| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265225 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St James Living Center | 415 Sidney Street,<br>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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265225 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St James Living Center | 415 Sidney Street,<br>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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure one resident (Resident #1) remained free from accidents when facility staff failed to remove his/her oxygen and supervise him/her while smoking to ensure his/her safety. On 7/6/25, the resident failed to remove his/her oxygen while smoking in the courtyard and caught fire to his/her nasal cannula which resulted in severe burns to his/her nares and the right side of his/her head. The facility census was 45.The administrator was notified on 7/8/25 of the Past Non-Compliance Immediate Jeopardy (IJ) which occurred on 7/6/25. Upon discovery, the administrator conducted an investigation, notified appropriate parties, and educated Housekeeper A. Facility staff reviewed the smoking policy, audited the care plans and smoke assessments for all residents who smoke, placed signs on the courtyard door to remind staff and residents to take off oxygen, placed a oxygen rack outside the door to enter the facility, placed a fire blanket in the courtyard, and in-serviced all employees on smoking safety. The IJ was corrected on 7/8/25.1. Review of the facility's Smoking Policy for Residents, dated 02/26/24, showed staff were directed as follows:-Smoking privileges for residents must be evaluated by the Social Service Director (SSD);-Residents are not permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession. -Every resident must pass the smoking evaluation to be an independent smoker, this assessment will be completed annually.Review of the facility's investigation, dated 07/07/25, showed staff documented on 07/06/25 Resident #1 smoked with oxygen on and received a burn to the right side of his/her face and nares.Review of Resident #1's Entry Minimum Data Set (MDS), a federally mandated assessment tool, showed the resident admitted on [DATE].Review of the resident's physician order sheet (POS), dated 07/03/25 to 7/8/25, showed an order for two liters of oxygen per minute per nasal canula as needed to keep oxygen saturation (measurement of how much oxygen your blood is carrying as a percentage of the maximum it could carry) at or above 92%.Review of the resident's nurse's notes, dated 7/6/25, showed Licensed practical Nurse (LPN) B was notified by a housekeeper, at approximately 3:30 P.M. the resident caught himself/herself on fire. LPN B ran to smoking area and found the resident in his/her wheelchair with his/her nasal canula hanging on the ground with the nose piece burnt/melted. The cigarette on the ground by the nasal canula started to burn again. The nurse stomped on the sparks, turned off the oxygen and removed the tubing from the tank. The nurse brought the resident inside the building and assessed him/her. The nurse documented the resident's mouth was darkened with soot in the back of his/her throat, burned hair on the back of the resident's shirt, and a half dollar sized burn to the side of his/her head. The nurse called the administrator, nurse on call and physician. Staff sent the resident to the emergency department. Review of the resident's progress notes, date 7/6/25, showed the resident returned from the hospital with burns to his/her nasal cavity and the right side of his/her head. New orders to apply bacitracin to his/her nasal cavities and right head. Nose is red, and uncomfortable. Denies pain to his/her right head. Review of the resident's baseline care plan, dated 7/8/25, showed staff did not assess the resident's cognition, oxygen use, or smoking ability.Review showed the resident's medical record did not contain documentation staff completed the resident's smoking assessment or interventions to ensure the resident's safety while smoking. During an interview on 7/8/25 at 1:10 P.M., the SSD said he/she was responsible for ensuring smoking assessments and smoking policies were done when a resident is admitted . He/She is supposed to have the smoking assessments and signed policy done within five days of admission, but tries to have them done as soon as possible. He/She did not have the resident's smoking assessment or policy done when he/she admitted , because the SSD also had three discharges done the same day and it got overlooked. He/She was told that on 7/7/25 the resident was outside smoking with oxygen on when the housekeeper came out to do the other residents supervised smoke break. He/She said the resident caught on fire and the housekeeper got the nurse as soon as it happened. Observation on 7/8/25 at 1:23 P.M., showed the resident with a burn to the right side of his/her head, burns to his/her nasal passages, and singed eyebrows.During an interview on 7/8/25 at 2:26 P.M., Housekeeper A said Resident #1 was already outside on Sunday (7/6) around 3:30 P.M., when he/she came out with the residents who required supervision when smoking. He/She turned toward the resident and saw flames coming from the resident's nasal cannula. The resident had ripped out the nasal cannula as he/she ran to help him/her. Sparks were coming from the cannula on the ground, so he/she stomped on it to put it out and then ran for a nurse to help. He/She had been educated on how to assist the residents during smoke breaks, but had never been |