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	12/16/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure residents are free from accidents when staff failed to properly secure straps in the facility's van during transportation to an appointment, resulting in one resident flipping backward in their wheelchair (Resident #1). The census 101. The Administrator was notified on 12/16/25 of the past non-compliance. The facility in-serviced staff responsible for providing transportation to residents on proper wheelchair positioning and the facility's policy of transporting one wheelchair-bound resident at time in the medical van. The deficiency was corrected on 12/8/25. Review of the facility's policy on Fleet Safety Program, dated 2021, showed the following:-Purpose: To promote safe operation of vehicles within the facility's community and to satisfy auto insurance underwriting requirements;-Policy: The facility established the Fleet Safety Program applicable to all associates and volunteers of the facility and community;-Driving Guidelines: Accident Protocol will be followed in the event of an accident while driving a facility vehicle or when driving a personal or rented vehicle for business purposes;-Accident Protocol: In the event of an accident involving a facility vehicle or a personal or rented vehicle being driven on company business: Contact the police and unless they instruct you to do otherwise, do not leave the scene until the police have arrived and collected necessary information. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/19/25, showed: -Diagnoses of spinal stenosis (a narrowing of spaces within your spine which puts pressure on the spinal cord often causing numbness and pain), anxiety, and depression;-Required total assistance of staff for transfers;-Falls: Yes. Review of the resident's care plan, updated 11/4/25, showed:-Problem: Resident is at risk for falling related to weakness and physical performance limitations affecting balance, gait, strength and muscle endurance;-Approach: Keep bed in lowest position with brakes locked. Remind the resident to use call light. Keep call light within reach at all times. Review of the resident's progress notes, dated 12/3/25, showed:-At 10:04 A.M., during transport to a doctor's appointment, transport reported the resident fell back in his/her wheelchair. No visual injuries. Complaints of pain in head and neck. Family was notified. Vital signs: blood pressure (BP) 153/85 (normal blood pressure 120/80), pulse (P) 72 (normal pulse 60 to 100);-At 10:14 A.M., resident transported to hospital via ambulance;-At 4:10 P.M., resident returned from the hospital accompanied by family. Paperwork received from family. Resident in main dining room for evening meal. Diagnosis of closed head injury. Vital signs: BP 131/65, pulse 78, oxygen saturation (O2 sat) 92% (normal O2 sat 95 to 100%). Neuro checks (neurological assessments) completed and within normal limits. Resident responds appropriately to verbal stimuli. Eating dinner without issue. During an interview on 12/16/25 at 11:26 A.M., Van Driver D said he/she works at the facility as a van driver and has driven residents in the medical van. The facility's policy is that only one wheelchair resident can be in the medical van at a time because the van only has six straps. He/She was recently in-serviced regarding this. During an interview on 12/16/25 at 12:56 P.M., Van Driver A said he/she worked at the facility as a van driver and he/she was the driver when the resident fell backward in his/her wheelchair. On 12/3/25, Resident #3 was being transported to an appointment in the facility's medical van along with another resident. Both residents' appointments were at the same place and around the same time. Van Driver A made the decision to take both residents at the same time to prevent them from being late. He/She placed the first resident in the van and strapped his/her wheelchair in place, then placed Resident #3 in the van and strapped his/her wheelchair in place. While driving, he/she made a turn and Resident #3's wheelchair flipped backward. He/She pulled the van over and checked to see if the resident was hurt. The resident said he/she wasn't hurt. Van Driver A sat the resident upright in his/her wheelchair, secured him/her in the van with the wheelchair straps, and returned the resident to the facility since they weren't that far. He/She has transported two residents in the medical van before without a problem. He/She has been in-serviced on the facility's policy of only transporting one wheelchair resident in the medical van due to the number of straps in the van. The medical van has six straps and in order to transfer two residents safely, it needs to have eight straps. During an interview on 12/15/25 at 8:30 A.M., the facility's Executive Director said she was unaware the facility's medical van didn't have eight straps until after the resident's fall. All van drivers have been in-serviced and completed a return demonstration on how to properly position a wheelchair resident on the medical van and facility's policy of transporting only one wheelchair-bound resident at a time in the medical van. In addition, van drivers have been in-serviced to call 911 whenever a resident has an incident or falls during transportation. 2683397