STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265120	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure hot water at fixtures accessible to residents located in resident rooms on the 200 hall is maintained between the regulatory temperature range of 105 degrees Fahrenheit (F) and 120 degrees F. The deficient practice had the potential to affect 44 residents residing on 200 hall. The census was 175. Review of the facility's water temperature regulation for residential programs policy, revised 1/29/13, showed:-The comfort and preferences of the individual are balanced with the abilities and safety of the individual. This is outlined in the individual's plan;-1. The ability and safety risk of everyone receiving residential services related to management of water temperatures should be documented in the individual's plan;-The considerations to screen and document for safe management of water temperatures would include, but not be limited to: -a. Physical ability to manipulate faucets/ handles to control the mixture of hot and cold water from the source; -b. Physical ability to remove oneself from water temperature source or to communicate the need to be removed; -c. Cognitive ability to recognize changes in water temperatures, know what to do to change the water temperature as it comes out of the faucet, and/or communicate the need for help; -d. Physical or health issues that result in changes in sensation or ability to feel sensations, such as diabetic or other neuropathy, peripheral vascular disease, conditions that may cause thickening of the skin, etc., and; -e. Use of medications that may change the ability to feel sensations in or that may make skin more sensitive to changes in temperature or burning;-2. The necessary strategies, equipment and/or supervision to assure safety for water temperature regulation is to be outlined in the individual's personal plan;-3. Each agency supporting individuals in residential services should have a policy, procedure, or guideline related to management of water temperatures, including periodic measurement and documentation of temperature measurements;-4. In situations in which individuals do not have the abilities to regulate water temperatures or have a physical or health condition that makes self-regulation unsafe, water temperatures are not to exceed 120 degrees Fahrenheit at the point of use. 1.During an interview on 8/13/25 at 1:56 P.M., Resident #1 said the hot water has been cold for the last two weeks. The resident said when the Certified Nurse Aides (CNAs) need hot water to give him/her bed baths or to wash his/her face, they must go to a different room to get hot water because there is not hot water in his/her room. Observation on 8/14/25 at 9:50 A.M., showed the water temperature in his/her room measured 99.5 degrees F when tested with a digital thermometer for two minutes. 2. During an interview on 8/14/25 at 10:01 A.M., Resident #16 said the water is not hot it is cool, and he/she would prefer if the water was warm to wash his/her face. Observation on 8/14/25 at 10:05 A.M., showed the water temperature measured 89.4 degrees F when tested with a digital thermometer for two minutes. During an interview on 8/14/25 at 10:07 A.M., Resident #11 said the hot water is too cold sometimes. During an interview on 8/15/25 at 9:58 A.M., Resident #11 said it takes a long while for water to warm up, it must run awhile. The resident also said it's been this way for several weeks. When asked if the water was too cold to shower with or perform personal hygiene, and the resident nodded in agreement. 3. Observation on 8/14/25 at 10:10 A.M., showed the hot water temperature in room [ROOM NUMBER] measured 97.1 degrees F when tested with a digital thermometer for two minutes. 4. During an interview on 8/14/25 at 10:11 A.M., Resident #15 said there is a problem with the hot water in the room not being hot. He/She said since there is no hot water so he/she doesn't use it. Observation on 8/14/25 at 10:15 A.M., showed the water temperature measured 92.1 degrees F when tested with a digital thermometer for two minutes. 5. Observation on 8/14/25 at 10:19 A.M., showed the hot water temperature in room [ROOM NUMBER] measured 94.2 degrees F when tested with a digital thermometer for two minutes. 6. During an interview on 8/14/25 at 10:07 A.M., Resident #2 said he/she washes his/her hands every time after he/she uses the bathroom. He/She said every time he/she turns on the hot water, there is no hot water in his/her room. Observation on 8/14/25 at 10:23 A.M., showed the water temperature measured 93.0 degrees F when tested with a digital thermometer for two minutes. 7. During an interview on 8/14/25 at 10:39 A.M., Resident #17 said the hot water does not get hot enough even if he/she lets it run. He/She can't wash his/her face because the hot water is cold. He/She has been at the facility for a month or two and the hot water has been like that since he/she has been at the facility. Observation on 8/14/25 at 10:42 A.M., showed the water temperature measured 84.0 degrees F when tested with a digital thermometer for two minutes. 8. Observation on 8/14/25 at 10:46 A.M., showed the hot water temperature in room [ROOM NUMBER] measured 86.0 degrees F when tested with a digital thermometer for two minutes

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized comprehensive care plans to address specific needs of the residents for four sampled residents. (Resident #1, Resident #2, Resident #7 and Resident #8). The census was 175.Review of the facility's Comprehensive Person-Centered Care Plan policy, last reviewed 10/23/19:-Policy: Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care;-Definitions: -Interdisciplinary Team (IDT): All disciplines will collaborate to develop a plan of care that meets the residents' needs, preferences, and goals; -Baseline Care Plan: Is the baseline plan of care and is developed within 48 hours of admission and updated with a change in resident condition as applicable until completion of the comprehensive care plan; -Comprehensive Person Centered Care Plan (CCP): Contains services provided, preference, ability, and goals for admission, desired outcomes, and care level guidelines; -Kardex: Is part of the comprehensive care plan and is used as a tool to make staff aware of the resident's daily care needs;-Procedure: -1. The Comprehensive Person-Centered Care Plan shall be fully developed within 7 days after completion of the admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff; -2. A baseline care plan is to be developed within 48 hours. Develop initial goals based upon admission orders/resident's input and is recorded on the Baseline Care Plan user defined assessment (UDA). Provide the resident or resident's representative (RR) a copy of the baseline care plan and physician's orders, document delivery of the baseline care plan in the medical record; -3. The IDT, along with the resident and/or RR, will identify resident problems, needs, strengths, life history, preferences, and goals; -4. For each problem, need, or strength a resident-centered measurable goal is developed; -5. Staff approaches are to be developed for each problem/strength/need (including Preadmission Screening and Resident Review (PASARR) recommendations as applicable). Assigned disciplines will be identified to carry out the intervention; -6. The comprehensive person centered care plan can be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change and annual assessments per the Resident Assessment Instrument (RAI, assess residents and develop individualized care plans) manual; -7. The Care Conference IDT UDA is documented to reflect a review of the care plan goals and approaches; -8. The Kardex will serve as part of the comprehensive plan of care and will be completed with the baseline care plan; -9. Upon a change in condition, the comprehensive person centered care plan or baseline care plan will be updated if applicable: -The baseline care plan/comprehensive person centered care clan is updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence; -The name of the resident/RR who the plan of care was discussed with will be documented on the care conference IDT UDA. 1. Review of Resident #1's admission MDS, dated [DATE], showed: -Cognitively intact;-Rejection of care not exhibited;-Upper and lower extremity impairment on both sides;-Dependent with eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing and personal hygiene;-Diagnoses included quadriplegia (medical condition causing partial or total loss of function in all four limbs and the torso), muscle weakness, dysphagia (difficulty swallowing), high blood pressure and diabetes. Review of the resident's care plan, in use during the survey, showed:-Focus: History of potential for resistance to care adjustment to nursing home. Refusing to allow nursing staff to obtain blood sugars argumentative with staff, recording staff with his/her cell phone creates fabrications regarding staff confrontational with staff, ineffective coping with nursing home placement and his/her diagnosis, created 7/14/25;-Goal: Will cooperate with care through next review date, created 7/14/25;-Interventions: -Allow the resident to make decisions about treatment regime, to provide sense of control, created 7/14/25; -Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care, created 7/14/25; -Encourage as much participation/interaction as possible during care activities, created 7/14/25; -Known triggers for resisting care are: Nothing listed, Behavior is de-escalated by: Nothing listed, created 7/14/25; -Praise when behavior is appropriate, created 7/14/25;-Nothing listed on care plan regarding activities of daily living (ADLs, basic tasks that individuals perform to maintain their daily life) and level of care resident required;-Nothing listed on care plan regarding the resident's personal preference of washing face and brushing teeth every morning;-Nothing listed on care plan regarding splints for both of resident's hands and brace for resident's right foot;-Nothing listed to show the resident received restorative therapy

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement appropriate interventions for falls for one resident (Resident #6) who had no fall mats next to the resident's bed. The facility failed to adequately assess resident falls by ensuring residents received treatment and care in accordance with acceptable standards of practice when the facility failed to accurately complete post (after) fall 72 hour monitoring report (neurological (neuro) evaluation - pulse (P), respiration (R), and blood pressure (BP) measurements; assessment of pupil size and reactivity; and equality of hand grip strength) if the fall was unwitnessed or if the resident had an incident in hitting their head (Residents #6 and #5), and failed to complete incident follow up documentation (IFU) for 72 hour post fall in the progress notes each shift, for three of three residents sampled (Residents #6, #5 and #4). In addition, the facility failed to maintain water temperatures so they did not exceed 120 degrees Fahrenheit (F). The census was 175.Review of the facility's Accident and incident documentation and investigation policy, reviewed 4/26/23, showed: -Policy: Accidents and/or incidents involving residents will be investigated and documented on an incident report entry in the electronic health record (EHR). An Incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents;-Procedure:-1. General information: -The licensed nurse assigned at the time of the resident care accident/incident is responsible for conducting an investigation of the circumstances surrounding the accident/incident, and for notifying the supervisor, Director of Nursing (DON), and/or the Administrator as appropriate; -The licensed nurse at the time of the incident is responsible for initiating/completing the incident report, ensuring that all items have been completed as applicable to the accident/incident; -The licensed nurse at the time of the incident is responsible for documenting the incident in the resident's medical record in accordance with the guidelines below and set forth in the incident report;-2. Notification & Documentation: -The licensed nurse shall document the incident and notify the supervisor and DON for follow through as needed;-The licensed nurse may complete a nurses note and update the resident care plan as needed;-The nurse's notes may contain the following documentation: -Clear objective facts of what occurred; -An evaluation of the residents condition at the time of the accident/incident may include a description of the resident, vital signs (VS). and other physical characteristics apparent as a result of the accident/incident; -Any treatment provided; -Notification or attempts to notify the resident's physician. family, and/or legal representative, or any other health care professional or individuals involved with the resident's care; -The charge nurse's date and time of the documentation. Review of the facility's water temperature regulation for residential programs policy, revised 1/29/13, showed:-The comfort and preferences of the individual are balanced with the abilities and safety of the individual. This is outlined in the individual's plan;-1. The ability and safety risk of everyone receiving residential services related to management of water temperatures should be documented in the individual's plan;-The considerations to screen and document for safe management of water temperatures would include, but not be limited to: -a. Physical ability to manipulate faucets/ handles to control the mixture of hot and cold water from the source; -b. Physical ability to remove oneself from water temperature source or to communicate the need to be removed; -c. Cognitive ability to recognize changes in water temperatures, know what to do to change the water temperature as it comes out of the faucet, and/or communicate the need for help; -d. Physical or health issues that result in changes in sensation or ability to feel sensations, such as diabetic or other neuropathy, peripheral vascular disease, conditions that may cause thickening of the skin, etc., and; -e. Use of medications that may change the ability to feel sensations in or that may make skin more sensitive to changes in temperature or burning;-2. The necessary strategies, equipment and/or supervision to assure safety for water temperature regulation is to be outlined in the individual's personal plan;-3. Each agency supporting individuals in residential services should have a policy, procedure, or guideline related to management of water temperatures, including periodic measurement and documentation of temperature measurements;-4. In situations in which individuals do not have the abilities to regulate water temperatures or have a physical or health condition that makes self-regulation unsafe, water temperatures are not to exceed 120 degrees Fahrenheit at the point of use. 1. Review of Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/5/25, showed:-Severe cognitive impairment;-Always

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure residents who received dialysis (the process of filtering the blood for individuals with kidney failure) services had current dialysis orders that included the location for the dialysis services for one resident (Resident #2), the days of week the resident would go to dialysis and what the dialysis chair time was for two residents (Resident #2 and Resident #8). The facility also failed to ensure the dialysis services had been addressed on the resident's individual care plan for chair time for three residents (Resident #2, Resident #8 and Resident #7). Additionally, the facility failed to contact and document the notification to the physician and resident representative (RR) when the resident refused dialysis or when the dialysis treatment ended early for three of three residents (Resident #2, #7 and #8). The census was 175.Review of the facility's Hemodialysis (HD, medical treatment for kidney failure that uses a machine to filter waste products and excess fluid from the blood) protocol policy, reviewed 10/25/24, showed:-Protocol: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis;-Procedure:-The facility will inform each resident before or at the time of admission, and periodically thereafter during the resident's stay, of dialysis services available;-The facility will coordinate and collaborate with the dialysis facility to assure that: -The resident's needs related to dialysis treatments are met; -The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments; -Documentation requirements are met to assure that treatments are provided as ordered by the nephrologist (doctor who specializes in kidney care and the diagnosis and treatment of kidney diseases), attending practitioner and dialysis team, and; -There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff; -The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes; -The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a Dialysis Communication Form or other form, that will include, but not limit itself to: -History: -Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; -Physician/treatment orders, laboratory values, and vital signs; -Advance Directives and code status; specific directives about treatment choices; and any-changes or need for further discussion with the resident/representative, and practitioners; -Hemodialysis will be done in an outpatient setting according to physician's orders (PO), unless your facility has an onsite in-house dialysis unit; -Facility will ensure resident has plan of care to include dialysis services. 1. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/9/25, showed:-Cognitively intact;-Rejection of care not exhibited; -While a resident received dialysis;-Diagnoses included end stage renal disease (ESRD, permanent kidney failure where the kidneys can no longer function adequately, requiring dialysis), chronic obstructive pulmonary disease (COPD, progressive lung disease that makes breathing difficult by obstructing airflow to the lungs), abnormalities of gait and mobility, muscle weakness, high blood pressure, and diabetes. Review of the resident's care plan, in use during the survey, showed:-Focus: The resident has renal insufficiency related to ESRD, created 7/18/25;-Goal: -The resident will have no signs or symptoms of complications related to fluid overload through the review date, created 7/18/25; -The resident will have no signs or symptoms of complications related to fluid deficit through the review date, created on 7/18/25;-Interventions: -Assist resident with activities of daily living (ADL, basic tasks that individuals perform to maintain their daily life) and ambulation as needed. Watch for shortness of breath (SOB) and match level of assistance to residents current energy level, created 7/18/25; -Monitor and report changes in mental status: lethargy (unusual tiredness, drowsiness, and lack of energy or mental alertness), tiredness, fatigue, tremors and seizures, created 7/18/25; -Monitor for signs and symptoms hypovolemia (increased pulse, increased respirations, decreased systolic (SBP, top number, normal is below 140), sweating, anxiousness) or hypervolemia (jugular venous distention (JVD, large veins in the neck visibly bulge, indicating increased pressure in the right side of the heart), increased blood pressure (BP), lung crackles (abnormal, non-musical, popping or crackling sounds heard in the lungs during breathing), headache, shortness of breath (SOB), dependent edema (swelling that occurs in the body parts closest to the ground, like the legs, feet, or hands, because gravity