

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2025
NAME OF PROVIDER OR SUPPLIER  St Sophia Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure staff consistently notified physicians when blood glucose/sugar levels (the concentration of glucose in the blood) exceeded the parameters ordered by the physician or the parameters in accordance with the facility's policy. In addition, the facility failed to ensure staff consistently documented blood glucose levels on the Medication Administration Record (MAR) and/or failed to ensure staff documented explanations when they used the codes NA (not administered, see nurses notes), NI (no insulin required) or HD (hold, see nurses notes) on the MAR. The facility identified 48 residents with routine blood glucose monitoring. Of those 48, eight were sampled and problems were found with four (Residents #8, #15, #16 and #17). The census was 170. Review of the facility's Notification Of A Change In A Resident's Condition policy, approved on 11/1/18 and last reviewed on 4/28/21, showed:-Policy: The attending physician and the Resident Representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations;-Responsibility: All Licensed Nursing Personnel-Procedure: Guidelines for Notification of Physician/Resident Representative:-Significant Change or Unstable Vital signs. Glucometer reading below 70 or above 200 unless specific parameters given by physician for reporting;-Document in the Interdisciplinary Team (IDT) Notes: Resident Change in Condition. Physician Notification. Notification of Resident Representative. Review of the facility's Licensed Practical Nurse (LPN) and Registered Nurse (RN) job descriptions, revised 5/2022, showed:-Essential Function of the LPN and RN: Assesses and documents the resident's condition and nursing goods. Accurately and promptly implements physician's orders. Administers medications;-Reports to: Director of Nursing (DON). 1. Review of Resident #8's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/7/25, showed:-Adequate hearing;-Unclear speech - slurred or mumbled words;-Makes Self Understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;-Ability To Understand Others: Usually understands - misses some part/intent of message but comprehends most conversation;-Moderately impaired cognition;-Diagnoses of high blood pressure, renal (kidney) disease, diabetes mellitus (low/high blood glucose levels) and stroke;-Received insulin injections six out of the last seven days. Review of the resident's care plan, showed:-7/18, Focus: Diabetes Mellitus and has an order for insulin. Goal: Will have no complications related to diabetes. Interventions: Diabetes medications as ordered by doctor. Monitor/document for side effects and effectiveness. Review of the resident's physician's order sheet (POS), showed:-Order Date 8/4/25: Insulin lispro (fast acting insulin), inject per sliding scale (the amount of insulin administered is determined by the blood glucose level) if 200-250 = 2 units (u), 251-300 = 4u, 301-350 = 6u; 351-400 = 8u. Subcutaneously (injection is given in the fatty tissue, just under the skin) before meals at 7:30 A.M., 11:00 A.M. and 4:00 P.M. Call physician if blood sugar is less than 70 or greater than 400;-Order Date 9/13/25: Lantus SoloStar (long-acting insulin) inject 32 units (u) subcutaneously between 4:00 P.M. and 9:00 P.M. daily. Review of the resident's MAR, dated 8/1/25 through 8/31/25, and the resident's progress notes, showed:-Order Date 7/28/25 Discontinue (DC) Date 8/4/25: Lantus SoloStar. Inject 24u at 3:00 P.M.-8/2 and 8/3, the nurse documented NA (NA/not administered, see nurse's note). Review of the resident's nurse's notes/progress notes, showed no documentation why NA had been documented on the MAR;-Order Date 8/4/25 DC Date 8/17/25: Lantus SoloStar. Inject 24u between 4:00 P.M. and 9:00 P.M. Staff initialed the insulin had been administered as ordered;-Order Date 8/17/25 DC Date 9/13/25: Lantus SoloStar. Inject 28u between 4:00 P.M. and 9:00 P.M. Staff initialed the insulin had been administered as ordered;-Order Date 7/20/25 DC Date 8/4/25: Insulin Lispro. Inject per sliding scale if 200-250 = 2u, 251-300 = 4u, 301-350 = 6u, ; 351-400 = 8u. Subcutaneously before meals at 7:30 A.M., 11:00 A.M. and 4:00 P.M. No order when to notify the physician: -Order Date 8/4/25 No DC Date: Insulin Lispro. Inject per sliding scale if 200-250 = 2u, 251-300 = 4u, 301-350 = 6u, ; 351-400 = 8u. Subcutaneously before meals at 7:30 A.M., 11:00 A.M. and 4:00 P.M. Call physician if blood sugar is less than 70 or greater than 400:-8/6 at 7:30 A.M., the nurse documented a blood glucose level of 54. Review of the progress notes showed no documentation the physician had been notified;-8/9 at 4:00 P.M., the nurse documented a blood glucose level of 541 and NA. Review of the progress notes showed no documentation the physician had been notified or if the resident received insulin;-8/30 at 4:00 P.M., the nurse documented NI (no insulin required), but did not document the blood glucose level. Review of the Weights and Vitals Summary located in the FMR showed on 8/30 at 4:05</p>

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F 0677  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable.  (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure residents had oral care supplies (toothbrush, toothpaste and mouthwash) for their use in their rooms and failed to ensure staff provided oral care to residents. Twenty-three residents were sampled. Of those 23, five were interviewed and three said they did not have oral care supplies and staff did not offer to provide oral care (Residents #18, #8 and #15). The census was 170. Review of the facility Oral Hygiene policy, approved on 4/28/22 and last reviewed on 7/21/22, showed:-Policy: The Facility will provide Oral Hygiene to Residents as directed in the Plan of Care. Oral Care will include cleansing the Oral Cavity and removing Food/Debris; This may reduce Odor, Infection and provide Comfort;-Responsibility: Nursing Assistant (Certified Nursing Assistant (CNA), Licensed Nurses (Licensed Practical Nurses (LPNs) and Registered Nurses (RNs)), Nursing Administration, and Director of Nursing (DON);-Equipment Includes: Toothbrush, Toothpaste and Mouthwash. Review of the facility Certified Nurse Aide job description, revised on 1/2024, showed:-Essential Functions of CNAs: Provides Residents with hygiene supports including nail care, light hair or other grooming, oral hygiene, bathing, and incontinence care;-Reports to: Director of Nursing. 1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/14/25, showed:-admission date of 8/8/25;-Adequate hearing;-Clear speech - distinct intelligible words;-Makes self understood: Understood;-Ability to understand others: Understands - clear comprehension;-Cognitively intact;-No behavioral symptoms (physical, verbal or other);-Rejection of care: Behavior not exhibited;-Oral hygiene: Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. Review of the resident's medical diagnoses located in the electronic medical record (EMR), showed diagnoses of muscle weakness, chronic kidney disease and high blood pressure. Review of the resident's care plan, located in the EMR, showed: -9/9/25, Focus: Activity of daily living (ADLs) deficit. Goal: Will maintain current level of function with ADLs. Intervention: One person assistance with ADLs. During observation and interview on 9/30/25 at 1:17 P.M., the resident was on his/her bed. The resident said staff do not offer to brush his/her teeth in the morning. Staff have not provided him/her with a toothbrush, toothpaste or mouthwash since coming to the facility about six weeks ago. He/She would like to have the supplies because he/she wants a fresh mouth. The resident gave permission for the surveyor to check his/her cabinet drawers. No toothbrush, toothpaste or mouthwash was found. During observation and interview on 10/1/25 at 1:18 P.M., CNA H said he/she was assigned to the resident today. He/She did not offer the resident oral care because the resident is able to do pretty much everything on his/her own. The resident said he/she could if he/she had the supplies. The CNA looked in the resident's cabinet drawers and could not find a toothbrush, toothpaste or mouthwash. The CNA said he/she always brushes his/her own teeth every morning, and oral care should be offered to the residents every day. 2. Review of Resident #8's admission MDS dated [DATE], showed:-admission date of 7/1/25;-Adequate hearing and vision;-Unclear speech - slurred or mumbled words;-Makes self understood: Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time;-Ability to understand others: Usually understands - misses some part/intent of message but comprehends most conversation;-Moderately impaired cognition;-No behavioral symptoms;-Rejection of care: Behavior not exhibited;-Functional limitation in range of motion: Impairment in one upper and one lower extremity;-Oral hygiene: Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Review of the resident's medical diagnoses, located in the electronic medical record EMR, showed diagnoses of end stage renal (kidney) disease, muscle weakness and diabetes. Review of the resident's care plan, located in the EMR, showed:-7/18/25, Focus: Activities of daily living deficit. Goal: Will maintain current level of function with ADLs. Intervention: One person assistance with ADLs. During observation and interview on 9/30/25 at 1:17 P.M., the resident (Resident #18's roommate) sat in his/her room in a wheelchair feeding himself/herself lunch. The resident said staff do not offer to brush his/her teeth in the morning. He/She had been at the facility for about two or three months and had not had his/her teeth brushed once. The resident gave permission for the surveyor to check his/her cabinet drawers. No toothbrush, toothpaste or mouthwash was found. During observation and interview on 10/1/25 at 1:18 P.M., CNA H said he/she was assigned to the resident today. He/She did not offer the resident oral care because the night shift was getting the resident up this morning and all he/she did was assist with the transfer</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure residents referred to the restorative program from the therapy department received the services according to the restorative therapy plan. The facility identified 19 residents receiving restorative services. Four of these residents (Residents #1, #21, #22, and #23) had a restorative exercise plan developed by the therapy department, and they were not receiving services as prescribed by skilled therapy. The facility had a census of 170. Review of the facility's Restorative Nursing Care policy dated 1/1/2014, showed: ~ Restorative care refers to nursing interventions that promote the resident ability to adapt and adjust to living as independently and safely as possible. ~ It is the policy of this facility to utilize the interdisciplinary restorative team in promoting optimal function for all residents, for the appropriate restorative program per their assessment of their functional needs. All residents who have an identified restorative need will be reviewed for the appropriate restorative program per their assessment of their functional levels. ~ Nursing and other staff may make referrals to the program per protocol. The referral should be made to the Restorative Nurse, and the nurse is then responsible for the development of the restorative program and communicating the restorative interventions for restorative care. The restorative team will complete the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff and Care Area Assessment (CAA). Based on the assessment, the care plan is developed promoting the highest practicable wellbeing of the resident. ~ Restorative forms will be used on all residents participating in the restorative program and along with therapy, the Restorative Nurse completes this form, and the Restorative care plan is developed. ~ The Restorative Nurse Aide will provide the service developed and document the services provided in the medical record along with a weekly summary and a monthly meeting will be held. 1. Review of Resident #1's record showed: -Diagnoses of incomplete quadriplegia (affects all four limbs but leaves some degree of movement and sensation intact). due to spinal cord lesion between the 5th and 7th cervical vertebrae and motor vehicle accident (MVA); -Requires maximum assistance with activities of daily living (ADLs) and locomotion; -Intact cognition. Review of the resident's care plan, dated 7/11/25, located in the electronic healthcare record (EHR) showed: -Resident will remain at optimal status and quality of life within limitations imposed by paraplegia; -Resident is to be assisted with locomotion and ADLs; -Physical therapy (PT), occupational therapy (OT), speech therapy (ST) evaluation and treatment as ordered; -Resident will develop no further loss of range of motion. Observation and interview on 9/30/25 at 9:00 A.M., showed Resident #1 said he/she does not get restorative like he/she is supposed to. Staff are to stretch his/her hands and fingers daily, and they haven't since he/she has been here, about one month. The resident has splints he/she is to wear daily. The restorative aides are to put them on him, but they don't. Observation showed he/she did not have them on during this interview. 2. Review of Resident #21's annual MDS, dated [DATE], showed the following: -Intact cognition; -Minimal memory issues. During an interview on 10/1/25 at 11:00A.M., the resident said he/she used to get restorative services but has not received any in at least two weeks. The Restorative Aide is always pulled to the floor and Restorative services are not delivered; it is hit and miss. 3. Review of Resident #22's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnosis of muscle weakness (generalized) Review of the resident's care plan dated 6/29/25, showed: -Limited mobility and requires assistance with Activities of Daily Living tasks; -Will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown; -PT, OT, referrals. During an interview on 10/1/25 at 1:00 P.M., the resident said he/she used to receive restorative services, but he/she has not had any services in a long time. He/she could not recall the last time he/she received restorative services and said he/she would like to get the restorative exercises again. 4. Review of Resident #23's admission MDS, dated [DATE], showed: -Cognitively intact; -Able to ambulate 10 feet; -Minimal assist with ADLs; -Functional Range of Motion- impairment on one side-lower extremity; -Uses a cane or walker. During an interview on 10/1/25 at 1:00 P.M., the resident said he/she used to receive restorative services, and they would come down and walk with him/her two to three times a week. It has been a while since restorative therapy walked with him/her. 5. Review of the restorative aide's binder showed restorative plans developed by therapy for Resident #1, #21, #22, and #23. The plans involved range of motion (ROM) exercises three times a week. Residents #1, #21, #22 and #23 received restorative therapy services two times within the prior ten days. 6. Review on 10/3/25 at 11:00 A.M. of the facility's daily staffing sheets, dated 9/23/25 through 10/3/25 showed the restorative aide was pulled to the</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide necessary Social Services (SS) by failing to promptly develop a discharge plan and/or seek professional medical and/or psychiatric evaluation(s) to determine if one resident had the right to discharge to the community with or without a place to reside, discharge against medical advice (AMA), or if the facility should seek legal advice about legal guardianship for the resident. The resident, who was homeless, but his/her own legal representative, was admitted to a local hospital on 4/13/25, for a medical condition and was then discharged to the facility on 4/30/25. The resident's diagnoses included bipolar disorder (characterized by periods of depression and periods of abnormally elevated mood) and anxiety. On 5/2/25, the resident was placed on a locked unit within the facility after expressing his/her desire to leave and attempting to leave. (Resident #2) The census was 170. Review of the facility Social Service Supervisor job description, revised on 5/2022, showed:-Essential Functions of Social Services Supervisor:-Assure that social service/discharge planning activities are integrated and coordinated within the hospital system by effective communication at all levels;-Develop specific, measurable, realistic plans and objectives, which enhance social service daily; -Perform psychosocial assessment and reassessment on all residents. Identify and address the psychosocial needs of residents and their family;-Demonstrates knowledge of clinical social work and discharge planning. Interpret and promote resident's rights and the Residents' [NAME] of Rights;-Interact professionally with resident and family and involve resident and family in the formation of the plan of care;-Coordinate and direct Social Service/Discharge Planning Department to ensure resident needs are met and center policy is followed;-Provide appropriate resources and support to Social Service/Discharge Planning Staff/Clinical Staff;-Reports to: Administrator. Review of the facility's Release and Procedure Release Against Medical Advice (AMA) policy, revised on 2/2024, showed:-Purpose: To establish guidelines for when a resident/Durable Power of Attorney/Responsible Party expresses a desire to leave the facility before the attending physician has written an order;-Procedure:-When a resident/Durable Power of Attorney/Responsible Party expresses a desire to leave the facility before the attending physician has written an order: Notify the attending physician. Notify the Director of Nursing Services and Administrator;-The attending physician or designee will provide the resident/Durable Power of Attorney/Responsible Party education concerning the risks involved in leaving the facility;-Document in the medical record a summary of facts leading up to the resident/Durable Power of Attorney/Responsible Party request to be released against medical advice. Review of Resident #2's pre-admission hospital medical record, located in the resident's facility electronic medical record (EMR), showed:-admission date of 4/13/25;-Expected discharge date of 4/30/25;-Medical history Included anxiety and bipolar disorder;-Resident presented to the emergency department with complaints of generalized weakness and fatigue. Resident states he/she is homeless and has no place to go. He/She reports a lot of family [NAME], and has been living in hotels. He/She is extremely talkative about his/her situation with family, family [NAME] and homelessness. Voices he/she does not know what to do;-Discharge Plan: Per chart review, in March 2025, resident at a local crises center asking for help with housing, has been homeless since December, was living with family. He/She eventually wants to get a senior apartment and has been (making) some calls but no luck. Provided housing resources and discussed Anchor House (temporary housing). He/She is interested in Anchor House and an application was left with the resident to fill out tonight. Will pick up and fax in the morning. He/She does have a monthly income and Medicaid is pending;-Plan is to discharge resident to long term care facility on 5/3/25, once the level II screening is complete;-The hospital records did not show the outcome for Anchor House. Review of the resident's Level II Preadmission Screening and Resident Review (PASRR, a person centered evaluation completed by the hospital for anyone suspected of having a serious mental illness, developmental disability or related condition. It helps to determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed), dated 4/29/25, showed:-PASRR related disability: Yes. Specify: Does have serious mental illness;-Resident indicated during evaluation that he/she is interested in the possibility of returning to the community;-The PASRR Level II evaluation indicated the following supports and services are to be provided by the facility: Behavioral support plan, structured environment, crisis intervention services, medication therapy, activity of daily living (ADL) program;-The following supports/services may be needed for resident to live successfully in a less restrictive/community</p>		