STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265225	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St James Living Center	415 Sidney Street, Saint James, MO 65559

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, facility staff failed to prevent the misappropriation of medications for two residents (Residents #1 and #2) out of four sampled residents, without the consent of the resident or the resident's representative. The facility census was 50. The administrator was notified on 05/09/25 of past Non-Compliance which occurred on 04/25/25. Staff immediately suspended CMT A, conducted an investigation, and notified the required parties and agencies. The administrator immediately in-serviced staff on the facility's policy regarding counting narcotics and abuse, neglect and misappropriation. Staff terminated CMT A on 04/28/25. The deficiency was corrected on 04/25/25. 1. Review of the facility's Abuse Prohibition Protocol Manual, undated, showed staff are directed as follows: - The purpose of training is to prohibit and prevent all forms of abuse, neglect, exploitation, and misappropriation of resident property; - Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 2. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/14/25, showed staff assessed the resident as moderately impaired for cognitive skills of daily decision making. Review showed staff documented the resident without anxiety, and not currently taking antianxiety medication. Review of the resident's physician order sheet (POS), dated 04/01/25 to 04/30/25, showed an order for Lorazepam 0.5 milligrams (mg) one-half (1/2) tablet daily for anxiety. Review showed the physician discontinued the order on 04/09/25. Review of the resident's medication administration record, dated 04/01/25 through 04/28/25, showed CMT A signed he/she administered Lorazepam .5 mg to the resident on 04/08/25 and 04/09/25 between 6:00 P.M. and 10:00 P.M. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Controlled Drug Receipt/Record/Disposition Form, dated 04/03/25, showed the pharmacy delivered 30 tablets of Lorazepam 0.5 mg on the evening shift. Review showed CMT A signed he/she administered Lorazepam 0.5 mg to the resident, one tablet on 04/09/25, 04/10/25, 04/11/25, 04/14/25, 04/15/25, 04/16/25, 04/17/25, 04/18/25, 04/21/25, 04/22/25, and 04/23/25, and 1/2 tablet on 04/24/25 and 04/25/25. 3. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/25/25, showed staff assessed the resident as cognitively intact, and currently taking antianxiety medication. Review of the resident's face sheet, undated, showed the resident with a diagnosis of a history of restlessness and agitation. Review of the resident's physician order sheet (POS), dated 04/01/25 to 04/30/25, showed an order for Lorazepam 1 mg one tablet three times daily. Review of the resident's medication administration record, dated 04/01/25 through 04/30/25, showed CMT A signed he/she administered Lorazepam 1 mg to the resident on 04/01/25, 04/02/25, 04/03/25, 04/04/25, 04/08/25, 04/09/25, 04/10/25, 04/14/25, 04/15/25, 04/17/25, 04/18/25, 04/21/25, 04/22/25, 04/23/25, and 04/24/25. Review of the resident's Controlled Drug Receipt/Record/Disposition Form, dated 04/14/25, showed the pharmacy delivered 30 tablets of Lorazepam 1 mg on the 04/14/25. Review showed CMT A signed he/she administered Lorazepam 1 mg to the resident on 04/25/25 at 6:00 P.M. Review of the facility's investigation, dated 04/25/25, showed staff documented the Business Office Manager (BOM) contacted the administrator in regards to a phone-in report from Certified Nurse Aide (CNA) C in which CNA C reported he/she had evidence CMT A had been stealing medications. Review showed the DON conducted a narcotics count on 04/25/25 at 5:15 P.M., which showed CMT A pre-popped all medications to pass that shift. Staff documented CMT A signed out Resident #2's Lorazepam 1 mg, but the medication was not present in the medication cup labeled with the resident's name. CMT A signed he/she administered the medication at 6:00 P.M. on 04/25/05. Review showed the physician discontinued Resident #1's Lorazepam on 04/09/25. Review showed CMT A signed out Lorazepam .25 mg for a total of 11 doses from 04/09/25 to 04/25.25. Review showed staff terminated CMT A on 04/28/25 for for patient abuse or neglect, theft or attempted theft of facility property, resident property, another employees' property, or visitor's property, and falsification of records. During an interview on 05/09/25 at 11:00 A.M., the BOM said CNA C called the facility and reported he/she had information regarding CMT A stealing resident's medications. During an interview on 05/09/25, at 12:35 P.M., the DON said when the administrator notified him/her of the allegation regarding CMT A stealing medications, he/she immediately conducted a narcotics count of the medication cart CMT A controlled that afternoon. He/She said CMT signed out Resident #2's Lorazepam, but the Lorazepam was not in the medication cup with the resident's name. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 05/09/25 at 1:45 P.M., the administrator said the BOM contacted him/her to notify him/her CNA C called the BOM, and alleged CMT A was stealing medications. He/She said he/she reviewed the information, suspended CMT A, notified the police and the state agency, and the DON conducted a narcotics count on the medication cart under CMT A's control. He/She said review showed he/she misappropriated a minimum of one Lorazepam 1 mg, and a minimum of 11 Lorazepam 0.5 mg. The administrator said he/she terminated CMT A on 04/28/25 for multiple offenses, including misappropriation and falsification of records. MO00253320