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 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when Certified Nursing Assistant (CNA) F threw a metal fork at the resident after a verbal exchange between them. The resident (Resident #1) was struck in the arm. The sample size was 10. The census was 153. Review of the facility's Abuse and Neglect Policy, last reviewed 1/20/26, showed:Policy: The facility is committed to protecting the residents from abuse, neglect, misappropriation of property, and exploitation 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. This also includes freedom from corporal punishment, involuntary seclusion, physical and/or chemical restraints not required to treat a medical symptom.Definitions: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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident.Willful: Means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Physical Abuse/Corporal Punishment: Includes, but is not limited to: Hitting, Slapping, Punching, Biting, and Kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to: Pinching, Spanking, Slapping of hands, Flicking or hitting with an object.Deprivation of Goods and Services: Deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Example includes staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s) which result in care deficits to the resident(s).Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including abuse that is facilitated or enabled through the use of technology. Examples include, but are not limited to:Keeping and/or distributing demeaning or humiliating photographs and/or recordings through social media or multimedia messaging;Photographs and/or recordings of resident that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perinea! care;Agitating a resident to solicit a response;Derogatory statements directed to the resident's face;Labeling resident's pictures and/or providing comments in a demeaning manner;Directing a resident to use inappropriate language;Showing the resident in a compromised position.Verbal Abuse: Use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/her. He/She also stated that he/she even went back to apologize to CNA F. As of today, resident is well and in good spirits and that he/she does not have any ill will towards CNA F. Will follow up with needs as directed. Observation and interview on 3/4/26 at 12:25 P.M., showed Resident #1 sat in his/her room. The resident states CNA F got mad because they were arguing back and forth. The CNA went behind the counter and grabbed a fork. The resident states he/she blocked it by holding up his/her arm. The resident showed where the fork hit him/her near his/her elbow. The resident said he/she normally does not say anything to the CNA. He/She was on the 300 hall in the courtyard area by 300 hall. The resident states overall he/she feels safe and forgives CNA F. The resident feels shocked that the CNA threw the fork and did not think nurses were supposed to do that. The resident was just standing in the hall. The CNA was walking away. It happened on the 300 hall. The resident reports that he/she went and apologized to the CNA after the incident, but the CNA did not apologize to him/her. During an interview on 3/4/26 at 12:30 P.M., CNA M stated he/she would consider throwing a fork or any item at a resident abuse. He/She is familiar with the resident and the resident is not aggressive or threatening. The resident does not raise his/her voice to anyone residents or staff or have known behaviors. During an interview on 3/4/26 at 12:32 P.M., Licensed Practical Nurse (LPN) said Resident #1 was pretty chill/relaxed. He/She would consider throwing anything including a fork at a resident abuse. During an interview on 3/4/26 at 12:35 P.M.,CNA G said he/she heard about the incident with Resident #1 and CNA F but was not here when the incident occurred. He/She would consider throwing anything at the resident abuse. The resident is very calm and CNA G said he/she is really surprised CNA F still works at the facility. The resident does argue sometimes but CNA G said he/she was not here so cannot say what happened. He/She said it does take a lot for the resident to yell and normally he/she just walks away. During an interview on 2/4/26 at 2:05 P.M., CNA L said he/she was not here when the incident happened between the resident and CNA F. He/She has worked with CNA F before and never seen the CNA act like that. He/She has also never seen the resident heated. During an interview on 3/4/26 at 2:35 P.M., CNA F states the incident happened on 2/21/26 around lunch time. He/She was passing lunch trays so around 1-2ish and was assigned the 300 hall. While he/she was passing trays, he/she noticed there was few residents outside smoking unsupervised. CNA F said he/she asked them who let them outside and they informed him/her it was the front desk. One of them, Resident #1 started screaming and cussing and started to walk towards the CNA with his/her cane. CNA F said when the resident is frustrated he/she does yell. He/She thought the resident was serious when the resident was yelling at him/her. CNA F said as the resident was coming towards him/her, he/she threw the metal fork at the resident. It was the fork from the tray he/she was holding. CNA F said he/she called over to the nurse, Registered Nurse (RN) E and the supervisor to let them know. After the incident, they took the resident back to his/her hall and the CNA was sent home. CNA F said he/she was [NAME] back last Wednesday but is not near the resident. CNA F said the resident never apologized but said he/she did apologize to the CNA. The resident was standing close, hand distance. The fork never hit the resident; the fork hit the floor. It did not hit the resident's elbow. During an interview on 3/4/26 at 3:00 P.M., the Administrator said the resident had on a heavy fleece so the fork did not cause any harm. The fork did hit the resident's left arm. The Administrator said the resident can have a temper when he/she does not get his/her way. CNA F was only allowed back after he/she was in serviced on abuse/neglect and also on customer service/throwing forks. During an interview on 3/4/26 at 3:56 P.M., RN E said he/she was at the nurse's station and heard the commotion and looked up when the incident occurred. The commotion was CNA F and Resident #1. They were down the hall and having a verbal exchange. CNA F was trying to pass trays and the resident was kind of standing over him/her. Certified Medication Technician (CMT) I was at the nurses station and went over to CNA F. The CMT took CNA F back towards the nurses station. That is when the resident followed. The resident and CNA F were still yelling and going back and forth. CNA F took the fork from the tray and threw it at the resident. The resident was coming up the hall when it happened. RN E does believe the fork hit (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's arm. The resident was going off and yelling and kind of calling CNA F out of his/her name. However, it was not an appropriate interaction between the resident and CNA F. RN E does feel like that does classify as abuse because something was thrown at a resident. RN E was surprised that CNA F was brought back as quickly as he/she was after the incident After CNA F threw the fork, the Assistant Director of Nursing (ADON) was already coming down the hall and walked CNA F out. RN E said this is the first time he/she has ever seen CNA F act like that. There have been no complaints from residents in the past about CNA F. Resident #1's normal behavior can be aggressive and intimidating. He/She's always yelling at staff. RN E said he/she is not sure if CNA F knew he/she hit the resident with the fork. The interaction or exchange was inappropriate, and the CNA should not have been going back and forth with a resident like that. The CNA should have walked away. Even if residents are yelling at them, staff should never be yelling at residents. During an interview on 3/5/26 at 9:50 A.M., the Administrator said the interaction between CNA F and Resident #1 was not appropriate. She would have expected CNA F to go different way and get someone's attention. There were other rooms for the CNA to go to step aside and go calm down. She said throwing/yelling is abuse. CNA F told the Administrator he/she knew it was wrong to say that. The CNA also had to have one on one in-service on abuse neglect and customer service before he/she came back. During an interview on 3/5/26 at 10:57 A.M., ADON B stated he/she did not see the incident between CNA F and Resident #1. He/She heard about it after the fact. ADON B is not quite sure what happened, but the resident was trying to hit the CNA. ADON B would consider the incident abuse in that context. ADON B said the resident had on a sweatshirt that kept the fork from hitting the resident. During an interview on 3/13/26 at 1:30 P.M. CMT I verified he/she witnessed the incident between Resident #1 and CNA F. The incident occurred on 2/21/26. CMT I said the smokers go outside in the courtyard which is at the start of the 300 hallway where CNA F was passing lunch trays. CMT I said it really bothered CNA F when they go outside without supervision so the CNA always says something. The day of the incident, CNA F was passing trays and saw Resident #1 and a couple other residents outside so CNA F started fussing at Resident #1. CNA F said you know you are not supposed to be out here right now. You cannot be out here without supervision. Resident #1 said back to the CNA, Who are you the superintendent? CNA F kept going and said you do this every day and we say something to you every day. CMT I said at this point, he/she was nurses station with RN E and did not know what was going to happen so he/she went down the hall to grab CNA F and take the CNA back to the nurses station. As CMT I was pulling CNA F away, CNA F grabbed a fork off the floor and threw it at Resident #1. CMT I does not know if CNA F felt threatened because the resident had a cane but the resident was pretty far back. CMT I said when the fork got thrown, CNA F was at the nurses station and Resident #1 was in the middle of the hallway going towards the nurses station. CMT I does not believe the fork hit the resident. CNA F was still going back and forth with Resident #1 so that is why CMT I went to bring the CNA to the nurses station. Resident #1 does not have history of behaviors but they had history of getting into it the past with the same scenario but that was just a quick verbal exchange, nothing like this. CMT I does feel that was abuse. CNA F could have walked away. Staff was supposed to redirect. He/She should have said nothing and just walked away. The resident apologized to CNA F the same day. CMT I did not see the ADON. After the incident, CNA F removed himself/herself off the floor. The incident got reported to someone and the CNA was taken off the floor. CMT I said this was the first time that he/she knows of something happening with CNA F. 2785045

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure staff implemented their Abuse Prevention Policy by not conducting a thorough investigation as required, when two residents had a physical altercation (Residents #7 and #8). The staff was unsure how many incidents between the two residents had occurred, the date they occurred, and was unsure of any history. The sample size was 10. The census was 153.Review of the facility's Abuse and Neglect Policy, last reviewed 1/20/26, showed:Policy: The facility is committed to protecting the residents from abuse, neglect, misappropriation of property, and exploitation 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. This also includes freedom from corporal punishment, involuntary seclusion, physical and/or chemical restraints not required to treat a medical symptom.Definitions: 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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident. Willful: Means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse/Corporal Punishment: Includes, but is not limited to: Hitting, Slapping, Punching, Biting, and Kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to: Pinching, Spanking, Slapping of hands, Flicking or hitting with an object. Training: -Facility staff shall be provided education upon hire, and at least annually thereafter, regarding Resident's Rights, including freedom from abuse, neglect, mistreatment, misappropriation of property, exploitation and the related reporting requirements and obligations.-Employees shall be trained in issues related to abuse prohibition practices such as:Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents.Staff rights to be free of reprisal and/or retaliation when reporting information related to any allegations.How to recognize signs of burnout, frustration and stress that may lead to abuse.What constitutes abuse, neglect, exploitation, and misappropriation of resident propertyAppropriate implementation of trauma informed care principles, prohibiting further abuse, and making accommodations for the residents' safety and control of their environment after an allegation has occurred.-Training shall also include prohibiting staff from using any type of equipment (e.g. cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or audio/video recordings of residents that are demeaning or humiliating.Prevention:-Staff members, volunteers, family members and others shall be encouraged to report incidents of abuse. There will be no negative repercussions for reporting against anyone who reports suspected abuse, neglect, involuntary seclusion, exploitation, or misappropriation of resident property. When an incident of resident abuse is suspected or determined, the incident must be reported to facility management regardless of the time lapse since the incident occurred.-Residents and/or their representatives shall be educated concerning the commitment of the facility to deal quickly and effectively with abuse or suspected abuse incidents upon admission and at least annually thereafter.-Identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur.-Identification and monitoring of any potential features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility.-Examples of steps that the facility may put in place immediately to prevent further potential abuse includes, but are not limited to, staffing changes, increased supervision, protection from (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	retaliation, trauma informed care, resident accommodations, and follow-up counseling for the resident(s).-When a resident wishes to participate in a sexual relationship the facility should determine thecapacity to consent and how a sexual relationship will be handled. The Administrator, DON and Physician shall collaborate to make a determination of capacity and document in the medical record. Review of the facility's investigation showed:Date/ time alleged incident reported: 2/28/2026 at 4:45 P.M,; Date/ time alleged incident occurred: 2/28/2026 at 4:00 P.M.; Location of incident: Resident #8's room;Name of person who reported alleged incident: Nurse Supervisor Type of abuse:Physical: Resident #7 put her hands around Resident #8's neck in a choking motion. Resident #8 attempted to stop Resident #7 from shaking him/her. During the shaking, the inner cannula [a removable, insertable tube used within a tracheostomy tube (surgically created opening (stoma) in the neck leading into the trachea (windpipe) to establish an airway) to maintain a clear airway by allowing for the safe removal and cleaning of accumulated secretions] on Resident #7 was dislodged.Resident physically injured: No injury noted to Resident #8's neck. No complaints of pain. No injury noted to Resident #7. The inner cannula was cleaned and reinserted by the nurse;Do the injuries require medical attention? The inner cannula trach cleaned and reinserted; Were there any witnesses to the alleged incident? Roommate of Resident #8;Name(s) and title/relationship of person(s) allegedly involved: Resident #8 and Resident #7. Summary of interviews with witnesses (List names and summary of their interviews): Roommate of Resident #8 stated that Resident #7 came in to see him/her. The roommate had been talking to Resident #7 earlier about something so he/she came back to the room to finish the conversation. Resident #8 said something like our room is so popular now. The roommate stated that Resident #8 said it jokingly in his/her opinion. Resident #7 did not seem to think that and stood up from his/her chair and started choking Resident #8. Resident #8 then grabbed Resident #7. The roommate then called for help. A staff member came in and separated the two. The roommate stated that he/she did not understand why Resident #7 thought that Resident #8 said mean something. They were friends.Summary of interviews with roommate/residents: Please see roommate's statement above. Summary of interviews with staff: CMT heard someone call for help. He/She went into the room and saw Resident #8 and Resident #7 in an altercation. The CMT separated the two residents and directed Resident #7 to leave the room. Resident #7 went toward the nurse's station where he/she was assessed by the nurse. Summary of interviews with residents' family member/visitors/DPOA: Resident #7's family was interviewed on 3/3/26 by phone by Assistant Director of Nursing (ADON) B and the Administrator. The family member stated that he/she was informed of the incident but believed Resident #7 who said the other person started it and provoked Resident #7. The family member also stated that he/she believed Resident #7 who said that he/she had been without his/her inner cannula and tracheostomy for several days. It was shared that Resident #7 is not a good historian. Also, the resident has a history of removing his/her inner cannula and manipulating his/her trach. The family member stated that he/she was not convinced that Resident #7 would do that. (See nurse's notes). Summary of investigator's findings: A physical altercation between Resident #8 and Resident #7 occurred. Resident #7 initiated physical contact by attempting to choke Resident #8 (putting his/her hands around his/her neck). Resident #8 grabbed his/her upper body and started shaking Resident #7 to get loose. During the shaking, the inner cannula was dislodged. Staff came and separated the two. Both were assessed. Upon examination by nurse practitioner, Resident #8 had no observable signs of pain or injury. Outcome of the investigation and any interventions/changes to plan of care/corrective actions taken if appropriate) taken: Resident #8 participated in follow-up interviews. He/She stated that he/she felt safe and had not experienced any further issues with Resident #7. Resident #8 returned to his/her usual activities. It was reported that Resident #7 had been removing and re-inserting his/her inner cannula repeatedly over a period of a few days. Resident #7 also stated that he/she had no further issues with Resident #8. Additional Comments: Both residents have diagnosis that contribute to them being poor historians and are both subject to embellishing details. Both resumed their usual daily routines. Resident #7 was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER St Sophia Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 936 Charbonier Road Florissant, MO 63031	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred to the hospital on 3/32026 secondary to removing inner cannula again and manipulation of trach. Date Investigation Completed: 3/6/26Date Investigation Received: 3/15/26 1. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/4/26, showed:-No cognitive impairment;-Diagnoses included multiple sclerosis (MS, a disease in which one's immune system attacks the protective barrier of nerves), left tibia (shinbone) fracture, depression, post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event), seizures, and asthma. Review of the resident's care plan, dated 8/27/25, showed:-Focus: Resident has experienced a traumatic event in the past, that currently affects their mental and psycho-social well-being. Resident has a history of sexual, physical, and emotional abuse. He/She also reports PTSD related to finding survivors as prior employment for 911 hazmat team;-Goal: Interventions will minimize exposure to trauma triggers and promote de-escalation should triggering occur;-Interventions: Identify any known triggers, provide calm environment, teach visualization and relaxation techniques, notify physician of any significant changes with psycho-social wellbeing. Review of the resident's medical record, showed:-A progress note, dated 2/28/26 at 3:45 P.M., Resident standing in the hallway informed staff they were fighting in Resident #8's room. CMT reported he/she saw resident peer choking resident . Resident stated he/she told resident to get the fuck out of her room and male/female peer started choking him/her. Resident was assessed and separated by CMT. Resident neck was slightly redden denies pain or discomfort. No bruising noted to neck. Call placed to physician. Made aware of altercation orders received for psychiatry consult. -A progress note, dated 2/28/26 at 10:27 P.M., Resident remain on follow up. Resident been pleasant this shift. Resident show no issues or altercation with anyone at this time. Resident in bedroom with call light in reach.-A progress note dated 3/1/26 at 9:28 P.M., Resident remain on follow up. Resident been pleasant this shift. Resident show no issues or altercation with anyone at this time. Resident in bedroom with call light in reach.-A progress note, dated 3/2/26 at 11:57 P.M., Resident remains on observation related to altercation, no complaints pain or discomfort voiced. No further altercations noted, no behaviors seen. Resident remained in room all shift. Physician aware.-A progress note, dated 3/3/26 at 4:26 P.M., Residents in hallway stated they are fighting this writer observed resident sitting in her wheelchair with another resident standingover her, Resident informed this writer that resident standing over her choke her because I told her to get the F out of my room. Resident was assessed neck was slightly redden skin was intact resident ask to put call light on if someone comes into her room that he/she does not want in his/her room. Physician was made aware of altercation. Orders received for Psychiatry Consult. Message left on resident?s family.-A progress note, dated 3/3/26 at 11:11 P.M., Resident remains on observation related to altercation, no complaints pain or discomfort voiced. No further altercations noted, no behaviors seen. Resident remained in room all shift. Physician aware. Review of the medical record, showed a provider note, signed 3/2/26 at 11:51 A.M., which included: -Chief Complaint: Request from staff related to altercation with another resident on 2/28/26 per staff note;-History Of Present Illness:Staff report that on 2/28/2026 the resident was found standing in the hallway and informed staff that he/she was in a fight with another resident. The incident was observed by a staff member. The resident stated 'he/she told resident to get the f**k out of his/her room' and the other resident started choking him/her. The two residents were separated by the staff member that observed the encounter and reported that this resident had a slightly reddened neck but denied pain and/or discomfort at the time. The staff observed no bruising noted to the neck. The staff contacted the physician and an order to consult Psychiatry was ordered. The resident was seen in his/her room. He/She was wearing a gown when he/she came out of the bathroom. The resident was able to ambulate to the bed from the bathroom and he/she was not wearing appropriate footwear and did not have on his/her boot. When asked what happened, he/she reported He/She decided to put his/her hand on me and that he/she accidently pulled his/her tracheostomy out. The resident reports that he/she was pushed up against the wall by the other (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and hit his/her Head, Left shoulder, and Right knee. He/She reports that he/she has been nauseated and having loose stools since the encounter and endorses that it is likely related anxiety due to potentially seeing the other resident after the encounter. He/She has no injury palpated or visualized on the head, or bilateral shoulders, or left elbow. He/She has full range of motion (ROM) of both arms. He/She had a light bruise (fading purple) to the right lateral knee area that is fading and appears to be improving. He/She has full ROM of the knee and is able to ambulate as evidenced by his/her ability to ambulate independently from the bathroom to the bed. He/She was advised to take his/her as needed anxiety medication and to drink small sips of water more frequently to stay hydrated. He/She report that the Zofran (nausea medication) he/she was given earlier had just dissolved in his/her mouth. The resident reports no other concerns at this time. The Psychiatry Nurse Practitioner (NP) was advised of the altercation in person at the facility. The ADON was advised that the resident was concerned about his/her pain medication The staff report no other concerns at this time. Resident denies fever, chills, chest pain, and/or shortness of breath.-Plan:Acute Stable Altercation with Another Resident with bruise Right lateral knee, improving; Continue Separate each resident Continue Psych Consultation;Continue Behavior monitoring every shift for behaviors;Continue Leave right lateral knee open to air;Chronic Controlled Anxiety;Continue Antidepressant Medication Monitoring every shift;Resident counseled and encouraged to take small sips of water more frequently to remain hydrated;Acute on Chronic Pain;Continue Document pain using 1-10 pain scale every shift. Risk for falls, malnutrition, and skin breakdown;Plan discussed with Nursing. Observation and interview on 3/5/26 at 11:40 A.M., showed Resident #8 in his/her room. The resident sat in his/her wheelchair and had a large boot cast to left foot. The resident states there were two different incidents with Resident #7. The first time Resident #7 came in cursing and the nurse made him/her leave. The next time Resident #7 was in his/her room, he/she came in to talk to the roommate. Resident #8 said when he/she said something to Resident #7, Resident #8 blocked him/her from the door. He/She then hopped out of his/her wheelchair and pushed the resident against the wall and went for his/her airway. Resident #8 said he/she pinched his/her nipple and could not breathe. Resident #8 said if he/she cannot breathe, then neither can Resident #7, so he/she grabbed the resident's tracheostomy and pulled it out. Resident #8 says he/she does not trust Resident #7. Resident #7 went to the hospital and is still there. Resident #8 does not want the resident back on this hall and does not feel safe in his/her room, at lunch, or smoke breaks. Resident #8 said the resident also got him/her with their elbow to his/her temples and has had a headache since the incident. 2. Review of Resident #7's medical record, showed:-admission 1/22/26;-Diagnoses included diabetes, muscle weakness generalized, bipolar disorder, and chronic respiratory failure. Review of the resident's care plan, initiated 2/28/26 and created 3/4/26, showed:-Focus: Potential to be physically aggressive related to anger and poor impulse control;-Goal: Will demonstrate effective coping skills through the review date;-Interventions: Administer medications as ordered, Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, assess and interpret needs, when becomes agitated intervene before agitation escalates. If response aggressive, staff to walk calmly away and approach later. Review of the resident's medical record, showed:-A progress note, dated 2/28/26 at 3:26 P.M., Resident in hallway informed this writer that resident were fighting. This writer observed resident standing over other resident with her inner cannula in his/her hand. Resident states other resident involved told him/her to get the F out of his/her room. This writer ask resident to leave the room. Inner cannula was reinserted at this time with supervision. No respiratory distress noted. Oxygen Saturation (O2, measures the percentage of oxygen-carrying hemoglobin in the blood, with normal levels for healthy individuals typically between 95% and 100%) at 97% at room air.-A progress note, dated 2/28/26 at 3:44 P.M., This writer observed resident in Resident #8's room in verbal altercation. Resident stated that resident told her to get the fuck out of his/her room and he/she became angry and try to choke resident. Behavior was redirected and ask to leave the room. He/She was holding his/her trach in his/her hand. He/She informed this (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	writer that Resident #8's roommate invited him/her into their room. Voiced no complaints of discomfort. No aggressive behavior noted at this time. Resident stated, that resident told him/her to get the fuck out of my room and do not like for people to holler at me this why I tried to choke him/her. Also, he/she informed this writer that he/she had been invited into the room by resident's roommate. Resident was escorted out the room by this writer and ask not to go back in the room at this time compliant with this writer.-A progress note dated, 2/28/26 at 11:18 P.M., Resident remain on follow up resident to resident. Resident been pleasant this shift. Resident show no issues or altercation with anyone at thistime. Resident in bedroom with call light in reach.-A progress note dated, 3/1/26 at 10:21 P.M., Resident remain on follow up resident to resident. Resident been pleasant this shift. Resident show no issues or altercation with anyone at thistime. Resident in bedroom with call light in reach.-A progress note, dated 3/3/26 at 2:46 P.M., This nurse was talking to resident in the hallway when I noticed his/her voice box was not in place and that the opening was closing. The resident was asked about his/her tracheostomy being out. He/She stated he/she was ok and that he/she did not need it because he/she was breathing fine. Informed resident that it was not ok and that he/she would still have to be assessed by doctor. Resident hesitant to say when it was removed but did say it was during an altercation with another resident. Talked to floor nurse and that nurse that handled the altercation to inquire about tracheostomy. The nurse that handled the altercation stated that it was the inner cannula that came out and was replaced and resident was assessed at that time there was not decannulation (permanent removal of a tracheostomy tube once a patient can breathe independently). Resident assessed after noticing inner cannula out and decannulation was noted. When this nurse returned to office to contact the doctor, the resident's guardian was calling and was upset that he/she had not been informed of tracheostomy being out and spoke with the nurse that had contacted him/her the night of the altercation who was also in the office. The nurse was trying to inform the guardian that it was not out when the nurse called him/her but guardian stated only thing he/she wanted to hear was that the resident was being sent out to hospital. The guardian asked us to allow him/her that grace because he/she was upset and could not hear {process} what we were saying.-A progress note, dated 3/3/26 at 3:19 P.M., ADON reported that resident's guardian would like for resident to be sent to hospital for evaluation due to decannulation of tracheostomy a couple of days ago. Resident's O2 Saturation 98% room air at this time. No acute distress noted.-A progress note, dated 3/3/26 at 3:29 P.M., Call placed to ambulance service to transport resident to hospital emergency room for evaluation. Estimated time of arrival, one hour, awaiting arrival of Emergency Medical Services (EMS) to facility.-A progress note, dated 3/3/26 at 5:31 P.M., Ambulance services at facility to transport resident to hospital. ADON aware and stated that physician is also aware of resident's condition and guardian's request that resident be sent to hospital for evaluation.-A progress note, dated 3/3/26 at 7:39 P.M., This nurse spoke with guardian. Informed him/her that resident had been sent to hospital, vitals. He/She was not in distress. Informed him/her that when he/she called we had just become aware of decannulation. He/She inquired as to why he/she had not been notified if tracheostomy out for days. Advised we were still trying to determine at what point he/she pulled it out. Per nurse that assessed resident, his/her tracheostomy was still in place and inner cannula was replaced. He/She spoke of resident's history behind why tracheostomy was needed and previous issues with another facility. Said he/she spoke with hospital and had the resident admitted . Wanted more info about when it came out and spoke of resident improvement with activity of daily living (ADLs). Review of the medical record, showed a provider note, signed 3/2/26 at 4:13 P.M., which included: Chief Complaint / Nature of Presenting Problem: Request from staff related altercation with another resident on either 2/28/2025 or 3/1/2026. History Of Present Illness:The staff report no concerns related to the resident at this time. Staff report the resident was in Resident #8's room in a verbal altercation with a resident and he/she was told to get the f**k out of the room and he/she became angry. The resident tried to choke Resident #8 and staff redirected the behavior. While leaving the room, he/she was holding his/her tracheostomy in his/her (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands. No injuries noted on the resident and he/she was separated from the other resident. The resident was seen sitting in his/her wheelchair in the doorway of his/her room. When asked about the incident he/she reported I don't want to talk about it. I already gave my statement. The incident was discussed with the Psychiatry NP this morning. The resident denies any concerns at this time. Denies fever, chills, chest pain, and/or shortness of breath. Physical ExamGeneral: no acute distress, appears obese, well developed, cooperative;Head: Normocephalic (normal shape and size); Eyes: extraocular movements intact, conjunctiva and sclera are normal;Ears: hears without difficulty;Neck: Tracheostomy status, site clean/dry; Mouth: Mucous membranes are moist; Cardiac: Appears well perfused, no chest pain;Pulmonary: nonlabored breathing, normal effort, no shortness of breath, no distress, tracheostomy statusAbdomen: differed;Musculoskeletal: Unsteady gait uses a wheelchair for mobility, no edema;Skin: tracheostomy to neck, no edema, no rash, no lesions, warm and dry;Neurological: Responds appropriately, Awake, Alert, Verbal, oriented to person, place, and situation;Psychiatric - mood stable, cooperative. Plan: Acute Controlled Behavior (Altercation with another resident, no injury) behavior concerning, aggressive behavior. Continue Separate residents;Continue may be seen by Psychiatrist/Psychologist as needed;Chronic Controlled Bipolar disorder Schizoaffective disorder;Psychiatrist/Psychologist as needed;Continue Behavior monitoring every shift;Continue Antipsychotic medication side effect monitoring every shift; Plan discussed with Nursing. During an interview on 3/11/26 at 2:00 P.M., Resident #7 stated he/she was still in the hospital. The resident reports he/she got in a fight with Resident #8 last week and Resident #8 pulled out his/her tracheostomy. He/She just had the strings hanging. Resident #7 said there was a history due to Resident #8 recently had tried to take his/her door dash food. Staff intervened and told Resident #8 not to touch that, it was not his/hers. Last Saturday, he/she was in the room talking to Resident #8's roommate. Resident #8 came in pissed that he/she was in there and started cussing the resident out. Resident #7 said the next thing he/she knows, he/she is out of his/her wheelchair, and up in the air with the tracheostomy hanging by a thread. The resident said staff intervened but the nurse did not assess his/her tracheostomy site. The resident said he/she was fine with no signs/symptoms of distress like shortness of breath. It was just his/her guardian that made him/her go to the hospital on 3/3/26. The site closed so he/she no longer has his/her tracheostomy. The resident reports he/she got evaluated at the hospital and they are going to do a Bilevel Positive Airway Pressure machine (Bipap machine, a non-invasive ventilator used to assist breathing by delivering pressurized air through a mask, with higher pressure during inhalation and lower pressure during exhalation) which he/she thinks will be much easier to handle. The resident said his/her guardian is not telling the resident much but he/she feels fine to go back to the facility. He/She has friends there and feels safe. The resident says he/she is fine. 3. Observation and interview on 3/4/26 at 11:10 A.M., showed Resident #8 was not in his/her room. The resident's roommate was in their room. The roommate reported there was a recent incident with another resident down the hall, Resident #7. He/She was in here talking with Resident #7 when he/she just started going off on Resident #8. Resident #8 was trying to joke with him/her. Resident #7 did not seem to like that and threatened Resident #8, so he/she told Resident #7 to get out. That is when Resident #7 backed Resident #8 into a corner. The roommate states he/she called for help and staff came in to assist. The roommate states he/she has no problems with Resident #8. Resident #8 is wonderful. They get along great. Both of them were in wheelchairs and have MS, so they understand each other and their struggles well. The roommate states he/she feels safe. 4. During an interview on 3/4/26 at 11:30 A.M., Licensed Practical Nurse (LPN) H states he/she is not aware of two incidents between Resident #7 and Resident #8. LPN H is only aware of one incident and was just told to keep them separated. 5. During an interview on 3/4/26 at 1:00 P.M., the Administrator stated she only knew of one incident with Resident #7 and Resident #8 that occurred on 2/28/26. She was not sure of any incident on 3/3/26. Resident #7 was in the hospital. She was planning to move one of the residents but not sure which one. They both eat and smoke at similar times. The facility staff could keep them (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on separate sides and may have to look at smoke times. If there was second incident, the staff definitely should have said something. She said the first incident happened in Resident #8's room. 6. During an interview on 3/4/26 at 2:00 P.M., LPN H reviewed the progress notes and said this was the first he/she has heard of two incidents if there were two incidents. There should not have been a history between the two of them. After the first incident, staff should have been listening out for them and Resident #7 should not have been allowed to get back into Resident #8's room. 7. During an interview on 3/4/25 at 2:05 P.M., Certified Nursing Assistant (CNA) L said he/she knows Resident #7 was in Resident #8's room, Saturday 2/28/26. He/She was helping Resident #8's roommate. Resident #7 should not have been in that room again if they have history of altercation. 8. During an interview on 3/5/26 at 9:50 A.M., the Administrator said she believes there were two incidents between Resident #7 and Resident #8 but they both happened in one day on 2/28/26. The altercation was an all-day thing. It was same day but later that day. She should have been made aware of more than one incident between the two residents. Resident #7 should not have been in Resident #8's room after the first incident. She would expect staff to follow the abuse/neglect policy. 9. During an interview on 3/5/26 at 10:57 A.M., ADON B stated there was only one incident with Resident #7 and Resident #8. They did have problems before that. Resident #8 reported prior that some words had been said like an inappropriate conversation, but nothing physical had happened, just inappropriate words. 27939082794304

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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 observation, interview and record review, the facility failed to ensure services provided met professional standards of practice when staff failed to follow physician orders for a resident's Peripherally Inserted Central Catheter (PICC, flexible tube that delivers long term intravenous (IV) treatments through a vein) line (Resident #9). The dressing was ordered to be changed weekly. The date on the dressing was worn off and illegible. The sample size was 10. The census was 153. Review of the facility's Physician Orders Policy, reviewed 9/8/22, showed:-Policy: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines.-Responsibility: Licensed Nurses, Nursing Administration, and Director of Nursing (DON).-Procedure: Physician Orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe Orders.Orders must be Recorded in the Medical Record by the Licensed Nurse authorized to transcribe such Orders.-Physician Orders must be documented clearly in the Medical Record. The requiredcomponents of a Complete Order:-Date and Time of Order-Name of Practitioner Providing Order-Name and Strength of Medication/Treatment-Quantity/Duration-Dosage/Frequency-Route of Administration-Indication/Diagnosis-Stop Date. if indicated-Physician Orders that are missing required components, are illegible or unclear must beclarified prior to implementation.-Physician Order Sheet (POS) will be maintained with current Physician Orders as New Orders are received. Discontinued Orders will be marked as discontinued with the date, and all new Orders will be written in the appropriate area on the POS with the date the order was received.-Physician Orders will be transcribed to the appropriate Administration Record(Medication Administration Record (MAR) or Treatment Administration Record (TAR) 1. Review of Resident #9's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/20/26, showed:-Cognitively intact;-admission 1/29/26;-Diagnoses include end stage renal disease, pressure ulcer sacral region stage 4 (severe, full-thickness wound over the tailbone, characterized by extensive tissue loss with directly exposed or palpable bone, tendon, or muscle), diabetes, depression, muscle weakness, and cognitive communication deficit. Review of the resident's care plan, showed:-Focus: PICC Line;-Goal: Will have no adverse effects from the use of a peripherally inserted central catheter;-Interventions: Dressing changes should be performed on a weekly basis or when dressing is dirty, wet, or loose. Ensure insertion site is clean and protected with sterile dressing. Review of the resident's electronic Physician Order Sheet (ePOS), showed:-An order, dated 1/29/26, change IV dressing on left brachial vein (PICC) every week. Every night shift every Thursday. Review of the resident's February MAR, showed:-Change IV dressing on left brachial vein (PICC) every week. Every night shift every Thursday;-Marked as completed on 2/5/26, 2/12/26, 2/19/26, 2/26/26. Review of the resident's March MAR, showed:-Change IV dressing on left brachial vein (PICC) every week. Every night shift every Thursday. -Due to be completed on 3/5/26, 3/12/26, 3/19/26, and 3/26/26. Review of the medical record, showed:-A progress note, dated 3/4/26 at 14:16, PICC line dressing changed with no difficulty. Remains patent and intact. No abnormalities to report at this time. IV therapy continues. An observation on 3/4/26 at 11:55 A.M., showed the resident lay in bed. The resident had a PICC line to his/her left upper arm. The dressing date was not legible. The dressing appeared to be coming off and not adhering to the skin at the corners. The resident said he/she was not sure when the dressing was last changed, but he/she gets his/her antibiotics through the PICC line. During an interview on 3/4/26 at 12:02 P.M., Assistant Director of Nursing (ADON) A said Resident #9's PICC dressing should be changed once a week. The dressing date should not have a one in front of it. It should be dated for last week. ADON A stated he/she will go check the resident's PICC line dressing after lunch. During an interview on 3/5/26 at 9:20 A.M., ADON A states he/she changed the dressing yesterday and the dressing was old. The date was hard to read. He/She thinks it may have been 2/12 but not sure. It could have been January. The date should have been (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/28 and it was not. He/She said staff should not have been charting the dressing change as done when it was not done. He/She would expect the dressing change to be done weekly as ordered. The night shift is responsible for completing the dressing change and he/she plans to in-service staff. During an interview on 3/5/26 at 9:50 AM., the Administrator said she would expect staff to follow physician orders. She would have expected the PICC line to be changed weekly and staff should not document a medication/treatment as done if it has not been done. During an interview on 3/5/26 at 10:00 A.M., the Registered Nurse Consultant (RNC) said he/she would expect staff to follow physician orders. The PICC dressing should have been changed weekly as ordered. Any treatment or medication should not have been charted as done if not done.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure a resident with pain received prescribed opioid pain medications as ordered by the physician for four days (Resident #8). The sample size was 10. The census was 153. Review of the facility's Physician Orders Policy, reviewed 9/8/22, showed:-Policy: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines.-Responsibility: Licensed Nurses, Nursing Administration, and Director of Nursing (DON).-Procedure: Medications will be ordered from the Pharmacy to ensure prompt delivery. Medications available from the Emergency Drug Supply (E-Kit) or Automatic Dispensing Unit (ADU) shall be utilized for the first dose until a supply arrives from Pharmacy if available. Review of the facility's Pain Management Policy, reviewed 11/15/22, showed:Policy: The Facility will use a systematic approach to Pain Management; Recognition, Evaluation, Treatment, & Monitoring of Pain. Individuals experiencing Pain may receive Pharmalogical/Non-Pharmalogical Interventions to assist in Pain Management. The Facility will provide Employees Education on Pain Management & Opioid Overdose. Responsibility: Nursing Personnel, Nursing Administration, and DON. Procedure: Recognition: Evaluate/Prevent: Recognize when Resident is experiencing Pain and identify circumstances when Pain can be anticipated. '-Evaluate Resident for Pain on admission and Routine Evaluations.-Manage/Prevent Pain, consistent with the Comprehensive Evaluation and Plan of Care, Current Professional Standards of Practice, & Resident's Goals/Preferences. Pain Evaluation: Nursing will complete a Pain Evaluation Tool, appropriate for the Resident's Cognitive Status, to assist with Evaluation of a Resident's Pain.-Evaluation of Pain by the Licensed Nurse or Medical Provider.-History of Pain & Treatment-Ask the Resident to Rate the Intensity of his/her Pain using a numerical scale, Verbal or Visual Descriptor that is appropriate and preferred by the Resident.-Reviewing the Resident's Current Medical Conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, CVA, venous and arterial ulcers, and multiple sclerosis).-Identifying Key Characteristics of Pain: Duration Frequency Location Timing Pattern (e.g., constant, or intermittent) Radiation-Obtaining Descriptors of Pain (e.g., stabbing, aching, pressure, spasms).-Identifying activities, Resident care or treatment that precipitate or exacerbate Pain and those that reduce or eliminate Pain.-Impact of Pain on Activities of Daily Living (e.g., sleeping, social activities, physical activity and mobility, emotions, intimacy, appetite, and mood, etc.). Current Prescribed Pain medications, Dosage, Frequency, Treatments, and Modalities. Pain Management and Treatment: Based on the Evaluation, Nursing in collaboration with the Physician/Prescriber, other Health Care Professionals, the Resident and/or the Resident's Representative will Develop, Implement, Monitor, and Revise as necessary intervention's to Prevent/manage Resident's Pain beginning at Admission.-The Interventions for Pain Management will be incorporated into the components of the Comprehensive Care Plan, addressing medical conditions that may be associated with Pain Management Goal.The Interdisciplinary Team, the Resident and/or the Resident's Representative will collaborate and discuss realistic, and measurable goals for Treatment.-Pharmacological interventions will follow a systematic approach for selecting Medications/Doses to Manage Pain. The Practitioner and IDT Team is responsible for developing a Pain Management Regimen that is specific to each Resident who has Pain/Potential for Pain. General Principles for Analgesics: Evaluate the Resident's medical condition, current medication regimen, cause and severity of the Pain and course of Illness to determine the most appropriate Analgesic for Pain Therapy.-Consider evidence-based practice tools to assist in the Evaluation of the Resident's Pain.-Consider Administering Medication Routinely instead of PRN or combining longer acting medications with PRN Medications for breakthrough Pain.-Utilize the most effective and least invasive route for Analgesic Administration (e.g., oral, rectal, topical, injection, infusion pump and/or transdermal).-Use lower doses of Medication initially and titrate slowly upward until comfort is (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	achieved.-Reassess and adjust the Medication Dose to optimize the Resident's Pain relief while monitoring the effectiveness of the Medication and work to minimize or manage side effects.-Review Medical Conditions which may require several Analgesics and/or adjuvant medications; Documentation will clarify the rationale for a Treatment Regimen and acknowledge associated risks.-Opioids will be Prescribed and Dosed in accordance with current professional standards of practice and manufacturers guidelines to optimize their effectiveness and minimize their adverse consequences.-Nursing will Notify Practitioner if the Resident's Pain is not controlled by the current Treatment Regimen.-Referral to a Pain Management Clinic for other Interventions that need to be Administered under the close supervision of Pain Management Specialists will be considered for Residents with Advanced, Complex, or poorly controlled Pain.Monitoring, Reevaluation, & Care Plan Revision: Nursing will reassess Resident's Pain Management for effectiveness and/or adverse consequences (e.g., constipation, sedation, anorexia, change in mental status, delirium, respiratory depression, pruritus, nausea, vomiting, addiction and falling or drowsiness) at established intervals.-If Re-Evaluation findings indicate Pain is not adequately controlled, the Pain Management Regimen and Plan of Care will be revised as indicated.-If Pain has resolved or there is no longer an indication for Pain Medication, the Interdisciplinary Team will work to discontinue or taper Analgesics (as needed to prevent withdrawal symptoms). Review of the Resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 3/4/26, showed:-No cognitive impairment;-Diagnoses include multiple sclerosis (MS, a disease in which one's immune system attacks the protective barrier of nerves), left tibia (shinbone) fracture, depression, post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event), seizures, and asthma. Review of the resident's care plan, dated 8/27/25, showed:-Goal: Resident has a history of pain related to neuropathy, bilateral lower extremity pain, right ankle pain with edema noted;-Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date;-Interventions: Administer analgesia (pain relief) as per orders, Identify and record previous pain history and management of that pain and impact on function, monitor/record/report to nurse resident complaints of pain or requests of pain treatment, notify physician if interventions are unsuccessful or if current complaint is significant change from residents past experience of pain, encourage resident to try different pain relieving methods. Review of the resident's Pain assessment dated , 2/28/26 showed:-Current Pain Level: No pain-Effects of Pain on Activities of Daily Living (ADLs):-Sleep and Rest: Yes;-Social Activities: Yes;-Appetite: Yes;-Physical Activity and Mobility: Yes;-Emotions: Yes;-Intimacy: No.Medications/Treatments/Modalities:Describe all methos of alleviating pain and their effectiveness: Voiced no complaints of pain/discomfort.Comments: Continue to monitor. Review of the resident's electronic Physician Order Sheet (ePOS), showed:-An order, dated 11/19/25, Oxycodone Oral Tablet 5 milligram (mg). Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Review of the resident's March Medication Administration Record (MAR), showed:-Oxycodone 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Scheduled: 0000, 0400, 0800, 1200, 1600, and 2000.-Medication shown as given on 3/1/26 at 0000 and 0400. -Medication shown as not administered (NA) see nurses note:-3/1/26 0800, 1200, 1600, 2000;-3/2/26 0000, 0400, 0800, 1200, 1600, 2000;-3/3/26 0000, 0400, 0800, 1200, 1600, 2000;-3/4/26 0000, 0400, 0800, 1200, 1600, 2000;-3/5/26 0000, 0400, 0800. Review of the resident's medical record, showed:-A progress note, dated 3/1/26 at 20:55, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Medication needs prescription.- A progress note, dated 3/1/26 at 20:56, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Medication needs new prescription.- A progress note, dated 3/1/26 at 21:54, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Not in stock. -A progress note, dated 3/1/26 at 23:09, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Not in stock.-A provider note by (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Nurse Practitioner (NP), dated 3/2/26, The Assistant Director of Nursing (ADON) was advised that the resident was concerned about her pain medication as the nurse told her she did not have it only Tylenol and that the script had been sent in, but the nurse cannot pull it. The staff report no other concerns at this time.-A progress note, dated 3/2/26 at 05:50, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Med not in stock.-A progress note, dated 3/2/26 at 11:12, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Medication not available due to new pharmacy change 3/2/26.-A progress note, dated 3/2/26 at 14:01, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Pharmacy change occurring unable to give medication awaiting new scripts.-A progress note, dated 3/2/26 at 17:23, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Pharmacy change requiring new e-prescriber scripts to be sent to new pharmacy awaiting medication. -A progress note, dated 3/3/26 at 09:03, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Resident pain medication not available awaiting medication from new pharmacy.-A progress note, dated 3/3/26 at 11:50, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Pharmacy change awaiting medication from pharmacy.-A progress note, dated 3/3/26 at 16:31, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Facility changed pharmacy awaiting medication to facility.-A progress note, dated 3/3/26 at 20:14, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. awaiting medication to facility.-A progress note, dated 3/4/26 at 09:07, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Not available.-A progress note, dated 3/4/26 at 11:24, Oxycodone Oral Tablet 5 mg. Give 2 tablet by mouth every 4 hours for pain related to left tibia fracture. Not available. An observation and interview on 3/4/26 at 11:40 A.M., showed the resident in his/her room. The resident sat in his/her wheelchair and had boot to his/her left foot. The resident reported he/she has been out of pain pill Oxycodone for several days since the facility switched pharmacies. He/She is hurting without his/her pain pill because of the broken foot. An observation and interview on 3/5/26 9:30 A.M., showed the resident in the main hallway. The resident sat in his/her wheelchair, crying. The resident was not wearing his/her boot. The resident stated he/she is just overwhelmed and in a lot of pain. He/She just wanted to go outside to get some fresh air and was told to wait due to the rain. He/She asked for pain medication overnight and was given anxiety medication. During an interview on 3/5/26 at 9:45 A.M., Certified Medication Technician (CMT) J said he/she has been giving the resident Tylenol as needed. They just switched pharmacy, so they are trying to get the resident's oxycodone approved. They switched Monday and have been working on it. The resident does not seem like he/she is in pain. He/She just asked for anxiety medication not pain medication. During an interview on 3/5/26 at 9:48 A.M., Licensed Practical Nurse (LPN) K said they just got a new pharmacy. Oxycodone is not in new system. The resident does seem like he/she is in pain. The resident gets pain medication scheduled several times a day every day. LPN K was not sure how long he/she has been out. They switched pharmacy on Friday. The resident asked for anxiety medication and then had to give Tylenol for headache. During an interview on 3/5/26 at 9:50 A.M., The Administrator said the resident or any resident should not be out of pain medications for 4 days. She would expect staff to notify the Administrator, supervisor, DON and ADON to get the medication at the facility. During an interview on 3/5/26 at 10:00 A.M., the Registered Nurse Consultant (RNC) said they started with the new pharmacy officially on Monday after the pharmacy brought some medications on Friday to start the process. Stock medications should be in pyxus (an automatic medication dispensing system) . If someone is out of pain medication, staff had to call to get the medication or a different medication for pain relief. The RNC would expect to wait less than 24 hours to receive pain medication once requested. The prescription for the resident's pain medication was received yesterday. The RNC verified 3/4/25 was the date the pharmacy received the new prescription which (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is also the day the RNC reports she was made aware of the issue to get it fixed. For pain medications, the facility had to have a valid script to have in e-kit for pain medications. The RNC said if the resident has been out since 3/1/26 that is four days and was not acceptable. Due to signature issue, they had to have a brand new prescription, but it is not ok for the resident to have to wait all week. The medication is supposed to arrive today. During an interview on 3/5/26 at 10:57 A.M., ADON B said he/she was aware the resident was out of ordered Oxycodone. The medications have been getting transferred from the pharmacy. ADON B said he/she has been working on getting the resident's medication since Sunday, but could not pull the medications from the Pyxis.