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| 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 10/30/2025 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff implemented their Abuse Prevention Policy by not conducting a thorough investigation and report to the state survey agency as required, when two residents had a physical altercation (Residents #24 and #25). The sample was eight. The census was 171. Review of the facility's Abuse Prevention Policy, dated 10/21/22, showed the following:-Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual;-Definition: -Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident;-Investigation:-1. The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect and provide protection to any alleged victims to prevent harm during the continuance of the investigation;-2. The Administrator, or designee, shall report any allegations of abuse, neglect, or misappropriation of resident property as well as report any reasonable suspicion of crime in accordance with Section 1150B of the Social Security Act to the Department of Health as required. -Reporting:The facility will report any knowledge of actions by court of law against any employee, which would indicate unfitness for service as a nurse aide or other staff member to the [NAME] nurse's aide registry or licensing authorities; 2. Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, are reported immediately, but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency, and local law enforcement as required);3. Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident;4. Findings will be reviewed by the Interdisciplinary Team. -Implementation of this policy:-1. All staff and others who may have unsupervised access to residents will read and have maintained in their facility personnel file, this signed Abuse Prevention Policy. -2. The components of this Abuse Prevention Policy and Procedure, specific to prohibition of abuse, neglect, misappropriation, involuntary seclusion and misappropriation of property, the reporting requirements and investigative procedures shall be reviewed with each employee during orientation, and again no less than annually. -3. All residents/family members will be made aware of the prohibition of abuse, neglect, exploitation, involuntary seclusion, and misappropriation of resident's property upon admission. -4. This subject and these items shall be reviewed no less than annually at resident council, family council, and general staff meeting. -5. All residents and family member will be interviewed during other times, for example, at care planning conferences to determine whether complaints or suspected events of abuse or neglect have been reported and investigated. Review of Resident #24's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/8/25, showed the following:-Moderate cognitive impairment;-No behaviors;-Supervision with activities of daily living (ADLs);-Diagnoses of high blood pressure, dementia and anxiety disorder. Review of the resident's care plan, dated 10/16/25, showed the following:-Focus: Resident can be physically and verbally aggressive towards other residents;-Interventions: Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Review of the resident's nurse's notes, dated 10/16/25 at 6:00 P.M., showed nursing observations, evaluation, and recommendations were reported to the resident's physician and psych Nurse Practitioner (NP). The resident to be sent out to hospital emergency room for a psychiatric evaluation treatment and medication review. Review of the resident's nurse's notes, showed no additional documentation regarding the resident-to-resident altercation. During an interview on 10/29/25 at 9:57 A.M, the resident said he/she was fine but did not remember any altercation. Review of Resident #25's admission MDS, dated 10/16/25, showed the following:-No cognitive impairment;-No</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p> |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on observation, interview and record review, the facility failed to follow the facility's policy, and notify the physician and the Registered Dietician (RD) of an 11.5-pound (lb) weight loss in 56 days for one resident (Resident #17). The sample was eight. The census was 171. Review of the facility's Weight Variances Policy, dated 3/31/21, showed the following:-Policy: All residents who experience significant, insidious and/or unintentional/unplanned weight loss or gains shall be assessed for nutritional status by Registered Dietitian. Recommendations from Registered Dietitian to include but not limit to adding calorie rich/preferred snacks between meals, fortification, supplements, liberalizing diet, and plan for expected weight changes; -Residents receiving supplements shall be monitored for acceptance by the Dietary Manager/Nursing Staff. Residents at risk for unintentional/unplanned weight variance may be monitored with weekly weights. Weights shall be reviewed by the Registered Dietitian for review and assessment;-Responsibility: Nursing Personnel, RD, Dietary Personnel and Dietary Manager;-Procedure:Residents shall be weighed, and weights reported monthly to the Registered Dietitian. If significant, insidious, or unintentional/unplanned weight variances are identified or, if low body weight or malnutrition is identified, a Registered Dietitian consult shall be notified. The Registered Dietitian shall assess the resident and submit a request for monitoring and/or intervention. Once the order is obtained nutrition intervention is communicated to Dietary Manager and/or designee through nursing and/or Nutrition Management.Residents assessed at risk may be weighed weekly. Residents shall be assessed for progress monthly or as needed by the Registered Dietitian and adjustments to care made according to resident progress. Resident progress shall be reviewed with the Director of Nursing and Dietary Manager. All progress or any changes made shall be documented in the medical records and care plan updated accordingly. Review of the facility's Notification of a Change in Condition Policy, dated 4/26/23, showed the following: -Policy: The Attending Physician/Physician Extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) 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, Nursing Administration and Director of Nursing; -Procedure: -1. Guidelines for Notification of Physician, Resident Representative (not all inclusive); -Significant Change or Unstable Vital Signs; -5% Weight Gain/Loss in 30 days; -2. Document in the Interdisciplinary Team (IDT) Notes: Resident Change in Condition; Physician/Physician Extender Notification; Notification of Resident Representative. Review of Resident #17's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/25, showed the following:-No cognitive impairment;-No behaviors;-Independent with most activities of daily living;-Diagnoses of high blood pressure, diabetes and asthma;-120 lbs;-No weight loss. Review of the resident's weights, showed the following:-8/29/25: 119.5 lbs;-9/4/25: 119.5 lbs. Review of the resident's care plan, dated 9/23/25, showed the following:-Additional diagnoses included dehydration, unspecified severe protein-calorie malnutrition and gastro-esophageal reflux disease (GERD, a common condition in which the stomach contents move up into the esophagus);-Focus: The resident has a nutritional problem or potential nutritional problem and a diagnosis of malnutrition. Resident has an order for glucerna supplements (diabetic supplement);-Interventions: Monitor, record and report to the physician as needed any sign or symptoms of malnutrition or significant weight loss: three pounds in one week, more than 5% in one month, more than 7.5% in three months and more than 10% in six months. Provide and serve diet as ordered;-Goal: The resident will maintain adequate nutritional status as evidenced by maintaining baseline weight, no signs/symptoms of malnutrition and consuming at least 75% of at least three meals daily through review date. Review of the resident's progress notes, dated 9/30/25 at 11:31 P.M., showed the charge nurse was notified resident was admitted to hospital for hypoglycemia (low blood sugar) and hypotensive (low blood pressure). Review of the resident's weights, showed the following:-10/2/24: 116.5 lbs. Review of the progress notes, showed:-No note of readmission;-10/4/25, a physician progress note, with insulin orders;-10/7/25 at 3:06 P.M., the resident remained on therapy. The resident eats a regular texture diabetic diet. Resident eats all meals in room per choice;-10/8/25 at 5:02 P.M., resident complained of increased pain, swelling to the back of head, dizziness and hypotensive. Resident transported to hospital;-10/10/25 at 8:52 P.M., resident returned to facility. Physician reinstated previous medications. Review of the resident's weights, showed the following:-10/5/25: 115 lbs;-10/10/25: 116 lbs. Review of the resident's Order Summary Report, showed the following:-10/11/25, Glucerna Shake two times a day for nutrient supplement. Review of the resident's progress notes, dated</p> | | |