STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265636	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Living Center	#2 Nazareth Lane Saint Louis, MO 63129

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one resident (Resident #1) received care consistent with professional standards when staff failed to report a large bruise and abrasion to the resident's head immediately, delaying assessment, proper care and required notifications to family and physician. The sample size was three. The census was 88.Review of the facility's Change in Condition policy, dated 10/2/23, showed:-Purpose: To provide care and services based upon the current needs of the resident under the direction of the attending provider. To inform resident/resident representative and attending provider when a significant change in resident condition occurs;-Policy: When a significant change in the resident's physical, mental or psychosocial status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative;-Procedure: --Licensed nursing associate: --Assess significant change in the resident's condition noted through direct observation, interview or report for other staff; --Obtain a set of vital signs and repeat as needed or ordered; --Open matrix event and conduct a symptom review and assessment, as condition warrants; --Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed; --Notify the resident/resident representative; --Document symptom(s), assessment, observations, resident/resident representative and medical provider notification; --Monitor and provide treatment as ordered by the attending provider. Review of Resident #1's medical record, showed:-Diagnoses included Alzheimer's disease and age-related osteoporosis (weak/brittle bones). Review of the resident's progress notes, showed on 10/13/25 at 1:20 P.M., the resident's hospice worker reported a knot to the resident's head. Upon assessment, a large knot with bruising was noted to the left side of the forehead and a small cut to the center of the knot. The nurse practitioner (NP) and family were made aware. The resident had no pain or discomfort. After cleansing the area, a small scab fell off. There was no bleeding noted. At 8:44 P.M., the resident continued on observation related to a bump on his/her head. The resident did not display any signs of pain or discomfort during observation. He/She has a golf ball sized bump to the left side of the forehead with small abrasions at the center. Review of a typed statement dated 10/14/25, by Certified Nurse's Aide (CNA) A showed the employee was feeding the resident on 10/12/25 and he/she got hold of the tray before the CNA could get to it and turned it over on him/herself. The CNA got the resident another tray and cleaned him/her and the room up. The CNA did not report the incident because he/she did not think anything about it. Review of event information report, dated 10/13/25, showed:-Event category and description: Other events -Situation, Background, Assessment and Recommendation (SBAR)-Physician/NP/Physician Assistant (PA) communication Tool and progress note;-When occurred: 10/13/25, 10:56 A.M.-Description: Knot to forehead;-Vitals for this event: No vitals have been recorded for this event;-Orders for this event: Post-fall signs for fall with injury-complete and record full set of vitals;-Progress notes for this event: There are no associated progress notes. Review of a written statement by Certified Nurse's Aide A, dated 10/14/25, showed when the CNA went to check on the resident on 10/13/25, he/she had a big bruise on his/her forehead with a small amount of dried blood. During interviews on 10/22/25 at 12:00 P.M. and on 10/23/25 at 10:30 A.M., CNA A said he/she did not receive report on the morning of 10/13/25 when he/she started his/her shift and did not know the resident was injured. When he/she went to check on the resident around 9:00 A.M., to get the resident ready for breakfast, he/she noticed the large knot on the resident's head. He/She did not say anything because he/she thought someone would have already reported it since the knot did not look new and the blood was dried on the cut. During an interview on 10/23/25 at 2:00 P.M., the hospice social worker said he/she got to the facility around 10:00 A.M. on 10/13/25. The resident was sleeping so he/she sat by his/her bedside for a little while until he/she woke. He/She noticed a large spot of blood on the resident's pillow and dried blood on the bed rail. When the resident turned over, to his/her left side, the social worker noticed a golf sized knot on his/her head with dried blood on it. He/she immediately went to the nurse's station to report the injury to the nurse who had no idea what happened. The nurse checked the resident's medical record to see if there was any note about what happened and there was nothing documented. During an interview on 10/22/25 at 1:50 P.M., Licensed Practical Nurse (LPN) D said he/she was not working the resident's floor on 10/13/25, but he/she was standing at the nurse's station when the hospice staff came and reported the injury. He/She and the floor nurse went in and assessed the resident together. The resident had a large knot on his/her head. During an interview on 10/22/25 at 2:00 P.M., LPN D said on 10/13/25, the hospice social worked came to