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	01/08/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure treatments and medications were administered as ordered for two of four sampled residents (Resident #4 and Resident #2). The census was 93.Review of the facility's policy on Physician Services, dated 2019, showed the following:-Policy: It is the policy of the facility to provide care and services related to Physician Services in accordance with State and Federal regulations;-Procedure: #8. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift. Review of the facility's policy on Administering Medications, dated 2020, showed the following:-Purpose: To ensure safe administration of resident's medication as indicated and ordered by the provider;-Policy: To administer resident medications in a safe manner that will ensure the six rights of patient identification for administration;-Procedure: 1. Medications are to be administered by licensed nurses or as delegated, trained associates. 2. Medications are administered in the accordance with the orders;-Medication error is the preparation or administration of drugs or biologicals which is not in accordance with the attending providers orders, manufactures specifications or accepted standards and principles of the professional providing the services;-Examples of medication errors: Omissions. 1. Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/9/25, showed the following:-Diagnoses of diabetes, high blood pressure, and peripheral vascular disease (poor circulation);-Required moderate assistance of staff for bathing and dressing; -Two arterial ulcers (ulcer caused by fluid build-up in the skin from poor arterial function)/venous ulcers (lower leg ulcer that develops when the leg veins fail to return blood back toward the heart normally). Review of the resident's care plan, dated 10/3/25, showed the following:-Problem: Chronic wounds to his/her gluteal (buttocks), left ischium (hip), left ankle and left heel;-Approaches included treatment orders per physician and weekly skin assessments. Review of the resident's physician order sheet (POS) and treatment administration record (TAR) for December 2025, showed:-A physician order, dated 12/4/25, to cleanse left heel with wound cleanser, apply Aquacel AG (an antimicrobial wound dressing used for infected or at-risk wounds) to wound bed and cover with foam dressing daily and as needed (PRN);-On 12/4/25, and 12/6/25 through 12/9/25, staff documented the treatment as completed;-On 12/5/25 and 12/10/25, staff documented the treatment not completed due to resident at dialysis;-No documentation that incomplete treatments were completed on a different shift. Review of the resident's progress notes, showed the following:-From 12/4/25 through 12/10/25, no documentation regarding the resident's wound treatment;-On 12/11/25 at 2:29 P.M., staff documented the resident seen by wound company. Dressing removed from left heel dated 12/8/25. No signs/symptoms of infection. Odor noted to old dressing. No change in treatment plan. Review of the wound care company note, dated 12/11/25, showed the following:-Chief complaint: Vascular wound (a persistent skin ulcer caused by poor blood circulation in the arteries or veins) to the left (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	heel;-History of present illness: Vascular wound to the left heel. Resident states the wound has been present for several weeks. Resident has an MRI (a specialized imaging test) scheduled for mid-December;-Plan of care: Goal of treatment: Heal. Wound progress: Dressing in place dated 12/8/25, wound has 70% granulation (healing tissue) and 30% eschar (hard dead tissue) with a small amount of drainage. Further review of the resident's TAR and progress notes for December 2025, showed:-From 12/11/25 through 12/14/25, and 12/16/25, staff documented the resident's treatment completed;-On 12/15/25, staff documented the treatment not completed due to resident at dialysis;-No documentation that incomplete treatments were completed on a different shift. Observation on 12/16/25 at 9:10 A.M., showed the resident sat in his/her wheelchair. His/her left heel had a dressing dated 12/16/25. Licensed Practical Nurse (LPN) A removed the dressing from the resident's left heel. Observation showed a wound approximately 3.0 by 5.0 centimeters (cm) with a red and yellow wound base. LPN A cleaned the wound with normal saline, dried and applied Aquacel AG, large gauze pad and a gauze wrap. During an interview on 12/16/25 at 9:15 A.M., LPN A said he/she completed the resident's treatment earlier that morning. He/She has found the resident's dressing unchanged at times. Wound treatments are to be completed as ordered. Further review of the resident's TAR and progress notes for December 2025, showed:-On 12/17/25, staff documented the treatment not completed due to resident at dialysis;-No documentation that the incomplete treatment was completed on a different shift. Review of the resident's MRI results, completed 12/18/25, showed the following: -MRI of the left foot completed;-Findings: Osteomyelitis (bone infection) of the left heel. Review of the resident's progress note, dated 12/18/25 at 4:59 P.M., showed new order received to send to emergency room (ER) related to MRI results. During an interview on 1/5/26 at 3:02 P.M., the Director of Nurses (DON) said she expected the staff to complete the resident's dressing change when he/she returned from dialysis. The DON was unaware staff weren't completing treatments as ordered. During an interview on 1/5/26 at 3:25 P.M., the resident's physician and Medical Director said she expected the staff complete the dressing change to the resident's foot as soon as possible. During an interview on 1/8/26 at 10:00 A.M., the Administrator said he expected staff to complete orders as written by the physician. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:-Diagnoses of high blood pressure, anxiety, and depression;-Required maximum assistance of staff for bathing and toileting;-Required moderate assistance of staff for personal hygiene, dressing and putting on shoes. Review of the resident's POS and medication administration record (MAR) for November 2025, showed:-A physician order, dated 3/31/25, for levothyroxine (a medication used to treat underactive thyroid) 175 micrograms (mcg), once a morning at 6:00 A.M.;-From 11/1/25 through 11/13/25, 11/16/25, 11/20/25, and 11/23/25, staff documented the medication not administered;-On 11/14/25,11/15/25, 11/17/25 through 11/19/25, 11/21/25, 11/22/25, and 11/24/25 through 11/30/25, staff documented the medication administered. Review of the resident's progress notes, showed the following:-On 11/10/25 at 10:48 A.M., staff documented levothyroxine 175 mcg not administered on 11/3/25. Physician and family aware;-On 11/11/25 at 1:24 P.M., staff documented levothyroxine 175 mcg not administered on 11/7/25. Physician and family aware;-No further documentation regarding missing levothyroxine. During an interview on 1/5/25 at 1:50 P.M., LPN B said he/she works the night shift. He/She was aware the resident's levothyroxine was not available. He/She was unable to say why the medication wasn't available. Medications are usually ordered by the Certified Medication Technician (CMT) on day shift. LPN B assumed the medication was on order. During an interview on 1/5/26 at 3:02 P.M., the DON said she expected the staff to notify her if they are unable to obtain a resident's medication or if it was unavailable. In addition, staff are to notify the family and the physician each time a medication was missed. During an interview on 1/5/26 at 3:25 P.M., (continued on next page)

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