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	12/31/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure medical records containing protected health information (PHI) were not accessible to individuals who do not have the right to view the protected health information, for one resident (Resident #23) when staff provided an after-visit summary for Resident #23 to the family of a different resident. The facility census was 159.Review of the Know Your Rights statement, posted at the front entrance of the facility showed resident rights included confidentiality. Medical, personal, social or financial affairs should be considered privileged information. During an interview on 12/31/25 at 1:30 P.M., the family member for Resident #10 said a couple weeks ago on December 17th, the resident's nurse handed him/her the after-visit summary for Resident #23. The family member told the staff person about the mistake, and the staff person told the family member that he/she did not care and did not want the paperwork back and the family member could do whatever he/she wanted to with the documents. The family member still has the after-visit summary for Resident #23's doctor visit that includes the resident's name, date of birth , and follow-up testing that was recommended and he/she would provide a copy to the surveyor. Review of the record provide by Resident #10's family member, showed an after-visit summary dated December (the rest of the date not legible). Only the front page of a multi-page record was provided. The front page of the record included the resident's full name, medical record number, date of birth , referrals for an MRI of the spine and the pain clinic, and results of an x-tray completed during the visit. Review of Resident #23's medical record, showed no after-visit summary dated December matching the record sent, available in his/her medical record. During an interview on 12/31/25 at 3:40 P.M., the Administrator and Director of Nursing (DON) said only the residents, their guardian, and power of attorney (POA) should have access to a resident's medical record. The Administrator said if staff find out they accidentally gave someone's medical records to the wrong family member she would expect them to take the paperwork back. Management then must notify the legal team and notify the family. 2697454

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 - Few	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)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to provide a homelike environment for two residents sampled (Resident #10 and Resident #12) by not keeping Resident #10's room swept daily and having a bedside table with screws sticking out of the table. The facility staff also left two plates stacked by the air conditioning unit in Resident #12's room over a period of two days. The plates had dried food on them. In addition, the facility failed to ensure a sufficient number of plates were available to provide a homelike environment, providing Styrofoam plates in place of dining plates (Residents #6 and #7). The facility census was 159.Review of the facility's Resident's Rights Policy, last reviewed 4/26/23, showed the facility shall treat Residents with kindness, respect, and dignity and ensure Resident Rights are being followed:-Upon admission to the Facility the Resident and/or Resident Representative will be informed of the residents' bill of rights. Resident/Resident representative will sign the residents' bill of rights acknowledgement;-A copy of the residents' bill of rights will be posted in the facility; Area visible to residents and families;-Employees will receive education and training on resident rights upon hire and annually.-The Administrator/Designee will process concerns with resident rights. Review of the Know Your Rights statement, posted at the front entrance of the facility showed resident rights included be treated with consideration and respect, with full recognition of dignity and individuality. 1. Review of Resident #10's medical record, showed:-Moderate cognitive impairment;-Diagnoses include stroke, aphasia (inability to understand or express speech), hemiplegia (paralysis on one side of the body), and schizophrenia. Observation on 12/30/25 at 10:45 A.M., showed the resident lay in bed asleep. The resident's call light on the floor near the top of his/her bed. The resident's bedside table had two screws sticking up out of the table. There was trash on the floor under his/her bedside table and trash along the wall to the resident's right side. On 12/31/25 at 11:42 A.M., the resident's room was in the same condition as the previous day. Observation on 12/31/25 at 3:11 P.M., showed the resident lay in bed asleep. The resident's room was cleaned with no trash on the floor. The bedside table still had two screws sticking out the top. During an interview on 12/31/25 at 3:15 P.M., Floor Tech B said the floor techs are responsible for the main area and hallways in the facility. The housekeeping staff should be sweeping rooms daily as well as cleaning resident rooms daily. During an interview on 12/31/25 at 3:20 P.M., the Housekeeping Supervisor said screws on bedside table are not homelike. The resident has an older bedside table that is not used anymore. 2. Review of Resident #12's medical record, showed:-Cognitively intact;-Diagnoses include diabetes, high blood pressure, and hemiplegia. Observation on 12/30/25 at 11:35 A.M., showed staff in the resident's room to provide wound care. The resident has two dirty plates on the air conditioning unit. The top plate has dried food and dried ketchup on the plate. During an interview on 12/30/25 at 11:45 A.M., the resident said the plates were from meals served the previous day. Observation on 12/31/25 at 11:50 A.M., showed the resident in his/her room. The two plates remained in the same location. The resident also had an untouched Styrofoam plate wrapped on his/her bedside nightstand. The resident says that it is from the night before and was brought cold when it was supposed to be warm. During an interview on 12/31/25 at 3:20 P.M., the Housekeeping Supervisor said she expects staff to clean rooms every day. If plates are in the room, she expected her staff to take them or tell nursing. Trash should be taken in the morning and then she expected staff to go back and check room before they left. They have been shorthanded lately. They only had one staff person for the 100-hall yesterday. 3. Review of Resident #6's medical record, showed:-Diagnoses included high blood pressure, vitamin D deficiency, and muscle weakness;-A care plan, in use at the time of the investigation, showed: The resident has nutritional problems or potential nutritional problems related to food choice. Interventions included dietician will meet with the resident twice a day and discuss resident's likes and dislikes. During an interview on 12/30/25 at 2:02 P.M., the resident said staff have been serving on Styrofoam for a long time. They do not have enough plates. They will come and get residents' plates before we are done eating so they can wash them for the next meal. Half of the time he/she does not even eat the food because it is cold and it sweats because of the plastic wrap. He/She usually must ask staff to microwave it. He/She keeps his/her own peanut butter and jelly so he/she can make a sandwich. Observation at this time, showed the resident had a Styrofoam plate wrapped in plastic wrap sitting on his/her bed. The plate contained a taco, refried beans and corn. Review of Resident #7's medical record, showed:-Diagnoses included high blood pressure, diabetes, gastric ulcer, and muscle weakness;-A care plan, in use at the time of the investigation, showed: The resident has diabetes and is at risk for abnormal blood sugar. Interventions included encourage resident

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, when the narcotic count sheet for one resident was lost, resulting in 30 narcotic pain pills with no reconciliation (Resident #12). The census was 159. Review of the Controlled Substance Storage Policy, revised 03/2017, showed:-Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations.-Procedures:-The director of nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized licensed nursing and pharmacy personnel have access to controlled substances.-A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule 11, III, IV, and V medications, including those in the emergency supply. Review of Resident #12 medical record, showed:-Diagnoses included opioid dependence with opioid-induced mood disorder, sleep apnea, and hemiplegia left sided (weakness on one side of the body);-An order dated 9/18/25, for Oxycodone (narcotic pain medication) 20 milligram (mg). Give 1 tablet by mouth every 6 hours for pain. Review of the resident's December 2025, medication administration record (MAR), showed staff documented the administration of Oxycodone 20 mg:-At 12:00 A.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25;-At 6:00 A.M. on 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25;-At 12:00 P.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25 ;-At 6:00 P.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, and 12/22/25. During an interview on 12/31/25 at 2:15 P.M., the Pharmacy Technician said on 12/15/25, the pharmacy sent the resident's 30-day supply, 120 tablets of Oxycodone 20 mg divided on four cards of 30 tablets each and their records show it was received by the facility on 12/15/25. Review of the resident's Controlled Substance and Narcotic Sheets, on 12/31/25 at 2:30 P.M., showed three of the four sheets with accurate reconciliation of medication given. One Oxycodone 20 mg 30 tablet count sheet unavailable for review with no reconciliation for the tablets administered:-At 12:00 A.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25;-At 6:00 A.M. on 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25;-At 12:00 P.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, 12/22/25, and 12/23/25 ;-At 6:00 P.M. on 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/25, and 12/22/25.During an interview on 12/31/25 at 2:30 P.M. , Licensed Practical Nurse (LPN) A said narcotic medications are signed in when they are delivered from the pharmacy. The resident receives four cards of Oxycodone 20 mg. Each card is accounted for on the Controlled Substance Sheet. Reconciliation is completed at the beginning and end of each shift and any discrepancies are reported to the Director of Nursing (DON). LPN A does not recall any recent discrepancies and has not had any residents report not receiving their pain medication. During an interview on 12/31/25 at 2:40 P.M., the DON said she cannot find that narcotic sheet that is missing. The narcotic sheets should all be accounted for and she expects staff to sign out any controlled medication administered as well document the administration of the medication on the MAR. During an interview on 12/31/25 at 3:40 P.M., the Administrator said there should there be an accurate reconciliation of narcotics.