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	11/06/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to provide care in a manner to prevent the risk of accidents and injury for one resident who was transferred without using a mechanical lift as ordered and according to the resident's plan of care (Resident #1). The census was 170. Review of the facility's Total Lift Transfer policy, dated 11/28/22, showed the facility will utilize a total lift device on residents who are unable to assist with transfers:-Full Body Lift: A lifting device used to provide safety of the resident/employees during transfers.-Procedure: Measure resident for appropriate sling size according to manufacturer. Position the sling under the resident with the base of the sling at the base of the resident's spine, top of the sling at the top of the head, cross straps prior to hooking the straps of the lift. Match the corresponding colors on each slide of the sling & observe that all sling loops are securely connected. Standing next to the Resident, press the up button on the lift controls to slowly raise the Lift to the height necessary to clear the surface. Standing next to resident use the down button on the lift control to slowly lower the resident to the desired surface, guide/steady as necessary. Detach the Sling from the lift ensuring the bar of the Lift does not touch Resident. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/19/25, showed moderately impaired cognition and dependent on all transfers - helper does all of the effort, resident does none to complete the activity. Review of the resident's electronic health record, showed:-An order dated 9/9/25, to use Hoyer Sling (a mechanical total lift device), appropriate with resident's weight size; use Hoyer lift for all transfers;-Diagnoses included hemiplegia and hemiparesis (weakness or paralysis on one side of the body), history of falling, unsteadiness of feet, dementia, and legal blindness. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: Limited physical mobility;-Goal: Will remain free of complications related to immobility, including fall-related injury;-Interventions: Use Hoyer sling appropriate with resident's weight size, use Hoyer lift for all transfers. Does not walk. Observation on 11/5/25 at 11:43 A. M., showed Certified Nurse Assistants (CNAs) B and C transferred the resident, using a gait belt, from wheelchair to bed. CNA B leaned the resident forward while he/she sat on the wheelchair and placed the gait belt around the resident's waist. The wheelchair was positioned parallel to the bed, approximately one foot away from the edge of the bed. CNA B stood at the resident's left side while CNA C stood on the right side. The wheelchair was not locked. Both CNAs lifted the resident by holding onto the gait belt with one hand with their other hands pushing on the wheelchair's arm rest. CNA B instructed the resident to stand up. Both of the resident's knees were bent, did not straighten, and appeared contracted and he/she did not stand up. The resident's feet did not touch the floor while staff carried the resident by the gait belt from the wheelchair to the bed. The resident showed discomfort, moaning and yelling during the transfer. During an interview on 11/6/25 at 11:01 A.M., CNA J said at the start of the shift they receive a full report from the previous shift's staff of all the residents assigned to them, including transfer method. If he/she was not sure of the resident's care and transfer status, he/she would ask the nurse prior to transferring or providing care. Any orders should be followed, including transfer orders. During an interview on 11/6/25 at 11:15 A.M., Licensed Practical Nurse (LPN) A said CNAs received reports and complete a walk-through with the previous shift staff prior to starting their shift. Staff were expected to follow the transfer orders for the resident. Resident #1 was to be transferred using a Hoyer lift at all times. During an interview on 11/6/25 at 12:01 P.M., the interim Director of Nursing (DON) said CNAs received report from previous shift and from their nurse. They were expected to follow the resident's care plan and their Kardex (quick reference tool for a resident's care plan). The CNAs should not transfer the resident without using the Hoyer lift, as ordered, for resident's safety. During an interview on 11/6/25 at 2:46 P.M., the Administrator and the Regional Director of Operation said they expected the staff to follow the appropriate transfers for all residents as ordered and according to their care plan. 2657487

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on interview and record review, the facility failed to ensure nursing staff working in the facility were licensed to practice in the state of Missouri, when a Licensed Practical Nurse (LPN) on duty, who obtained their nursing license in a different state was working as a LPN in the facility with no Missouri nurses license. This had the potential to affect all residents. The census was 170.Review of the facility's current Human Resources (HR) General Position Information, showed graduated practical nurses (GPN, an individual who had graduated from nursing school to work as an LPN but had not yet passed the nursing boards) may only work for maximum of 90 days following graduation date. Review of Nursys Quick Confirm License Verification Report (the national database for nurse licensure verification, discipline, and practice privileges, created and operated by the National Council of State Boards of Nursing), showed LPN D not listed as licensed in the state of Missouri. He/She was only licensed and authorized to practice in Illinois state, with license original issue date of 10/29/25. Review of LPN D's employee file, showed:-A Certificate of Completion in the Practical Nursing Program, program completed on 6/16/25;-LPN D started employment on 6/25/25 as a full-time LPN-GPN (Graduate Practical Nurse). Review of the facility's staffing schedule dated 10/1/25 through 11/6/25, showed the following dates LPN D was scheduled to work as a GPN or LPN: 10/5 through 10/7, 10/10, 10/14, 10/22, 10/24 through 10/26, 10/29 through 10/31, 11/3 and 11/4/25. During an interview on 11/5/25 at 3:24 P.M., LPN D said he/she was employed by the facility since June 2025 as a GPN. He/She passed the licensure examination a couple weeks ago and started working as an LPN at the facility right after that. He/She was providing care and administering medications to residents with tracheostomies (a hole surgically recreated in the airway for individuals who cannot breath through the mouth and nose), tube feedings, and administering insulin medications. He/She also provided wound care treatment to his/her assigned residents. He/She was rarely monitored or paired with an experienced nurse. During an interview on 11/6/25 at 12:01 P.M., the interim Director of Nursing (DON) said GPNs were expected to work with another nurse at all times. There should be oversight from a licensed nurse every day they work. HR was responsible for checking and reviewing the employees' credentials. The DON expected HR to follow-up the GPN's status. LPN D resigned on 11/5/25, due to the phone call and questions from the state surveyor. During an interview on 11/6/25 at 2:46 P.M., the Administrator and the Regional Director of Operation (RDO) said they were not aware that LPN D was not licensed in Missouri. The Administrator and the DON both started their employment on 11/3/25 and were not made aware of the situation. They expected the HR staff to make sure all employee credentials were checked and verified. The RDO said HR should track the 90-day mark of the GPNs. GPNs should be precepted or working with another nurse until officially licensed. During an interview on 11/7/25 at 9:55 A.M., Regional HR said he/she was not aware of LPN D's status. The facility had 2 HR personnel prior to him/her taking over the position temporarily. He/She expected the facility HR to verify the applicants background and if they were authorized to work in the state. He/She expected the facility HR to collect the school's transcript records, copy of the NCLEX (National Council Licensure Examination) registration and authorization to test with the date of testing. A GPN can work until licensed or for 90 days after graduation, whichever comes first. 2657062