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	01/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all residents were treated in a dignified manner when staff did not offer a resident (Resident #2) a chance to leave his/her room after his/her roommate (Resident #3) expired at approximately 1:47 A.M. The resident was left in his/her room with the roommate for almost four hours until the funeral home picked up the roommate's remains at approximately 5:09 A.M. The sample was 9. The census was 165. Review of Resident #3's medical record, showed:-A progress note dated [DATE] at 1:47 A.M., Emergency Medical Services (EMS) calls the code and gives a time (of death) 1:47 A.M. EMS departs from the facility;-A progress note, dated [DATE] at 5:09 A.M., funeral home here for the departure. Review of Resident #2's medical record, showed:-Cognitively intact;-Diagnoses include quadriplegia (paralysis of all 4 limbs), malnutrition, diabetes, and general muscle weakness. During an interview on [DATE] at 3:47 P.M., the Administrator said staff should have taken Resident #2 to an empty room after Resident #3 passed. Observation and interview on [DATE] at 10:00 A.M., showed Resident #2 lay in bed. The resident was located in the bed furthest from the door. The resident said the night/morning after Resident #3 died, the staff closed the privacy curtain between his/her bed and his/her roommate and left the room. The resident thinks they closed the room door too. The resident said his/her roommate was over there for a while after he/she died. No one came in and asked him/her if he/she wanted to leave the room or if he/she was ok. Resident #2 said he/she did not like that. It made him/her really upset and uncomfortable, especially since he/she just lost his/her son recently. During an interview on [DATE] at 10:33 A.M., Licensed Practical Nurse (LPN) H said if a resident's roommate passes, he/she would ask the roommate to come out of the room or at least offer them the option to come out of room. He/She would expect any nurse or aide to offer that. During an interview on [DATE] at 10:45 A.M., Certified Nursing Assistant (CNA) I said if a resident passes away, staff will take the roommate out of the room. Especially if family comes to visit the resident that passed away. He/She is not sure what happened when Resident #3 died. During an interview on [DATE] at approximately 3:30 P.M., the Administrator and Director of Nursing (DON) said they would expect staff to ask resident's roommate to leave the room after the roommate passed away. The DON said it is not dignified to leave them in the room or to have the family see the deceased loved one with the roommate still in the room. 2719769

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure services provided met professional standards when staff failed to obtain a repeat weight as requested by the dietician for one resident (Residents #9) after the resident was noted to have significant weight loss. The facility also failed to ensure requested labs from an outside provider were completed and followed up on timely for one resident (Resident #4). The sample was 9. The census was 165.1.Review of Resident #9's medical record, showed diagnoses include diabetes, aphasia (difficulty communicating), dysphagia (difficulty swallowing), dementia, and delusional disorder. Review of the resident's care plan, in use at the time of the investigation, showed:-Focus: Resident has nutritional problem or potential nutritional problem related to multiple comorbidities and age/diagnosis process;-Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight within 5-10% of usual weight no signs/symptoms of malnutrition, and consuming at least 75% of at least 2-3 meals daily through review date;-Interventions: Monitor/document/report as needed any signs/symptoms of dysphagia, registered dietician to evaluate and make diet change recommendations as needed. Review of the resident's Weight Summary, showed:-On 11/10/25, 192.5 pounds (lbs);-On 12/6/25, 187.2 lbs;-On 1/5/26, 166.2 lbs;-No further weighs documented. Review of the resident's Registered Dietician progress note, dated 1/9/26 at 11:48 A.M., showed WEIGHT WARNING: Value: 166.2 lbs. Requesting reweight. During an interview on 1/22/26 at 12:18 P.M., Certified Nursing Assistant (CNA) C said he/she is the restorative aide and responsible for obtaining and documenting the weights. The dietician reviews them and sends an email to the Administrator, Director of Nursing (DON), Dietary Manager, and Assistant Director of Nursing (ADON) if the dietician wants anyone reweighed. The ADON will then email CNA C to inform him/her. He/She was supposed to reweigh the resident and thought he/she had reweighed him/her. The resident was on his/her list. He/She will go ahead and reweigh the resident now since he/she cannot find the weight. Observation on 1/22/26 at 12:30 P.M., showed the resident's weight measured 163.7 lbs. During an interview on 1/22/26 at approximately 3:30 P.M., the Administrator and DON said if the dietician requests a weight be repeated, they would expect that to be completed and documented within 24-48 hours of the request. The reweights are communication from the dietician through risk management or emails. The dietary supervisor or ADON are responsible to share the information with the restorative aide. 2. Review of #4's medical record, showed:-Diagnoses include liver cancer, generalized muscle weakness, and Alzheimer's disease;-An order, dated 1/2/26 and marked as complete on 1/6/26, Complete Blood Count (CBC, blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets)/Comprehensive Metabolic Panel (CMP, checks liver and kidney function). May discontinue after results have been faxed. Review of the resident's progress notes, showed:-On 1/6/26 at 5:29 P.M., contacted oncologist office listed on appointment sheet. Transferred to voicemail, informed that labs were drawn and pending. Left callback number for any further questions. Will fax final labs per request if received prior to appt on 1/7/26.-On 1/07/26 at 9:10 A.M., this nurse called to follow up with oncologist office regarding lab work. Spoke with the Nurse Coordinator, informed CBC and CMP drawn but still pending, was unsure if lab work needed for appointment this morning.Review of the resident's lab results report, received date 1/6/26 at 11:26 A.M. and reported 1/7/26 at 11:48 A.M., show: CMP hemolyzed (a blood sample has been rejected because red blood cells burst, releasing hemoglobin into the liquid portion (serum/plasma) and rendering it pink/red, often making test results inaccurate). Call to reschedule. During an interview on 1/22/26 at 11:45 A.M., ADON L said the resident's lab results are done by an outside provider so that is why they are not in the computer. The resident needed a CBC and CMP. During an interview on 1/22/26 at 1:01 P.M., the social worker at (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the oncology office said after the resident's appointment in December, the office sent orders with the resident and the CNA who accompanied the resident. The nurse at the office also called and faxed the orders. The resident was last seen in the office on 12/18/25 and labs were ordered to be completed between Christmas and New Year. The resident was supposed to have an appointment on 1/7/26. The appointment was cancelled by the facility for transportation issues. The labs requested were not completed until 1/15/26 and they were drawn at their office. They never received any results from the facility and were not aware of any concerns with the specimen being hemolyzed. During an interview on 1/22/26 at approximately 3:30 P.M., the Administrator and DON said they would expect staff to follow up on lab results that were hemolyzed or not completed. The labs should have been redrawn prior to the office having to complete them on 1/15/26. They would also expect any new orders or appointments to be entered in the medical record when a resident returns from an outside provider appointment. 27161722717219

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff followed their Enhanced Barrier Precautions (EBP) policy when a staff member assisting with wound care did not wear an item of personal protective equipment (PPE), which was the gown, for one resident (Resident #5). Further review of the medical record, showed the resident was not ordered to be on EBP Precautions despite multiple open areas. The sample was 9. The census was 165. Review of the facility's Enhanced Barrier Precautions policy, last reviewed 5/15/24, showed:-Policy: The facility may expand the use of PPE and refer to the use of gowns and gloves during high-contact care activities that provides opportunities for transfer of multi-drug resistant organisms (MDROs) to hands/clothing. The use of gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection/colonization.-Responsibility: Direct Care Employees, Housekeeping/Laundry, Nursing Administration, & Director of Nursing (DON).-Procedure: Examples of High-Contact Resident Care Activities requiring Gown & Glove Use for EBP included: Dressing; Bathing/Showering; Providing Hygiene; Changing Linens; Changing Briefs or Toileting; Wound Care: Skin Opening requiring a Dressing.-Steps:--Post signage on the door/wall outside of the resident' s room indicating the use of Enhanced Barrier Precautions;--Post signage in the resident room with information on use of Enhanced Barrier Precautions & required PPE (e.g., Gown & Gloves). Enhanced Barrier Precautions signage should include information on high contact resident care activities that require the use of gown and gloves;--PPE should be available inside of the resident' s room. Review of the resident's medical record showed diagnoses include hemiplegia (weakness on one side of the body) following stroke left side and high blood pressure. Review of the resident's care plan, in use at the time of the investigation, showed:-Focus (initiated 12/24/25): Resident has pressure ulcer (wound caused by prolonged pressure or shearing) to sacrum (tailbone area) related to immobility and episodes of bowel and bladder;-Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date;-Interventions: Administer treatments as ordered and monitor for effectiveness, Follow facility policies/protocol for the treatment/prevention of skin breakdown.-The resident's care plan has no mention EBP precautions for the resident. Review of the resident's electronic physician order sheet (ePOS) and January 2026 Treatment Administration Record (TAR), showed no order for EBP precautions. Observation on 1/22/26 at 10:10 A.M., showed Licensed Practical Nurse (LPN) A and LPN B at the treatment cart outside of the resident's room. LPN A gathered wound care supplies, entered the resident's room, and set the items on a disposable pad placed on the resident's bedside table. LPN A and LPN B wash their hands. LPN B placed on gloves and stood at the resident's bedside. LPN A placed on gloves and a gown from a shelf that hung on the resident's door. LPN A placed an extra gown on the bed and pointed to LPN B. LPN B did not put on the gown. Both staff assisted to roll the resident to his/her left hip to expose a large, open wound to the buttocks area. The extra gown fell off the bed and onto the floor. LPN A removed the old dressing and cleansed the wound. LPN A removes his/her gloves, used hand sanitizer and placed on new gloves. LPN B stood across on the other side of the bed and held the resident's hips to keep the resident on his/her side and stable. LPN A placed the ordered treatment to the wound. LPN A cleaned up the trash, removed his/her gown and gloves and washed his/her hands. He/She removed the trash from the room. LPN B assisted the resident to be positioned on his/her right side and then exited the room. During an interview on 1/22/25 at approximately 3:30 P.M., the DON and Administrator said they would expect staff to follow their policy. They would also expect both nurses to wear appropriate PPE for EBP. 2719769