

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 02/26/2026
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview, and record review, the facility failed to follow acceptable nursing practice when facility staff left a pain medication in one resident's room at the bedside (Resident #7). The resident had not been assessed safe to self-administer medications. The medication was the resident's Morphine Sulfate Extended Release (Schedule Class II Opioid pain medication). During a skin assessment observation for the same resident, a white tablet identified as Oxycontin (Schedule Class II Opioid pain medication) was found under the resident, in his/her bed. The resident did not have a physician order for Oxycontin 10 mg. The sample was 14. The census was 160. Review of the facility's Oral Medication Administration Policy, dated 12/2017, included:-Purpose: To administer oral medications in a safe accurate, and effective manner.-Review and confirm medication orders for each individual resident on the Medication Administration Record prior to administering medications to each resident. Discuss with resident and determine if there is a need for any as needed medication such as for pain.-Administer medication and remain with the resident while medication is swallowed. Caution with residents who have difficulty swallowing. Do not leave medications at bedside, unless specifically ordered by prescriber. Review of the facility's Controlled Substance policy, dated 12/2017, showed:-Policy: 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 and state laws and regulations.-Procedures: All controlled substances are stored and maintained in a locked cabinet or compartment. Review of Resident #7's medical record, showed:-admission date 11/3/25;-Diagnoses include depression, diabetes, right above knee amputation, and paraplegia (lower body paralysis);-No order or assessment to self-administer medications. Review of the resident's electronic physician order sheets (ePOS), showed:-An order dated 1/24/26, for Morphine Sulfate Extended Release (ER) 60 milligram (mg). Give 1 capsule by mouth every 12 hours for osteoarthritis.-No order for Oxycontin 10 mg. Review of the resident's February 2026 medication administrator record, showed Morphine Sulfate ER 60 MG (Morphine Sulfate). Give 1 capsule by mouth every 12 hours for osteoarthritis. Scheduled for 9:00 A.M. and 9:00 P.M. Last dose given 2/19/25 9:00 A.M. dose. Observation on 2/19/26 at 9:45 A.M., showed the resident lay in bed with no staff present in the room. On the bedside table, a medication cup with a round brown pill sat next to a small cup of water. The resident said that was his/her medication. The resident picked up the medication cup and swallowed the pill. During an interview on 2/19/26 at 9:55 A.M., Licensed Practical Nurse (LPN) A said he/she does not know why there would be medication at bedside. He/She gave the resident their morphine earlier this morning and the resident took the medication. The resident must of spit it back out. During an interview on 2/19/26 at 10:00 A.M., Certified Medication Technician (CMT) B said he/she has not given Resident #7 his/her medications yet this morning. CMT B is not sure what medication that the resident just took but must have been from the nurse. The resident medications should not be left in the room. Nursing should stand there and watch them take their medications. Observation on</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265120	Facility ID: 265120 If continuation sheet Page 1 of 3

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/19/26 at approximately 11:15 A.M., showed Assistant Director of Nursing (ADON) C entered the resident's room to complete a skin assessment. ADON C rolled the resident to his/her left side. Under the resident was a small round white pill. ADON C said that it must be his/her morphine and put the pill on the bedside table. He/She completed the skin assessment and then left the room with the white pill.</p> <p>Observation and interview on 2/19/26 at 11:30 A.M., showed ADON C at the nurse medication cart. ADON C crushed the medication found under the resident and disposed of it. ADON C opened the medication cart and the narcotic box. He/She said that medication was not Morphine but Oxycontin. Further observation in the medication narcotic box showed the resident was not prescribed Oxycontin. ADON C is not sure how the medication would have been in the resident's bed. Another resident on the unit has a card of Oxycontin located in the narcotic box. The resident's morphine was a small brown pill that matched the medication he/she had at his/her bedside earlier that morning. ADON C said a nurse may have pulled both medications at the same time and then gave Resident #7 the wrong medication. During an interview on 2/19/26 at 12:45 P.M., the Director of Nursing (DON) and Administrator said they would expect the nurse to check the resident's mouth if they believe the resident is known for spitting out medications or pocketing them in their mouth. They would not expect any controlled medications to be in the resident's bed or the resident to have any medications not prescribed to him/her. During an interview on 2/19/26 at 2:05 P.M., ADON D said nurses should sign out narcotic medications as they are pulled. Nursing staff should make sure residents take the medication before they leave the room. Resident #7 is not known to pocket or spit out medications.</p> <p>2737849</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident funds were placed in an account separate from the facility operating account. The facility did not provide residents with refunds of their personal funds from the operating account in a timely manner for 39 residents (Resident #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41 and #42). The facility census was 160.1. Record review of the facility-maintained Accounts Receivable (A/R) Aging Report, dated [DATE], showed the following residents with personal funds held in the facility operating account. Review showed Resident #42's name did not show on the A/R Report due to the facility refunding \$1,834.00 on [DATE], four days prior to running the Accounts Receivable Report on [DATE]. Resident - Amount Held in Operating Account#1 \$40.80 #2 \$197.00#3 \$4,940.38#5 \$1,099.00#6 \$1,114.80#7 \$50.00#8 \$253.09#9 \$1,888.00#10 \$5.47#11 \$174.00#12 \$2.00#14 \$1,646.62#15 \$165.53#16 \$1.08#17 \$654.38#18 \$92.00#19 \$5.10#20 \$1,917.01#21 \$917.00#22 \$698.06#23 \$912.20#24 \$123.41#25 \$50.00#26 \$2,974.90#27 \$37.52#28 \$391.00#29 \$23.94#31 \$153.00#32 \$90.08#33 \$701.00#34 \$11,395.00#35 \$191.00#36 \$1,464.00#37 \$72.00#38 \$25.00#39 \$1,578.04#40 \$137.55#41 \$1,143.21#42 \$1,834.00Total \$39,158.17 Record review of the facility maintained paperwork showed the facility processed paperwork to generate check #16339, dated [DATE] in the amount of \$1,834.00, made payable to Resident #42. Record review of the facility-maintained paperwork showed the facility did not provide the Personal Fund Account Balance Report for expired Resident #5, #7, #8, #11, #15, #16, #17, #18, #19, #23, #25, #27, #28, #29, #36, #37, #38, #40 and #41 to the Missouri HealthNet Division Third Party Liability Unit until [DATE], one day after the department started a case managed investigation. During an interview on [DATE] at 1:43 P.M., the Business Office Manager (BOM) said Resident #42 had a credit balance in the amount of \$1,834.00 as a result from the resident paying for 07/2025 and 08/2025 and should not have. The credit balance was brought to the BOM's attention on [DATE], but he/she had not looked into the refund. He/She said the previous BOM left on [DATE] and did not process the resident's refund. During email correspondence dated [DATE] at 1:23 P.M., the BOM said the refund requests were sent to home office for Resident #1, #2, #3, #6, #10, #14, #20, #21, #24, #26, #31, #32, #33, #34 and #39. During an interview on [DATE] at 2:51 P.M., the BOM said he/she was working with corporate to verify why Resident #9, #12, #22 and #35 had bad debt write-offs instead of receiving refunds.2787398</p>		