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	08/14/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, facility staff failed to notify one resident (Resident #1's) physician, when staff assessed the resident with a significant change in condition and administered Narcan for suspected overdose. The facility census was 45. 1.Review of the facility's Charting and Documentation policy, undated, showed staff are to document any time the physician is called about the resident as well as their response. 2. Review of Resident #1's Baseline care plan, dated 8/4/25, showed staff assessed the resident alert and cognitively intact, experienced seizures. Review showed staff are to monitor medications, provide safe environment, monitor condition and report changes to Director of Nursing (DON) and Physician. Review of the resident's nurse's notes, dated 08/11/2025, showed staff documented the resident was lethargic, with pinpointed pupils, and unresponsive to name. Narcan nasal spray administered, resident unresponsive. Called 911. Resident began breathing more deeply after administration. Resident transferred to local hospital for evaluation. The record did contain notification of the physician. Review of the resident's rapid drug screen, dated 8/11/25, showed the resident positive for Opiates and Benzodiazepines. 3. During an interview on 8/13/25 at 9:11 A.M., the administrator said the physician was not notified and orders have not been changed since this incident. He/She said he/she would expect the physician to be notified and is unsure why it was not done. He/She said the charge nurse, Registered Nurse (RN) A was in charge to notify the physician.During an interview on 8/13/25 at 9:30 A.M., the DON said the physician should have been notified and he/she does not know why the physician was not notified. He/She said the charge nurse is responsible for all notifications. During an interview on 12:48 P.M., the physician said he/she was not notified and there is no documentation in the chart that his/her office was notified via telephone or fax. He/She said he/she expects to be notified of changes in a resident condition. He/She said he/she was not aware of the resident's overdose and therefore has not adjusted his/her medications which needs to be done. During an interview on 8/25/25 at 8:48 A.M., Registered Nurse (RN) A said he/she entered the resident's room to pass medications, resident was hard to arouse, resident was in and out of it. He/She administered the resident nasal Narcan per his/her orders. After administering Narcan, the resident was sent to the emergency room. He/She said he/she faxed the nonemergent fax line around 10:00 P.M., but did not call the physician because the family wanted the resident sent to the hospital for evaluation. He/She did not get a faxed confirmation because he/she was busy that evening. Complaint #2587617

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 B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, facility staff failed to complete an investigation when one resident (Resident #1) overdosed on a Benzodiazepine (a class of central nervous system (CNS) depressants that produce sedation, reduce anxiety, and relax muscles) and administered Narcan (a medication that can rapidly reverse the effects of an opioid overdose. The facility census was 45.1. Review of the facility's Investigation policy, undated, showed facility staff are directed to promptly and thoroughly investigate and try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. When an incident or suspected incident is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: -Who was involved;-Resident statements;-Resident roommate statements;-Interviews obtained from three to four residents who received care from alleged staff (if applicable);-Interviews obtained from three to four different department staff (if applicable);-Involved staff and witness statements of events;-Description of the resident's behavior and environment at the time of the incident;-Injuries present including a resident assessment;- Observation of resident and staff behaviors during the investigation;-Environmental considerations. 2. Review of Resident #1's Baseline care plan, dated 8/4/25, showed staff assessed the resident alert and cognitively intact, experienced seizures. Review showed staff are to monitor medications, provide safe environment, monitor condition and report changes to Director of Nursing (DON) and Physician.Review of the resident's medical records showed the medical record did not contain an investigation. Review of the resident's nurse's notes, dated 08/11/2025, showed staff documented the resident lethargic, with pinpoint pupils, and unresponsive to name. Narcan nasal spray administered, resident unresponsive. Staff called 911. Resident began breathing more deeply after administration. Resident transferred to local hospital for evaluation. Review of the resident's hospital records, dated 08/11/25, showed the resident admitted through the emergency room after an accidental overdose. Resident is on chronic opiate therapy for management of cancer related pain. Review of the resident's rapid drug screen, dated 8/11/25, showed the resident positive for Opiates and Benzodiazepines. 3. During an interview on 8/13/25 at 9:11 A.M., the Administrator said he/she was notified by the charge nurse, Registered Nurse (RN) A the resident was sent out because he/she was not stable. He/She said he/she later heard the resident was administered Narcan but was unsure if it was at the facility or at the hospital. He/She said he/she and the Director od Nursing (DON) should have been notified when Narcan was administered for a possible drug overdose at the facility and an investigation should have been started. He/She said he/she did not start an investigation because he/she was unaware of the full incident. During an interview on 8/13/25 at 9:30 A.M., the DON said he/she was not aware of any incident with the resident. He/She said he/she expects to be notified and in this case an investigation should have been started to rule out any medication errors, if medications need to be adjusted or if there was any abuse. Complaint #2587617