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	02/05/2026

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 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. Based on interview and record review, the facility failed to provide adequate assistance to prevent the risk of accidents by failing to ensure appropriate and safe transfer techniques were used in the care of one resident (Resident #1). The resident had a history of a knee replacement and had hardware surgically inserted into the lower end of the femur (upper bone of the leg). As early as 1/28/26, the resident reported pain to the right leg, and no documentation showed staff assessed the leg at this time. On 2/1/26, staff failed to use the foot pedals on the resident's wheelchair while propelling him/her to breakfast and lunch. This resulted in the resident's legs dragging and caused the resident more discomfort in the right leg. In addition, after the resident expressed more pain to the right leg, staff failed to transfer the resident with a mechanical lift per the facility's expectation. An x-ray completed at the facility found a right femur fracture, age-indeterminate (it could not be determined if the fracture was new or old). The physician could not confirm findings on the x-ray represented the initial fracture requiring hardware placement or a new acute fracture around the surgically placed hardware. The sample was 10. The census was 86.The Administrator was notified on 2/5/26 of the past non-compliance. The facility in-serviced nursing staff on using footrests while propelling in a wheelchair, moving residents with a suspected injury, and transferring residents using the proper transfer status. The deficiency was corrected on 2/3/26. Review of the facility's Safe Lifting and Movement of Residents Policy, effective 9/13/24, showed: -Policy: In order to protect the safety and well-being of associates and residents, and to promote quality care, all communities use appropriate techniques and devices to lift and move residents.-Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents;-Nursing associates, in conjunction with the rehabilitation associates, shall evaluate individual resident needs for transfer assistance on an ongoing basis. Associates will document resident transferring and lifting needs in the care plan. Evaluations shall include the following:--Resident's mobility (degree of dependency);--Resident's size--Weight-bearing ability;--Cognitive status;--Whether the resident is usually cooperative with staff; and-Associates responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices;-Mechanical lifting devices shall be used whenever possible, including lifting and moving residents when necessary. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/24/25, showed:-Severe cognitive impairment;-No upper or lower extremity impairment;-Resident needed substantial/maximal assistance with toileting, upper body dressing, personal hygiene; -Resident dependent with shower/bathe self, lower body dressing, and put on/take off footwear;-Resident uses wheelchair for mobility. For transfer, resident needed partial/moderate assistance with roll left and right and sit to lying;-Resident needed substantial/maximal assistance with lying to sitting on bed side, sit to stand, chair/bed to chair transfer, and toilet transfer;-Diagnoses include high blood (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: 265636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure, depression, anxiety, and non-Alzheimer's Dementia. Review of the resident's care plan, revised on 12/23/25, showed:-Problem: Falls, Unsteady Gait does not ask for assistance;-Goal: No major injuries related to falls through next review;-Approach: Staff to offer assistance with toileting/activities daily living care during rounds and as needed, make sure my walker/wheelchair is beside me and the bathroom light is turned on, transfer with gait belt and assist of one staff. Review of the resident's electronic Physician Order Sheet (ePOS), showed:-An order dated 2/1/26, for x-ray to right lower extremity. Pain, decreased range of motion and swelling on knee area;-An order dated 2/2/26 and end date 2/2/26, x-ray to right lower extremity. Pain, decreased range of motion and swelling on knee area; Review of the resident's medical record showed a provider note, dated 2/2/26, which included:-Chief Complaints: Patient is being seen for knee pain;-Resident with a history as below seen today for acute visit. On 2/1 the on-call physician was notified of patient having pain to Right Lower Extremity (RLE) with swelling, decreased range of motion, and pain with movement. Orders were given for x-ray Reviewed nurses notes today, no documentation of falls noted in the last 1 month;-Around 1:00 P.M., nurse came to report results of x-rays. Right femur x-ray showed an age-indeterminate distal femur fracture. This may represent the initial fracture requiring hardware placement, may represent a new acute peri (area around) hardware fracture, indeterminate given the lack of prior studies. Patient now with severe pain, swelling, deformity noted to the right knee. Will send to emergency room for further evaluation/treatment. Review of the facility's investigation into the Certified Nursing Assistant (CNA), who propelled the resident in a wheelchair with no foot pedals, showed:-Description of What Was Observed: Staff member was transporting Resident #1 to breakfast. While being pushed down the hallway, the resident suddenly screamed. The Licensed Practical Nurse (LPN), who was a few feet away, heard the scream and immediately responded. Upon evaluating the resident, the LPN noted that the wheelchair did not have foot pedals attached. He/She instructed staff to place the foot pedals on the wheelchair and then assessed the resident for pain. After the resident's feet were placed on the pedals, the resident denied further pain. No injuries were observed upon inspection. The LPN notified the on-call physician of the potential injury, and an x-ray was ordered. The resident was then taken to breakfast, where he/she voiced no additional complaints of pain. The resident remained in his/her wheelchair until lunch at 12:00 P.M. Shortly after lunch, the resident's family member arrived for a visit and expressed concern about a possible injury. The family member took the resident to his/her room. During an interview, the family member stated that he/she typically transfers the resident independently using a gait belt, despite acknowledging that the resident requires a two-person Hoyer lift (full body mechanical lift) transfer. The family member reported that when he/she moved the resident's leg off the pedal, the resident screamed. The family member then activated the call light for nursing assistance. Two staff members assisted with transferring the resident from the wheelchair to the bed. One staff member stood the resident, turned, and pivoted him/her toward the bed while the second staff member moved the wheelchair out of the way. The family member then grabbed the resident's ankles and assisted in lifting his/her legs into the bed. The resident expressed discomfort during this process;-Injuries Observed at Time of Incident: No visible injuries noted, only verbal discomfort expressed during movement of lower extremity. Resident has had knee surgery. Which causes his/her knees to naturally appear malformed.-Determined Cause or Contributing Factors: Lack of foot pedals on wheelchair and improper transfer. Review of the resident's progress notes, showed:-On 2/1/26 at 2:47 P.M., resident is complaining of pain to right lower extremity, assessments done, and notes is as follows: swelling on right knee, decreased range of motion, pain upon movement, physician on call notified. New order given for an x-ray;-On 2/1/26 at 8:08 P.M., x-ray (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative called facility and notified this writer that the x-ray will be rescheduled for tomorrow reason being they do not have a tech available for tonight;-On 2/2/26 at 10:40 A.M., resident Hoyer lift to bed with assistance of tech. Briefs changed. Complaints of pain when bilateral (both sides) lower extremity (BLE). X-ray done. Resident lying in bed resting;-On 2/2/26 at 12:50 P.M., x-ray results received. Age-indeterminate distal femur fracture. Report given to physician and Nurse Practitioner (NP). Orders to send to ER for assessment. During an interview on 2/4/26 at 9:10 A.M., the Director of Nursing (DON) said the resident was sent out on 2/2/26. He/She was found to have a right femur fracture. They do not think the fracture was caused by a transfer by the family. The resident did not have a fall. The CNA over the weekend was propelling the resident in his/her wheelchair. The resident's nurse heard the resident say ow. After the nurse attended to the resident, the physician was called and x-ray was ordered. The resident was sent out 2/2/26 after x-ray results came back. The resident is still in the hospital. He/She had history of osteoporosis (thinning of the bone) and knee replacement with hardware, so his/her knee/leg presented as looking off anyway. During an interview on 2/4/26 at 10:02 A.M., Licensed Practical Nurse (LPN) F said he/she sent the resident to the hospital on Monday, 2/2/26. The resident had been complaining of leg pain. He/She got in report that morning that the resident had fallen down a few days ago and the x-ray was ordered but not done. He/She believes that he/she was told the resident fell on Saturday but not sure. There were no notes in the medical record about the fall, only that the resident's leg hurt. During an interview on 2/4/26 at 10:30 A.M., the Administrator said when the facility first reported the incident with the resident. They were not sure what happened. They are still finishing their investigation. The resident has not had a fall documented since December. During an interview on 2/4/26 at 11:30 A.M., CNA C said he/she last worked with the resident on 2/2/26 when he/she provided feeding assistance to the resident. CNA C is not sure when the resident's leg injury happened. The resident said it was hurting last week. When he/she came in last Wednesday (1/28/26), the resident was complaining. He/She screamed and pointed/held the leg. The CNA saw it looked slanted so tried to find a Broda chair (medical reclining chair) because he/she figured it would be easier for the resident to sit in that. The CNA found a physical therapist to request the chair. The Physical Therapist (PT) went to assess and said the Broda chair was not appropriate but gave elevated foot pedals. CNA C said he/she reported the resident's symptoms to nurse on duty. The nurse told him/her the resident must have had a fall. CNAs do not know what nurses can see so assumed an x-ray was done at that time. CNA C worked with the resident the rest of the week and not much changed. The CNA returned on Monday and felt that something was wrong. When the CNA and another aide tried to get the resident up the resident was screaming louder. There was more swelling. If CNA C had known the leg was broken, he/she would not have gotten the resident up. Review of the resident's medical record, showed no documentation the resident was assessed for injury after reporting pain on 1/28/26. During an interview on 2/4/26 at 3:25 P.M., the Physical Therapist said he/she was the one who assessed the resident last week. The resident was not suitable for Broda chair but was for the elevated leg rest. The resident yelled out when the PT moved his/her leg. After the PT got the elevating leg rests, the resident did not yell at the PT the second time. The PT was not sure if the leg was swollen, the resident was wearing pants. The PT did let the nurse know. The resident is receiving occupational therapy for his/her wrist. He/She is not currently receiving physical therapy. The PT said it is not unusual for the resident to scream out. During an interview on 2/4/26 at 3:41 P.M., the resident's physician said on Sunday 2/1/26, the nurse notified the on-call physician about the resident. An x-ray and labs were ordered. The x-ray was ordered standard, not STAT so they would have 24 hours to complete the x-ray. During an interview on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/5/26 at 9:42 A.M., CNA G said he/she worked evening shift three days last week. He/She did not recall the resident complain of pain and was not grabbing at his/her leg. The resident's leg did not appear swollen and he/she did not cry out more than normal when rolling or transferring with the Hoyer lift. The resident did tend to cry out and yell a lot and would get agitated very easily. CNA G did not work over the weekend. The last day worked was Friday 1/30/26. He/She does not remember any signs of anything out of the normal for pain or the resident being hurt. The resident is transferred by a Hoyer lift. During an interview on 2/5/26 at 1:35 P.M., LPN B said he/she worked both Saturday and Sunday. On Saturday, the resident was acting normal. On Sunday, the LPN reports he/she was doing tasks and saw the assigned CNA, CNA A, propelling the resident in the wheelchair and heard screaming. The aide was propelling the resident with no leg rests and the resident's right leg was observed to be dragging. The resident's right leg has always been weak. The nurse went to assess the resident. When LPN B touched the resident's right leg, the resident screamed. The nurse touched the leg a second time and the resident did not scream. The resident then laughed. The nurse assisted getting the residents foot pedals and the CNA took the resident to lunch. LPN B said he/she called the physician because the resident's leg was dragging and it was a little swollen. The resident seemed ok. After lunch, LPN B said he/she saw CNA A and Certified Medication Technician (CMT) D in the resident's room with the family member and no Hoyer lift. LPN B stopped to make sure everything was ok. The resident was already transferred into bed. LPN B said the family member assisted in putting the resident to bed too. They should have used a Hoyer lift. LPN B said the resident's leg was a little swollen but the resident was not screaming and was calm. During an interview on 2/5/26 at 1:50 P.M, CNA A said he/she arrived at the facility at 6:45 A.M. on 2/1/26. Ther resident was already up in a wheelchair. The resident is a Hoyer transfer but did not have Hoyer sling under him/her. CNA A said he/she got other residents up and then came back to take the resident to breakfast. As CNA A propelled the resident, the resident hollered. CNA A said the resident yells a lot, so he/she just thought it was the resident's behavior. CNA A instructed the resident to put his/her legs up and CNA A continued taking the resident to breakfast. When CNA A was propelling the resident to lunch, it happened again but a louder holler and thought the leg looked swollen so the CNA just got nurse. LPN B asked if the resident had any foot pedals and found them in the corner of the room. CNA A said they got the foot pedals but normally the resident does not need them. The resident did holler when staff lift his/her leg on the foot pedal then he/she was fine. Around 12:30 or 1:30 P.M., staff put the resident to bed. CNA A said he/she asked CMT D to assist. They just lifted him/her and had the resident stand/pivot and set him/her on edge of bed. CMT D laid the resident's head down and then the resident's family member moved his/her legs. CNA A believes the injury happened the morning before he/she got there with the overnight CNA. The resident was in a chair and not on a Hoyer pad so CNA A believes the resident was already hurt. CNA A did not see the resident's leg drag when he/she was propelling the resident in the wheelchair. During an interview on 2/5/26 at 1:52 P.M., CMT D confirmed he/she assisted CNA A with the transfer. The family member was there but did not say anything except talking about getting x-ray because the resident hurt his/her leg. Staff and family stood the resident up and stand pivoted the resident to the bed. The family member grabbed the resident's leg and the resident made a noise but that was the only time. CMT D did not see any swelling of the right leg. CMT D said he/she was not aware of the resident's transfer status and does not normally transfer the resident. During an interview on 2/5/26 at 2:45 P.M., the Administrator said CNA A should have used foot pedals with the wheelchair and the Hoyer lift should be used. They would have expected the staff to get the nurse to assess when the family was wanting to transfer the resident without a Hoyer. At 4:45 P.M., (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator said based on their investigation findings they think the resident's injury may have occurred when he/she was transported in his/her wheelchair by the CNA. During an interview on 2/6 at 8:45 A.M., the Physician said it would be appropriate to transfer without the foot pedals only if they could self-propel. During an interview on 2/6/26 at 8:55 A.M., CNA H confirmed he/she worked the weekend of 1/30/26 through 2/1/26, with the resident. On Friday 1/30/26, the resident was in a mood where he/she did not like to be moved or messed with much. On Saturday, 1/31, the resident said ow and did not like his/her leg moved. CNA H said he/she told the charge nurse who reported that he/she would check on the resident. On Sunday 2/1/26, the resident was worse. The resident was crying after he/she changed the resident. CNA H was not sure where the pain was coming from. The resident has been known to thrown herself on the floor so CNA H said he/she just puts pillows around the resident so he/she cannot do that. CNA H said sometimes he/she just picks the resident up and places him/her on the recliner to calm him/her down when he/she is restless in bed. The resident was just tense but still somewhat normal. The resident did not like to be moved back and forth. The resident is supposed to be Hoyer transfer but they switch the resident so much. CNA H said he/she just does what everyone else does as far as transfers. He/she thinks the resident can also be a 1-2 assist. After the shift on Sunday night, the resident did not want to get up that next morning so CNA H just let the resident be in bed. 2733825