Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466

Randall W. Williams, MD, FACOG
Director

Eric R. Greitens
Governor

October 13, 2017

ELECTRONIC TRANSMISSION

Lisa Anderson, Administrator
St. Sophia Health & Rehabilitation Center
936 Charbonier Road
Florissant, MO 63031

CMS Certification No: 265120

Dear Ms. Anderson:

On 09/28/2017, an abbreviated survey was conducted at St. Sophia Health & Rehabilitation Center by the Section for Long-Term Care Regulation (SLCR) staff to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and Medicaid programs. This abbreviated survey found your facility was not in substantial compliance with the participation requirements.

As a result of the abbreviated survey findings listed on the CMS 2567 (Statement of Deficiencies) which was forwarded to you after the abbreviated survey, the SLCR, Region 7 office notified you that a federal remedy would be imposed. This action is based on the fact that a deficiency that constitutes a level of actual harm in the area of Quality of Care was found on the current abbreviated survey.

Based on the deficiencies cited during the abbreviated survey, denial of payment for new Medicare and Medicaid admissions will be imposed, pursuant to Section 1819 (h) and 1919 (h) of the Social Security Act and the enforcement regulations specified at 42 Code of Federal regulations (CFR) part 488, 11/02/2017, and will continue through 03/28/2018 or until the facility achieves substantial compliance.

Beginning 11/02/2017, the effective date of the denial of payment for new admissions, St. Sophia Health & Rehabilitation Center will be prohibited from submitting or receiving payment for services rendered to Medicare and Medicaid recipients who are admitted to the facility on or after that date.

Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.

For Medicaid, no later than 11/01/2017, the facility must submit to the MO HealthNet Division the following information: 1) the names of all residents in the facility; 2) the DCN numbers for all Medicaid eligible residents in the facility; and 3) the identification of any residents who have an application pending for participation in the Medicaid program. The information must be sent to Vickie Russell, MO HealthNet Division, 615 Howerton Court, P.O. Box 6500, Jefferson City, Missouri, 65102, FAX: (573) 526-7875.

Please note that Federal law, as specified in the Social Security Act at sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Competency Evaluation Programs (CEP) offered by or in a facility which within the last two years has operated under a section 1819(b)(4)(C)(ii)(II) or section 1919(b)(4)(C)(ii)(II) waiver; has been subject to an extended or partial extended survey; has been assessed a CMP of not less than $5,000 as adjusted annually under 45 CFR part 102; or, has been subject to a denial of payment; the appointment of a temporary manager; termination; or, in the case of an emergency, been closed and/or had its residents transferred to other facilities. If any of these provisions are applicable to your facility, NATCEP will be denied, and you will be advised under separate notification.

If substantial compliance with all requirements for participation in the Medicare and Medicaid program is not achieved by 03/28/2018, the facility's Medicare and Medicaid participation will be terminated.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et. seq. You must file you hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

MO_NE_LTCEnforcement@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with you written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health and Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building - Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Lisa Hauptman by phone at (816) 426-2011 or by e-mail at
MO_NE_LTCEnforcement@cms.hhs.gov

If you have any questions concerning the instructions contained in this letter, please contact Laura Morts, Program Manager, at 573/526-7889.

Sincerely,

Shelly Williamson, Administrator
Section for Long-Term Care Regulation
As Authorized by CMS

SW/hh

Enclosure

cc: Central Files
CMS RO
MO HealthNet Division
SLCR Region 7

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 ______	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST SOPHIA HEALTH & REHABILITATION CENTER	936 CHARBONIER ROAD FLORISSANT, MO 63031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		10/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/18/2017

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F 309	Continued From page 1	F 309		

Based on interview and record review, the facility failed to implement adequate interventions for one resident with cognitive impairment who pulled out their femoral dialysis catheter (a catheter used for exchanging blood to and from a hemodialysis machine), and suffered a massive hemorrhage. This affected one of three sampled residents (Resident #1). The census was 240.

Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/5/17, showed the following:
-Brief interview for Mental Status (BIMS, a brief screener of cognition), score of 12 (moderately impaired cognition);
-Understood/understands;
-Adequate vision, speech and hearing;
-No behaviors, no rejection of care;
-Required extensive assistance of staff for bed mobility, transfer, locomotion, dressing, toilet use and personal hygiene;
-Functional limitation of range of motion (ROM), upper and lower extremities on one side;
-Required wheelchair for mobility;
-Diagnoses included: Heart failure, high blood pressure, dementia, hemiplegia/hemiparesis, seizure disorder and chronic obstructive pulmonary disease (COPD, lung disease);
-Anticoagulant medication, received six days out of seven.

Review of the resident's care plan, dated 7/5/17, showed the following:
-Focus: Need for dialysis due to renal failure, at risk for complications and dehydration;
-Goal: No signs/symptoms of complications from dialysis through the review date;
-Interventions: Check and change dressing as

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F 309	Continued From page 2 needed at access site. Monitor/document, report to physician signs or symptoms of depression. Obtain order for mental health consult if needed. Monitor/document/report to physician, as needed, any signs or symptoms of infection to access site: Redness, swelling, warmth or drainage. Review of the resident's nurse's notes, showed the following: -On 9/7/17 at 4:09 P.M., the resident arrived by stretcher accompanied by two attendants and transferred to bed. Alert to self and place. Denied pain or discomfort. A single lumen peripherally inserted central catheter (PICC line, a form of intravenous access) to right upper arm. Dialysis catheter in right upper frontal thigh area. Scar tissue to right and left buttock and sacral area, no opened areas. Gastrostomy tube (g-tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach), in place to mid abdomen; -On 9/8/17 at 1:00 P.M., this nurse made multiple visits to the resident's room due to him/her playing with the g-tube valve. Resident had been clamping feeding off and turning valve off. Feeding infuser had been alarming off and on multiple times due to this situation. Abdominal binder placed with resident, no longer playing with the valve. Resident escorted to front of lobby to await transportation for dialysis; -On 9/8/17 at 6:40 P.M., spoke with the physician and notified of need for g-tube flush order and if to resume blood sugar and insulin orders with new orders received and noted. Review of the resident's physician's orders, dated 9/8/17 at 6:40 P.M., showed the following: -Give all meds by mouth or by g-tube; -Trazadone (an antidepressant) 50 milligrams at	F 309		

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F 309	Continued From page 3 bedtime (HS) for insomnia, take as needed; -Accu-checks three times a day (TID) at 6:00 a.m., 11:00 a.m., and 4:00 p.m. Further review of the resident's nurse's notes, showed the following: -On 9/9/17 at 1:57 A.M., the resident had remained awake all P.M., pulling at g-tube tubing and PICC line tubing, though promptings were given constantly. Requires constant watching. Has no short term memory. Is not aware of usage of call light. Forgets instruction immediately. Side rails up. Monitored as often as possible; -On 9/9/17 at 2:54 A.M., PICC dressing replaced, resident was in the process of removing old dressing. PICC dressing change required two staff to replace dressing per resident holding PICC tubing and would not remove hands after multiple requests. This shift resident has disconnected g-tube twice, remains awake the entire shift pulled at both g-tube and PICC tubing. Staff unable to get resident to stop these behaviors; -On 9/9/17 at 4:18 A.M., PICC dressing removed a second time this shift, replaced with new dressing. Contacted pharmacy to send in multiple central line dressings per repeated replacement necessary. Continues to pull at g-tube and PICC tubing after multiple requests to stop. Staff have attempted to replace tubing in his/her hands with different items, but resident continues to put those down and continue to pull at the tubing. Resident remains awake for entire shift thus far; -Late entry, (per facility electronic medical record, EMR, created on 9/11/17 at 12:10:44 P.M.) on 9/9/17 at 5:42 A.M., resident still awake, continued behaviors after trazadone administered	F 309		

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F 309	Continued From page 4 at 3:24 A.M. Review of the resident's medication administration record showed, trazadone, 50 mg, initialed as administered, HS documented as when given with no time noted. Further review of the resident's nurse's notes, showed the following: -Late entry, (per facility EMR, created on 9/11/17 at 3:48:08 A.M.), on 9/9/17 at 6:38 A.M., entered resident's room to do finger stick and to administer insulin. Compliant. Does not appear to be uncomfortable. Resident is awake and alert. Voiced no complaints. G-tube intact. Dialysis catheter intact. PICC line remained intact; -On 9/9/17 at 6:50 A.M., resident removed dressing to right groin again this shift and was able to pull out stitches and catheter. This nurse was called to the room to find a significant amount of blood on the floor and bed. Immediately applied pressure to site and yelled for the CNA to call the supervisor, stat and 911. Oxygen applied at 4 liters, increased gradually with increased loss of consciousness. Supervisor assisted with pressure to right groin; -On 9/9/17 at 6:55 A.M., call was placed to 911, informed 911 the resident pulled his/her dialysis port from their right groin. The resident is conscious at this time, able to move eyes when name is called. Resident no longer able to respond; -On 9/9/17 (effective date entered, 9/11/17 at 12:05 P.M.), clarification from notes dated 9/9/17 at 2:54 A.M. and 4:18 A.M., the dressing changes were to the dialysis fistula to the right groin, not to the PICC to the right arm.	F 309		

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F 309	Continued From page 5 During an interview on 9/27/17 at 8:40 A.M., (certified nurse aide) CNA C said he/she arrived for work around 8:30 P.M. on 9/8/17. He/she did not know the resident. The resident pulled at his/her PICC line and when CNA C told the nurse, the nurse replied, that's what he/she does. During the night, the resident pulled his/her g-tube out, enough for it to leak all over. The resident had a binder on, but was able to get up underneath it. Later, when he/she walked into the resident's room, the resident had the dialysis catheter in his/her hand, trying to pull it out. CNA C told Nurse A and Nurse B the resident was pulling at the dialysis catheter. He/she told them all night, about a thousand times, what the resident was doing. Neither nurse told him/her to get the resident up or told him/her to sit in the resident's room and watch him/her. CNA C started rounds in the morning. He/she was busy getting people up and when he/she walked past the resident's room, CNA C looked in and saw all the blood. During an interview on 9/14/17 at 9:00 A.M., Nurse A said when the resident returned from the hospital, he/she was significantly more confused than before his/her hospital stay. The resident was touching everything and Nurse A was told in report he/she would be in the room all night because of the behaviors. Nurse A said during the night, CNA C called him/her to the resident's room because the resident disconnected his/her g-tube. The resident also pulled off his/her dialysis dressing and by the time they changed his/her gown, the resident pulled the dressing to his/her PICC line down to his/her wrist. The resident pulled at his/her dialysis fistula and feeding tube. He/she cleaned the resident up twice because the resident pulled at his/her	F 309		

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feeding tube and was covered in tube feeding. Nurse A called the pharmacy for additional dressings. Around 3:23 A.M., he/she talked to the night supervisor about giving trazadone. Nurse A "borrowed" the trazadone from another resident because the resident's trazadone had not arrived yet. At 5:42 A.M., the resident was still having behaviors. The night supervisor told him/her to call the physician in the morning. Nurse A said CNA C yelled the resident was bleeding and when he/she arrived to the resident's room, the resident had pulled out the dialysis catheter and was holding the catheter in his/her right hand. Nurse A grabbed a blanket off the linen cart and applied pressure to the resident's groin. Nurse A did not think the resident would be able to pull the catheter out. If he/she would have thought about it, Nurse A would have put the resident at the nurse's station. Nurse A really didn't know what to do to get the resident to stop fidgeting.

During an interview on 9/14/17 at 8:32 A.M., Nurse B said he/she worked on 9/9/17 on the 10:00 P.M., to 7:00 A.M. shift. The first time he/she saw the resident, the resident was smiling and appeared to not be in any distress, although the resident was grasping at his/her g-tube. Nurse B thought the resident would understand direction, but after talking to him/her for a little while, he/she did not. Nurse B told the resident not to pull on the g-tube and he/she would pull on the g-tube. The resident was awake most of the night. The resident kept taking his/her dressings off, three or four times through the course of the night.

During an interview on 9/28/17 at 8:02 A.M., the night supervisor said on 9/9/17 around 1:00 A.M.,

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F 309	Continued From page 7 Nurse A called and said the resident removed his/her dressing. The night supervisor was not IV certified and did not touch the dressings. He/she retrieved a couple IV kits with dressings from another wing of the facility for Nurse A. The nurse could have called the physician for an Ativan (a sedative), but the resident did get a trazadone around 3:30 A.M. The night supervisor wished he/she had thought about wrapping the dialysis catheter with an ace wrap. With a person who at risk to fall, he/she would get them up and sit them at the nurse's station. The night nurse had done that many times. It's safest to put the resident at the nurse's station if someone was there to watch them. The nurses just thought the resident was pulling at the dressings. They "goofed up" by not calling the physician. During an interview on 9/27/17 at 3:10 P.M., Emergency Medical Technician (EMT) D said when he/she arrived on the scene, the resident's catheter was completely out of his/her leg. Staff had placed a blanket onto the site and applied pressure. There was a large amount of blood underneath the bed and on the bed. Some of the blood was liquid and some had coagulated. The resident was not conscious. Staff were unable to say when the incident happened or when he/she was last seen. Their stories conflicted. During an interview on 9/28/17 at 2:50 P.M., the Director of Nursing (DON) said the facility utilized one on one nursing care if a resident was a threat to themselves or others and the resident could have placed him/herself at risk by pulling at his/her dressings/catheter. During an interview on 9/28/17 at 3:07 P.M., the administrator said she expected staff to have	F 309		

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called either herself or the DON regarding the resident's behaviors. She did not believe staff exhausted all efforts at possible interventions. When in doubt, staff should let them know in a timely manner. Staff should have called the physician about the change in condition and she expected staff to follow the facility policy.

Review of the facility change in condition policy, dated 1/1/2014 and revised on 3/2017, showed the following:
-The facility will make every effort to inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there is the following;
-An accident involving the resident which results in injury and has the potential for requiring physician intervention;
-A significant change in the physical, mental or psychosocial status, that is a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications;
-A need to alter treatment significantly, that is a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment;
-A decision to transfer or discharge the resident from the facility;
-Procedure:
-If the physician cannot be reached, the medical director will be notified;
-During medical emergencies, notifications will be made as soon as possible.

MO00132748

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F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect one of three sampled residents (Resident #4) by not immediately intervening when staff witnessed another resident (Resident #5) engaged in nonconsensual sexual contact with Resident #4. A second episode of nonconsensual sexual contact was made. The resident was left unattended while staff left the room to report what	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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	265120	A. BUILDING ______ B. WING ______	R-C 11/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST SOPHIA HEALTH & REHABILITATION CENTER	**936 CHARBONIER ROAD FLORISSANT, MO 63031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1	F 323		

he/she saw to a supervisor. Further, the policy did not instruct staff to immediately intervene.
The census was 161.

Review of Resident #4's social services review, dated 10/9/17, showed the following:
-Mental status:
-Not oriented;
-Exhibited problems with memory;
-Severely impaired in the ability to make decisions.

Review of the resident's annual Minimum Data Set, (MDS), a federally mandated assessment instrument completed by staff, dated 10/12/17, showed the following:
-Brief Interview for Mental Status (BIMS), a brief screener that aids in detecting cognitive impairment, score of six (severe cognitive impairment);
-Experienced difficulty in focusing attention or having difficulty keeping track of what was being said;
-Experienced feeling down, depressed or hopeless;
-Physical behavior symptoms directed towards others occurred one to three days;
-Change in behavior symptoms became worse compared to prior assessments;
-Diagnoses of anxiety, unspecified intellectual disability and unspecified mood disorder.

Review of the resident's psychiatric consultation, dated 10/23/17, showed he/she was oriented to him/herself and exhibited fair or poor judgment, depending on the issues.

Review of the resident's physician's order sheet (POS), dated November 2017, showed the

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following:
-Diagnosis of mental retardation.

Review of Resident #5's quarterly MDS, dated 8/30/17, showed the following:
-BIMS of 10 (moderate cognitive impairment);
-Independent with walking in the room;
-Supervision only required when walking in the corridor or on the unit;
-Diagnoses of dementia and traumatic brain injury.

Review of the resident's psychiatric consultation, dated 9/27/17, showed the following:
-Height was six feet and four inches;
-Weight was 303 pounds;
-Ambulated with a cane;
-Alert and oriented to person, place and time;
-Attention and concentration was fair;
-Insight and judgement was fair or poor, depending on the issue;
-Diagnoses of depression and dementia without behavioral disturbance.

Review of the resident's POS, dated November 2018, showed an order, dated 11/1/17, for the resident to be sent to the emergency room for a psychiatric evaluation.

Review of the Resident #4's nurse's notes, showed the following:
-On 11/1/17 at 6:59 P.M., a late entry note, the Director of Nurses (DON) documented she was called to the resident's room by the Certified Medical Technician (CMT). He/she stated Resident #5 was in the resident's room. The nurse, the other charge nurse and the CMT went to the room. The door was shut. The nurse opened the door and witnessed Resident #5

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bending over the resident with his/her breast in his/her mouth;
-On 11/1/17 at 7:22 P.M., a call was placed to the physician and the responsible party. Statements were taken by the supervisor. The physician called back with an order to call the psychiatrist;
-On 11/2/17 at 12:21 P.M., Nurse J documented he/she immediately moved Resident #5 from Resident #4's room. An assessment was done and the resident appeared fine and no skin issues noted.
-On 11/2/17 at 3:32 P.M., the Assistant Director of Nurses (ADON) clarified the note on 11/2/17 at 12:21 P.M. The nurse notes the time Nurse J moved Resident #5 from the resident's room was on 11/21/17 at 6:45 P.M.

Review of Resident #5's nurse's notes, showed the following:
-On 11/2/17 at 2:56 A.M., the nurse received report that the resident was sexually inappropriate with another resident. He took the other resident's breast inside his/her mouth and proceeded to suck on it. Police report made and the resident was sent to the hospital for a psychiatric evaluation at 10:00 P.M.;
-On 11/2/17 at 3:22 A.M., the resident returned from the hospital and moved to a different room. No new orders noted;
-On 11/2/17 at 7:15 A.M., the resident was in the main dining room for breakfast. The day shift nurses were informed the resident is not to go to his/her previous unit, and is on 15 minute checks;
-On 11/2/17 at 10:00 A.M., the late entry note by Nurse J showed he/she was called to Resident #4's room by the CMT. The nurse, another nurse and the CMT went to the room. When the nurse opened the door, Resident #5 was bent over Resident #4 with his/her right breast out of his/her

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F 323	Continued From page 4 gown, and it was in Resident #5's mouth. When they asked Resident #5 what he/she was doing, he/she didn't say anything and walked out of the room and back into his/her room. Nurse J contacted the DON and was told to call the police. The call was made at 7:05 P.M., and the police came and questioned Resident #5; -On 11/2/17 at 10:15 A.M., the resident was transferred to a different unit; -On 11/2/17 at 6:36 P.M., a late entry note for 11/1/17 at 7:00 P.M., the nurse went to speak with Resident #4. The nurse asked Resident #4 what happened and why Resident #5 was in his/her room. Resident #4 giggled and said, "I asked him/her to come in my room and look at a family picture of mine. He/she says he/she's leaving from here tomorrow and I wanted him/her to see it. I like him/her, he/she is nice to me." The nurse asked what happened after Resident #5 showed him/her the picture. Resident #4 giggled and said, "He/she kissed my titty and licked on it." When the nurse asked if this upset him/her, Resident #4 said, "No, he/she is nice to me, he/she is kinda cute. I think he/she likes me. Am I in trouble? Was that wrong? I'm sorry if it is wrong." The nurse explained to Resident #4 he/she was not in trouble and no one should kiss him/her on any part of his/her "bathing suit." Resident #4 said, I guess you better tell Resident #5 not to do that then; -On 11/2/17 at 6:50 P.M., a late entry note for 11/1/17 at 7:10 P.M. showed the nurse asked Resident #5 what happened. He/she said, "I spend a lot of time with him/her. I take him/her from meals and talk to him/her a lot. I like him/her. What's wrong with that?" The nurse replied Resident #4 was mentally challenged and it wasn't fair for Resident #5 to make physical advances towards him/her. The nurse asked	F 323		

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Resident #5 if he/she understood. He/she said, "Yeah, I get it. Hands off."

Review of Resident #5's care plan, last updated on 11/2/17, showed the following:
-Focus: The resident has been noted to exhibit inappropriate behavior toward another resident;
-Goal: The resident will refrain from exhibiting any further inappropriate behavior;
-Interventions: The resident was educated on invading other resident's personal space and inappropriate behavior, he/she was moved to another room and placed on 15 minute checks. Social services would follow up daily for charting for one week, then two weeks for the next two weeks.

During an interview on 11/16/17 at 5:26 P.M., Resident #4 said he/she remembered Resident #5. Resident #5 gave him/her candy and gum. Resident #5 kissed him/her on the mouth and licked his/her "boob." He/she cried and asked if he/she was in trouble. After explaining to the resident he/she was not in trouble, he/she said he/she was scared of Resident #5.

During an interview on 11/15/17 at 1:55 P.M., Certified Nurse Aide (CNA) G said he/she worked at the facility for three years and was familiar with both residents. On 11/1/17 around 6:30 P.M., he/she put Resident #4 in bed and placed the gown on him/her. He/she left the room to tend to other residents, but returned to Resident #4's room to get linen. When he/she returned, Resident #5 was in Resident #4's room "hovering over him/her with his/her hand on Resident #4's chest." He/she did not think it was anything sexual although the room was dark, the television was off and the curtain was closed. He/she left

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F 323	Continued From page 6 both residents in the room and told Nurse H what he/she just witnessed. Nurse H told CNA G to tell Resident #5 to leave the room. He/she returned to the room and told Resident #5 to leave. In the past, he/she witnessed Resident #5 push Resident #4 in his/her wheelchair and rub his/her shoulders and arm. Resident #5 was alert and oriented. Resident #4 had the "mindset of a child and did not know anything about sex." However, if Resident #4 did not want it to happen to him/her, he/she would have screamed. After he/she told Resident #5 to leave, he/she continued with his/her rounds. CNA G told CMT I Resident #5 was caught in Resident #4's room. CNA G left the facility before the second incident took place. During an interview on 11/15/17 at 2:12 P.M., Nurse H said he/she worked at the facility for two and a half years and was familiar with both residents. On 11/1/17 around 6:30 P.M., CNA G approached the nurse's station and told him/her Resident #5 was in Resident #4's room. He/she told CNA G to tell Resident #5 it was too late for visits. CNA G did not tell him/her the lights and television were off and the curtains were closed. Later the same evening, CMT I came to the nurse's station and said, "You need to come see." He/she, Nurse J and CMT I got up and went to the resident's room. He/she did not witness the incident, because he/she did not run. Nurse J was the one who caught Resident #5 in the act. Resident #4 had the mindset of a child and was unable to consent. He/she saw Resident #5 touch Resident #4 in the past but did not think it was inappropriate. During an interview on 11/15/17 at 2:36 P.M., Nurse J said he/she worked at the facility for 16	F 323		

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and a half months and was familiar with both residents. On 11/1/17, he/she was at the nurse's station when CMT I approached and told him/her to come look at the residents. He/she opened the door and saw Resident #5 with his/her hand on his/her cane, another on the bed and Resident #4's breast in his/her mouth. He/she told Resident #5 to stop and leave the room. He/she notified the supervisors, families and physicians. Resident #4 had the mindset of a child and could not consent. CMT I must have been suspicious and followed Resident #5 to Resident #4's room. CMT I was aware Resident #5 was told to leave Resident #4's room earlier. Resident #5 must have snuck back in Resident #4's room. CMT I saw this and notified the nurses. Nurse J called the police. Looking back, Nurse J noticed Resident #5 targeted certain residents. It was usually residents who could not speak for themselves. He/she said if abuse or neglect was witnessed, the policy was to report it immediately.

During an interview on 11/15/17 at 4:25 P.M., CMT I said he/she worked at the facility for six years. He/she was in the unit passing medication on 11/1/17 at 6:40 P.M. He/she saw Resident #5 in his/her doorway "behaving suspiciously." He/she kept looking toward Resident #4's room. He/she did not question Resident #5 because he/she never witnessed this behavior from him/her. He/she completed the round of medication and went to the medication room for more supplies. When he/she returned, Resident #5 was gone. He/she noticed all the doors on the unit open, except for Resident #4's. He/she entered Resident #4's room and saw Resident #5 standing over Resident #4's bed and his/her head was over Resident #4's chest area. He/she did not stop the resident immediately because he/she

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F 323	Continued From page 8 wanted witnesses. He/she told the nurses and they entered the room and caught Resident #5 in the act. He/she was unaware CNA G told the resident to leave the room earlier that evening. He/she said if abuse or neglect was witnessed, the policy was to report it immediately. During an interview on 11/16/17 at 10:04 A.M., social services assistant (SSA) K said Resident #5 was alert and oriented and exhibited no behaviors. He/she was a "gentle giant." Resident #4 was alert to self and does not have the capacity to consent. After the situation took place, staff separated the two residents and placed them on one on one monitoring. He/she said if abuse or neglect was witnessed, the policy was to report it immediately. During an interview on 11/16/17 at 10:30 A.M., SSA L said Resident #5 was alert and oriented but suffered a brain injury. Resident #4 was alert but has the mindset of a five year old and was unable to consent. He/she did not have the ability to say what was wrong or right. If staff witnessed abuse or neglect taking place, the policy was to immediately separate the resident and ensure their safety, then inform the supervisor. When asked to clarify, he/she said, "You separate them. You do not allow the abuse to continue." During an interview on 11/15/17 at 3:07 P.M., the educational director said she was the supervisor on duty on 11/1/17. She was responsible for educating staff on abuse and neglect. She told staff to write statements. Resident #4 has the mindset of a child and cannot consent. Staff should have separated the residents immediately upon witnessing the act, then informed the nurse.	F 323		

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During interviews on 11/16/17 at 3:10 P.M. and 5:30 P.M., the administrator and DON said staff should have separated the residents first, then reported the incident. The expectation was to get the resident safe, then report the situation. Staff could have yelled out "help," if he/she was afraid to approach the resident.

Review of the facility's policy and procedure on abuse and neglect, revised in February 2017, showed the following:
-Purpose: To establish guidelines that prevents, identifies and reports resident abuse and neglect;
-Policy: All residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical system;
-Definitions:
-Abuse means the willful infliction, unreasonable confinement, intimidation, or punishment with resulting in 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.
-Sexual abuse is non-consensual sexual contact of any type with a resident.
-Resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched, kicked and result in physical harm, pain or mental anguish is considered resident-to-resident abuse. Resident-to-resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility will presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and/or

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F 323	Continued From page 10 physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary; -Initial/Immediate Protection during facility investigation: Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. Further review of the facility's policy and procedure, showed the facility did not address immediate staff intervention in the event abuse was observed or witnessed by staff. MO00135054 MO00135050 MO00135116	F 323		

TO:

Name: Jean Harper

Fax number: 314 340 3414

DATE: 10/31/17

PAGE 1 of 4

FROM:

Name: Lisa Anderson

Fax number: 314 831 1310

SUBJECT:

MESSAGE:- Revised POC

CONFIDENTIALITY NOTICE:

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PLAN OF CORRECTION

Provider/Supplier Name:	ST. SOPHIA HEALTH AND REHABILITATION CENTER
Street Address, City, Zip:	936 CHARBONIER ROAD, FLORISSANT, MO 63031
Date of Survey:	9-28-2017

CLIA IDENTIFICATION NUMBER-26 D0665501
PROVIDER NUMBER-1801261375

THIS PLAN OF CORRECTION IS SUBMITTED AS REQUIRED UNDER STATE AND FEDERAL LAW. THE SUBMISSION OF THS PLAN OF CORRECTION DOES NOT CONSTITUTE AS ADMISSION ON THE PART OF ST. SOPHIA HEALTH AND REHABILITATION CENTER AS TO THE ACCURACY OF THE SURVEYOR'S FINDINGS NOR THE CONCLUSION DRAWN THERE FROM. THE FACILITY'S SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUE AN ADMISSION ON THE PART OF THE FACILITY THAT THE FINDINGS ARE ACCURATE, THAT THE FINDINGS CONSTITUE A DEFICIENCY, OR THAT THE SCOPE AND SEVERITY REGARDING ANY OF THE DEFICIENCIES CITED ARE CORRECTLY APPLIED. THIS WILL ALSO SEVE AS OUR CREDIBLE LETTER OF ALLEGATION.

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING The facility will identify other situations having the potential to be affected by the same deficient practice as follows: All residents will be considered to be at risk for the alleged deficient practice. The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur as follows: 1) When a resident exhibits signs of agitation including pulling at any medically necessary apparatus to include, but no limited to G-tube, PICC Lines, dialysis catheters, Foley catheters, and nephrostomy. The resident will be assessed for pain, or any other un-met need, the resident will be treated appropriately and both physician and responsible party will be notified. 2) This will be monitored by the Licensed Nursing staff upon notification or visualization of change of condition. 3) Any deficient or inconsistent practice will be educated on immediately.	10-19-2017

	4) This will be reviewed at the next (2) QAPI meetings. QAPI meetings are held monthly 5) Upon return from dialysis, resident's dialysis site will be assessed to ensure the site is intact. 6) This will be monitored and documented by the licensed nursing staff up return of all resident's receiving dialysis. 7) Any deficient or inconsistent practice will be educated on immediately. 8) This will be reviewed at the next (2) QAPI meetings. QAPI meetings are held monthly. 9) Upon observation or notification of any resident requiring on-going monitoring, the nursing staff will initiate immediate 1:1 interventions. 10) In the event all efforts to provide 1:1 interventions have been exhausted, the Licensed Nursing Staff will discharge resident to his/her preferred hospital for evaluation and treatment. 11) This will be monitored by the Licensed Nursing staff upon notification and/or visualization. 12) Any deficient or inconsistent practice will be educated on immediately. 13) This will be reviewed at the next (2) QAPI meetings. QAPI meetings are held monthly. 14) Medications will be administered as ordered and in a timely manner. 15) Medication will be documented as given at time of administration. 16) This will be monitored by DON and/or designees. 17) All licensed nursing staff will be educated on appropriate administration of medication. 18) Any deficient or inconsistent practice will be educated on immediately. 19) This will be reviewed at the next (2) QAPI meetings. QAPI meetings are held monthly. 20) Upon the notification of a resident behavior that could be a potential for self-harm, the Licensed Nursing staff will assess resident causative factors for behavior and will initiate appropriate intervention up to and including immediate discharge to the residents preferred hospital. 21) This will be monitored by the DON and/ or designees. 22) Any deficient or inconsistent practice will be educated on immediately. 23) This will be reviewed at the next (2) QAPI	

	meetings. QAPI meetings are held monthly. 24) The staff will continue to alert the Administrator and/or DON when a change of condition occurs and/or in the case of any adverse event relating to but not limited to abuse, neglect, injury of unknown origin, mistreatment and/or misappropriation of property. 25) All staff has been educated on reporting timely in the case of an adverse event. 26) This will be monitored by Administrator, DON and/or designees. 27) Any deficient or inconsistent practice will be educated on immediately. 28) This will be reviewed at the next (2) QAPI meetings. QAPI meetings are held monthly.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07631	A. BUILDING: ______ B. WING ______	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST SOPHIA HEALTH & REHABILITATION CENT	**936 CHARBONIER ROAD FLORISSANT, MO 63031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4074	19 CSR 30-85.042(67) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F309.	A4074		10/19/17

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		10/18/17

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07631	A. BUILDING: ______ B. WING ______	R-C **11/20/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST SOPHIA HEALTH & REHABILITATION CENT	**936 CHARBONIER ROAD FLORISSANT, MO 63031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4073	19 CSR 30-85.042(66) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four (24)-hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F323.	A4073		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE