medications when they were verified, the old order would not be on the physician order sheet. The nurse did an assessment when the resident was admitted and it was documented in the progress notes. Review of the progress notes, dated 7/24/25 at 7:30 P.M., showed the patient is [AGE] years old with past medical history of diabetes, anoxic brain injury, polysubstance abuse, stroke history, seizure disorder, hyperlipidemia, hypertension and chronic end stage renal failure. Patient is here at the facility for respite care 7/24 through 7/28. Daughter takes care of patient at home regularly. Patient arrived at the facility in the hour of 1300. Resident was given a lunch tray and insulin was given after intake of 100%. Patient was calm and toileted soon after. In the hour of 1700 patient became combative and repeatedly trying to get out of chair without assistance. The nurse and other nursing staff tried to redirect patient, patient was not directable. The nurse tried to call family and let them know that patient was not taking the change of environment well. Family stated, what do you expect me to do. This nurse stated that, we do not want your (father/mother) to fall, what are some alternatives that you try at home to help redirect (him/her). Family stated to give patient his/her atarax, the nurse proceeded to give patient medication along with trazodone. Patient refused to sit down in the chair and threated to hit this nurse, and verbally got violent with the nurse, patient stood up and urinated on the floor in front of the nurse. Patient presumed to walk to down the hall and had a fall, and it was unwitnessed. Patient then was redirected to have a seat, where he/she then fell again by the central bathroom. Patient refused initial vital signs, the nurse, redirected patient, patient is now sitting at the nurse's station, no further report at this time 2573803

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary medications as ordered by the physician. In addition, they failed to notify and document the physician was made aware of the missed medications for one of 17 sampled residents (Resident #74). The census was 66. Review of the facility's Administering Medications Policy, dated revised December 2012, showed:-Medications shall be administered in a safe and timely manner, and as prescribed;-Medications must be administered in accordance with the orders, including any required time frame;-Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals);-If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administrating the medication shall document appropriately in the clinical chart. Review of the facility's Obtaining a Fingerstick Glucose Level, dated revised October 2011, showed:-Purpose: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level;-Documentation: The person performing this procedure should record the following information in the resident's medical record:-If the resident refused the procedure, the reason(s) why and the intervention taken;-The blood sugar results;-The signature and title of the person recording the data;-Reporting: Report results promptly to the supervisor and the attending physician;-Notify the supervisor if the resident refuses the procedure;-Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Adverse Consequences and Medication Errors Policy, dated revised April 2017, showed:-A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of professional(s) providing services. Examples of medication errors include omission-a drug is ordered but not administered. Review of Resident #74's medical record, showed:-Resident was alert with confusion, he/she could make needs known;-Was readmitted on [DATE] for respite care and discharged on 7/28/25; -Diagnoses included diabetes, anoxic brain injury (brain completely loses its oxygen supply, leading to potential brain cell death), polysubstance abuse, history of stroke, seizure disorder, high cholesterol, high blood pressure and chronic end stage renal failure (irreversible kidney disease). Review of the physician order sheet, dated active orders as of 8/22/25, showed: -A physician order for amlodipine besylate oral tablet 5 milligrams (mg), give 5 mg by mouth one time a day for blood pressure, order date 7/24/25;-A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics, order date 6/13/25;-A physician order for farxiga oral tablet 10 mg, give 1 tablet by mouth one time a day for give prior to breakfast, order date 6/13/25;-A physician order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety, order date 7/24/25;-A physician order for insulin glargine solution 100 unit/milliliter (ml), inject 14 units subcutaneously (under the skin) one time a day for diabetes, order date 7/24/25;-A physician order for keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant, order date 6/13/25;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure, order date 7/24/25;-A physician order for novolog flex pen subcutaneous solution pen-injector 100 UNIT/ML, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia, order date 7/24/25. Review of the Medication Administration Record (MAR), dated 7/24/25 through 7/25/25, showed:-A physician order for amlodipine besylate oral tablet 5 milligrams (mg), Give 5 mg by mouth one time a day for blood pressure; -7/25/25, A.M., HD (hold, see progress notes) was documented; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physician order for aspirin tablets chewable 81 mg, give 1 tablet by mouth one time a day for prophylactics; -7/25/25, 8 A.M., HD was documented; -A physician order for farxiga oral tablet 10 mg, give 1 tablet by mouth one time a day, give prior to breakfast; -7/25/25, 8 A.M., HD was documented; -A physician order for hydroxyzine hcl oral tablet 10 mg, give 10 mg by mouth four times a day for anxiety; -7/25/25 at 8 A.M., 12:00 P.M. and 4:00 P.M., HD was documented;-A physician order for keppra tablet 500 mg, give 1 tablet by mouth two times a day for anticonvulsant; -7/25/25 at 8 A.M. and 4:00 P.M., HD was documented;-A physician order for metoprolol tartrate oral tablet 50 mg, give 50 mg by mouth two times a day for blood pressure; -7/25/25 at 4:00 P.M., HD was documented;-A physician order for novolog flex pen subcutaneous solution pen-injector 100 unit/ml, inject as per sliding scale: if 181 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 -400 = 5 units; 401+ = 6 units 401 and greater give 6 units, subcutaneously three times a day for hyperglycemia; -Documentation showed:-On 7/24/25, was blocked off for medication to start on 7/25/25;-On 7/25/25 at 8 A.M., 12:00 P.M., 4:00 P.M. HD was documented; -On 7/26/25 at 8 A.M. and 12:00 P.M. were blank, at 5:00 P.M. the blood sugar was 400. Review of the progress notes, dated 7/24/25 through 7/25/25, showed:-On 7/24/25 at 7:30 P.M., patient arrived at the facility in the hour of 1300. Resident was given a lunch tray, and insulin was given after intake of 100%;-No documentation the results of the blood sugar or the type and amount of insulin administered. In addition, no documentation the physician was notified when the medications were held. During an interview on 8/19/25 at 4:30 P.M., Licensed Practical Nurse (LPN) C said the resident slept the first day he/she was at the facility. The second day, the resident would arouse to eat and take medications. The Certified Medication Technicians (CMTs) administer the scheduled medications, and the nurses complete the finger stick blood sugars and administered the insulin. The fingerstick blood sugars are documented on the MAR. If a medication was not administered or held, it should be documented on the MAR and the physician should be notified. The physician should be notified for each dose of medication not administered. During an interview on 8/20/25 at 10:28 A.M., CMT E said if a medication was held, it should be documented. The nurses are responsible for doing the fingerstick blood sugars and administering the insulin. During an interview on 8/21/25 at 9:50 A.M., CMT F said if the doctor held a medication, the nurse would enter it in the computer. The resident's medications were held because the resident was sleeping. Typically, the resident would go to bed at the beginning of day shift and sleep until lunch. He/She did not know if the resident was diabetic or not. The nurse would do the fingerstick blood sugars and the insulin. Sometimes, something for the nurses will pop up on the CMT MAR, but he/she never saw anything for the resident pop up on the CMT MAR. During an interview on 8/20/25 at 6:34 A.M., Assistant Director of Nursing (ADON) A said finger stick blood sugars should be documented on the MAR. If a medication was not administered, it should be documented in the progress notes and the physician should be notified. The physician is notified for each missed dose of medication. If a medication was held, it should be documented why the medication was held. She did not know what a blank on the MAR meant. During an interview on 8/21/25 at 12:18 P.M., ADON B said he/she was not sure why the staff held the medications. CMT F was not supposed to do fingerstick and insulin administration. ADON B looked at the resident's records and said that on 7/26/25, it looked like the resident did not receive the insulin because of the hole in the MAR. There's no documentation in the progress notes related to the medications being held and fingerstick results. Upon further review of the resident's record, ADON B said Registered Nurse (RN) D transcribed the insulin order incorrectly into the MAR. RN D entered the orders into the CMT MAR instead of the nurse MAR. The nurse did not see the insulin order until RN I revised and entered the insulin in the nurse MAR. ADON B said he/she expected the CMT (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to report to the nurse any medications held and to document in the MAR and progress notes. During an interview on 8/22/25 at 11:35 A.M., the physician said he could not recall if the facility called to report the resident's medications were not administered. During an interview on 8/22/25 at 11:52 A.M., the Administrator said residents who are admitted on respite care usually bring their medications from home. He expected staff to follow physician orders. If staff was unable to follow the orders, they should notify the physician and document it. Fingerstick blood sugars results should be documented. During an interview on 8/22/25 at 3:13 P.M., the Director of Nursing (DON) said she expected staff to notify the physician if medications were held or not given and to document appropriately. The Regional Nurse said fingerstick results should be documented anywhere in the residents' medical record, typically in the MAR. 25770892573803