STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17458C	A. BUILDING: _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH LIVING CENTER	#2 NAZARETH LANE SAINT LOUIS, MO 63129

(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
A4798	19 CSR 30-86.047(47)(A) Physicians Orders Followed Medication Orders. (A) No medication, treatment or diet shall be administered without an order from an individual lawfully authorized to prescribe such and the order shall be followed. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to follow physician's orders when staff did not administer medication for two of six sampled residents (Residents #1 and #2). The census was 99. 1. Review of Resident #1's medical record, showed the facility admitted the resident on 10/13/24, with diagnoses which included major depressive disorder, Parkinson's disease, high blood pressure, vitamin D deficiency, vitamin B12 deficiency, and generalized anxiety. Review of the resident's physician's order sheet dated 6/1/25, showed the following orders: -Atorvastatin (used to lower cholesterol and triglycerides) 10 milligrams (mg) to be given between 6:00 P.M. and 8:00 P.M. daily; -Sinemet (used to treat Parkinson's disease) 25-100 mg to be given four times at 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. daily; -Valium (used to treat anxiety) 2 mg to be given at bedtime between 8:00 P.M. and 10:00 P.M. daily; -Melatonin to be given at bedtime between 8:00 P.M. and 10:30 P.M. daily. Review of the resident's Medication Administration Record (MAR) dated 5/1/25 through 5/27/25, showed on 5/26/25, the following	A4798		

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A4798	Continued From page 1	A4798		

medications were not given to the resident:
-Atorvastatin 10 mg between 6:00 P.M. and 8:00 P.M.- Reason, not administered (previous shift);
-Sinemet 25-100 mg at 9:00 P.M. - Reason, not administered (previous shift);
-Valium 2 mg between 8:00 P.M. and 10:30 P.M. - Reason, not administered (previous shift);
-Melatonin between 8:00 P.M. and 10:30 P.M. - Reason, not administered (previous shift).

2. Review of Resident #2's medical record, showed the facility admitted the resident on 12/19/22, with diagnoses which included congestive heart failure, high blood pressure, prostatic hyperplasia (enlarged prostate) and atrial fibrillation (abnormal heart beat).

Review of the resident's physician's order sheet dated 6/1/25, showed the following orders:
-Eliquis (used to block clotting in the blood) 5 mg to be given at 9:00 A.M. and 5:00 P.M. daily;
-Bumetanide (used to treat high blood pressure) to be given at 9:00 A.M. and 5:00 P.M. daily;
-Atorvastatin 10 mg to be given between 8:00 P.M. and 10:30 P.M. daily;
-Gabapentin (used to treat partial seizures) 100 mg to be given at 9:00 A.M. and 10:30 P.M. daily;
-Tylenol 325 mg to be given between 8:00 P.M. and 10:30 P.M. daily;
-Tamsulosin (used to treat enlarged prostate) .4 mg to be given at 9:00 A.M. and 5:00 P.M. daily;
-Metoprolol tartrate (used to treat high blood pressure) to be given at 9:00 A.M. and 5:00 P.M. daily.

Review of the resident's MAR dated 5/1/25 through 5/27/25, showed on 5/26/25, the following medications were not given to the resident:
-Eliquis 5 mg between 8:00 P.M. and 10:30 P.M. - Reason, not administered (previous shift);

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A4798	Continued From page 2 -Bumetanide at 5:00 P.M.- Reason, not administered (previous shift); -atorvastatin 10 mg between 8:00 P.M. and 10:30 P.M. - Reason, not administered (previous shift); -Gabapentin 100 mg 5:00 P.M.- Reason, not administered (previous shift); -Tylenol 325 mg between 8:00 P.M. and 10:30 P.M. - Reason, not administered (previous shift); -Tamsulosin .4 mg at 5:00 P.M. - Reason, not administered (previous shift); -Metoprolol tartrate 50 mg 5:00 P.M. - Reason, not administered (previous shift). 3. During an interview on 6/2/25 at 10:26 A.M., Licensed Practical Nurse (LPN) B said he/she informed the Administrator prior to 5/26/25, the shift was not covered, there was no staff person scheduled to pass medications on the evening shift on 5/26/25. LPN B said the Administrator said she would ensure the shift was filled. LPN B said when he/she returned to the facility after being off, he/she learned the shift was not filled and the residents did not get medication passed to them on the evening shift. LPN B said the Administrator had left the facility without confirming with staff that they were aware they were scheduled to work on 5/26/25. 4. During an interview on 6/2/25 at 10:34 P.M., the Director of Human Recourses (DHR) said the scheduling for the staff is handled by the Administrator and the Director of Nursing (DON). Since the facility was currently without a DON, the Administrator has full control of the schedule and the responsibility of ensuring all staff positions are filled for each shift. The DHR said the Administrator has full authority to call in agency if a shift cannot be filled by staff. 5. During an interview on 6/13/25 at 3:27 P.M.,	A4798		

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A4798	Continued From page 3 Certified Medication Technician (CMT) D said he/she was scheduled to work on 5/26/25, on the evening shift, but received a text message from the Administrator saying there was not a medication technician working the evening shift for the other building. The Administrator told CMT D another CMT agreed to cover his/her post but CMT would need to go to the other building to pass medication. CMT D said he/she did not want to go to the other building as asked and why the other CMT did not just go to the other building and CMT D could just work his/her normal shift. CMT D said the Administrator did not say anything further and never told CMT D that no one was working to cover the shift. CMT D said he/she would have gone over to pass medication at the other building if he/she had known no one was working the post who could pass medication to the residents. 6. During an interview on 6/13/25 at 2:45 P.M., the Administrator said she was informed early in the morning on 5/26/25, that no one was scheduled to cover the medication pass in one of the buildings for the evening shift. The Administrator said she spoke with the day shift medication technician who agreed to stay over and work a double at his/her current building so CMT D could go to the building that did not have coverage. The Administrator said she messaged CMT D and asked him/her to go to the other building but CMT D refused. The Administrator said after CMT D refused to go to the other building the Administrator told the other medication technician to go home and not work a double shift. The Administrator said she did not call any other staff to cover the shift and did not call an agency to provide a temporary worker. The Administrator said the facility did not use agency staff. The Administrator said the post not	A4798		

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A4798	Continued From page 4 being covered and the residents not receiving the medication was ultimately her fault because she had the responsibility of ensuring all the posts were covered. The Administrator said she should have told the other medication technician to work at the other building instead of sending him/her home. *The higher classification merited due to the extent of the violation. MO00254963 MO00254825	A4798		

PLAN OF CORRECTION

Provider/Supplier Name:	Nazareth Living Center
Street Address, City, Zip:	#2 NAZARETH LANE, ST. LOUIS, MO 63129
Date of Survey:	6/13/25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	17458C

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of corrections is submitted as required under state law. The admission of the plan of correction does not constitute an admission on the part of Nazareth Living Center as to the accuracy of the findings or the conclusion drawn there from. This submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. The plan of correction is intended to constitute the facilities credible letter alleging compliance. Compliance will be achieved no later than the date of completion noted on this document.	
A4798	**What corrective actions (s) will be accomplished for those residents/staff found to have been affected by the deficient practice** Resident #1 – Physician and Family notified of missed medication. Internal process followed and no harm to resident. Resident #2 – Physician and Family notified of missed medication. Internal process followed and no harm to resident.	6/3/25
	How will you identify other residents having the potential to be affected by the deficient practice. All residents residing in the facility have the potential to be affected by the alleged deficient practice.	7/25/25
	What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur. ED or designee will educate Housing Director, DON and Staffing Coordinator on staffing expectations including staffing guidelines in accordance with Missouri Residential Care Facilities and Assisted Living Facilities regulation and ensuring that a CMT	7/25/25

	must be scheduled every shift to ensure medication administration services are provided. DON, Housing Director, and/or staffing coordinator will meet every other week on (day) to discuss staffing needs. Community will develop a weekend on-call rotation to cover the shift in the event of a CMT call-in to ensure that medication administration services are provided. Re-educate staff on medication administration documentation DON or designee will audit 10% of the medication administration record weekly for 8 weeks to ensure medications are being administered and documented per physician's orders.	
	How will the facility plan to monitor its performance to make sure that corrective actions/solutions are evaluated for effectiveness, achieved and sustained. The results of the audits will be reviewed by the Quality Council monthly for 2 months.	7/25/25

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.