STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265704	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Perryville, Llc, The	430 North West Street Perryville, MO 63775

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 32751 Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from abuse from another resident when staff failed to prevent Resident #2 from hitting Resident #1 which caused a hematoma (a collection of blood outside of the blood vessel) to the left side of the head. The facility also failed to ensure the resident was free from abuse from staff when staff removed Resident #1 from his/her room against their will, and rolled him/her onto a blanket and dragged the resident on the floor through the facility causing the resident to become anxious and require medication to calm down. The census was 120. On 02/25/25 at 3:30 P.M., the Administrator was notified of the immediate jeopardy (IJ) which began on 02/06/25. The IJ was removed on 02/27/25, as confirmed by surveyor onsite verification. Review of the facility's policy on Resident to Resident Altercations, updated 01/24/24, showed: -The staff member on the scene will immediately call a Code Gray on the walkie/talkie and/or overhead intercom; -Team members will attempt to separate residents and ensure the safety of all residents; -The team members will remain in the area of the disruption until further assistance arrives. Review of the facility's Abuse, Neglect and Exploitation Policy, dated 04/08/24, showed: -Each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. The resident must not be subject to abuse by anyone including but not limited to: facility staff; other residents; consultants or volunteers; staff of other agencies; family; legal guardians, friends or other individuals. -Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. 1. Review of Resident #1's face sheet showed: -Had a Public Administrator as a guardian; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses of Schizoaffective Disorder-Bi Polar type (a mental health disorder involving depression, hallucinations and delusions with bouts of manic behavior), and heart failure. Review of Resident #1's annual Minimum Data Set ((MDS) a federally mandated assessment instrument completed by the facility staff), dated 01/29/25, showed: - The resident was cognitively intact; - The resident triggered for delirium (confused thinking, agitation and memory problems), cognitive loss, and falls. Review of Resident #1's Care Plan, dated 03/05/25, showed: - The resident required supervision with all activities of daily living (ADLs); - The resident had a history of aggression and throwing urine on others; - The resident had impaired cognitive thought processes; - The resident resided on a secured behavior unit until 02/06/25. Review of Resident #2's face sheet showed: - Diagnoses of Autistic Disorder (a lifelong disorder affecting how a person communicates, interacts with others and behaves), Schizophrenia (a mental health disease affecting how a person thinks including delusions, paranoia and hallucinations), and delusional disorder (a serious mental illness causing unshakeable false beliefs). Review of the resident's quarterly MDS dated , 02/06/25 showed the resident was cognitively intact and no behaviors listed. Review of Resident #2's care plan, updated 03/05/25, showed: - The resident becomes agitated if medications aren't on time; - The resident had delusions and hits staff and other residents without warning; - The resident had a history of frustration, agitation, impatience and striking others; - The resident resided on a secured behavior unit; - The resident was placed on 1:1 on 11/14/24. Review of the facility's investigation, dated 02/06/25, showed: - On 02/06/25, Resident #2 asked Certified Medication Technician (CMT) A for medications; - CMT A informed Resident #2 it was too early for the medications; (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #2 was on one on one with a designated staff member, Certified Nurse Aide (CNA) B, due to a history of aggressive behaviors; - The resident became agitated and started to walk down the hallway; - CMT A was afraid of Resident #2 and locked himself/herself in a clean linen closet; - CNA B and Licensed Practical Nurse (LPN) C, followed Resident #2 halfway down the hall and stopped two rooms away; - Resident #2 went to the end of the hallway and stared into Resident #1's room for a period of a few minutes; - CNA B and LPN C watched as Resident #2 raised his/her arms up and ran into the room of Resident #1 and hit Resident #1 in the head; - Resident #1 sustained a hematoma (damaged blood vessels surrounding the tissue). During an interview on 02/25/25 at 2:00 P.M., CMT A said Resident #2 becomes very agitated and angry when he/she is told it is not time for his/her medication administration. CMT A said Resident #2 became very threatening toward him/her (on 2/6/25), so he/she removed himself/herself from the situation by hiding in the closet. CMT A said he/she did not feel CNA B and LPN C would be able to handle Resident #2 if he/she escalated in behaviors, and that is why he/she hid. CMT A said he/she peeked out of the closet and saw Resident #2 enter Resident #1's room. CMT A heard Resident #1 yelling for help. LPN C and CNA B stood at least two room doors away and did not attempt to de-escalate Resident #2 or prevent Resident #2 from hitting Resident #1. During an interview on 02/25/25 at 3:15 P.M., LPN C said CNA B had been assigned to monitor Resident #2 in a one on one capacity due to the resident's history of aggressive behaviors toward other residents. Resident #2 asked CMT A for a medication and CMT A told the resident it was too early. Resident #2 became agitated. When Resident #2 started to walk down the hallway, he/she and CNA B followed. LPN C said they had watched Resident #2 standing at the doorway to Resident #1's room and they stood back down the hall to provide the resident space and not approach him/her. They were two rooms behind Resident #2 observing, when Resident #2 ran into Resident #1's room and hit Resident #1. LPN C said he/she and CNA B then ran toward Resident #1's room and stopped Resident #2 from hitting Resident #1 again. LPN C said when Resident #2 had become agitated the staff should have intervened to protect Resident #1. LPN C did not say why he/she did not intervene and attempt to de-escalate Resident #2 before he/she struck Resident #1. During an interview on 02/25/25 at 4:20 P.M., CNA B said he/she had been assigned to monitor Resident #2 one on one, due to the resident's history of hitting other residents in the head. Resident #2 was agitated due to not getting the medication he/she requested. Resident #2 started down B Hall while he/she and LPN C followed, but not too closely. He/she said they stood about two rooms away. CNA B said Resident #2 stood at the doorway of Resident #1's room for awhile then raised his/her arms and took off toward Resident #1 striking him in the head. CNA B said he/she and LPN C then ran toward Resident #1's room and heard him/her screaming. They intervened and stopped Resident #2 from striking the resident again. He/she felt CMT A was trying to stay away from Resident #1. CNA B did not say why he/she or LPN C did not attempt to stop Resident #2 from striking Resident #1 the first time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/25/25 at 9:45 A.M., the Administrator (ADM) said he would expect all staff to protect the residents. He said staff are afraid of Resident #2 due to his/her size and strength. He expected the staff, CNA B and LPN C, to have stopped Resident #2 from hitting Resident #1. CNA B and LPN C should have called for assistance, but no Code Gray (in policy) that staff did not call for assistance when the resident became agitated knowing he had a history of attacking other residents 2. Review of the facility's investigation, dated 02/08/25, showed: - Resident #1 was removed from the B Hall after an incident involving Resident #2; - Resident #1 did not want to leave B Hall and went back to B Hall during the evening hours at approximately 10:00 P.M. to go to his/her old room; - Staff members LPN D and CNA E approached the resident and attempted to get Resident #1 redirected to his/her new hall; - Resident #1 sat in the floor and refused to get up; - Resident #1 continued to refuse to leave the B hall and laid in the floor while staff attempted to pull him/her to a standing position; - LPN D then placed a blanket on the floor and physically rolled Resident #1 onto the blanket; - LPN D and CNA E dragged the blanket and Resident #1 on the floor down B hall, through the lobby to his/her new room on A Hall at 11:30 P.M. Review of Resident #1's Medication Administration Record (MAR), dated February 2025, showed: - An order for Lorazepam (a drug used to treat anxiety) injection solution 2 milligram (mg) every 6 hours as needed for anxiety; - Lorazepam injection solution 2 mg given to Resident #1 on 02/07/2025 at 12:30 A.M. During an interview on 3/6/2025 at 10:20 A.M., CNA E said during the evening, Resident #1 came onto the B hall and said his/her room was there. The other staff members on the hallway told the resident that he/she needed to return to the A hall where the resident had been relocated to earlier that day. The resident sat on the floor and wanted to remain there. The charge nurse, LPN D, came to the B hall and told the resident he/she had to leave. CNA E said he/she requested multiple times to allow the resident to just remain on the floor and calm down and then redirect. LPN D got a blanket to put on the floor, rolled the resident onto the blanket and instructed CNA E to grab a corner and pull. LPN D drug the resident through the hallway to the A hallway. CNA E told LPN D this was not right. CNA E asked LPN D if he/she should write a statement and LPN D said no. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/6/2025 at 11:30 A.M., LPN D said on 02/06/25 when Resident #1 entered B hall the staff called him/her to come to the hall. Resident #1 was sitting in the hallway by the room that had previously been his/her room and wanted to go in. Staff, unknown to LPN D, were attempting to get the resident to stand up and the resident laid on the floor. LPN D said he/she tried to redirect. The staff said the resident had been attacked earlier and it was not safe to be there. LPN D said he/she attempted to reach the facility's Director of Nurses and on call staff and no one answered. He/she decided the resident needed to be moved to ensure his/her safety. He/she used the fireman blanket transfer (a blanket used to transfer people in emergency situations safely) to move the resident safely. The resident was pushed onto a blanket then rolled into the blanket. LPN D then had CNA E assist in dragging the blanket from Hall B, through the lobby to A hall. The resident was anxious and appeared nervous, but was not yelling or being aggressive at that time. Later in the shift Resident #1 became increasingly anxious and a Lorazepam injection solution 2 mg was administered on 02/07/2025 at approximately 12:30 A.M. LPN D felt it was the only way to ensure the resident was safe. During an interview on 02/25/25 at 9:45 A.M., the ADM said the two staff should not have treated the resident this way. He would have expected his other staff members to intervene with the physical abuse and did not understand why no staff stopped this from happening. COMPLAINT #MO249374 NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to provide staff with appropriate competencies and skill sets to provide nursing and related services to ensure resident safety and attain the highest practicable physical, mental, and psychosocial well-being for two sampled residents (Resident #1 and #2) when staff failed to implement interventions preventing Resident #2 from hitting Resident #1 and interventions preventing staff from physically moving Resident #1 against his/her will. The census was 120. On 02/25/25 at 3:30 P.M., the Administrator was notified of the immediate jeopardy (IJ) which began on 02/06/25. The IJ was removed on 02/27/25, as confirmed by surveyor onsite verification. The facility did not provide a policy regarding the unit staffing needs or specialized training needed to work on a locked behavior unit. The facility did not provide a documented mental health behavior training program for all staff including temporary agency staff working on the secured behavioral unit. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR), dated 07/27/23, showed: - A 50 plus years of mental illness with no family support; - Impaired judgement and decision making; - A long history of psychiatric treatments; - Required a secured behavioral unit. Review of Resident #1's face sheet showed: - Had a Public Administrator as a guardian; - Diagnoses of Schizoaffective Disorder-Bi Polar type (a mental health disorder involving depression, hallucinations and delusions with bouts of manic behavior), and heart failure. Review of Resident #1's annual Minimum Data Set ((MDS) a federally mandated assessment instrument completed by the facility staff) dated, 01/29/25, showed: - The resident was cognitively intact; - The resident refused care and physically disrupts the environment on a daily basis; - The resident triggered for delirium (confused thinking, agitation and memory problems), cognitive loss, and falls. (continued on next page)

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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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Care Plan, dated 03/05/25, showed: - The resident required supervision with all activities of daily living (ADLs); - The resident had a history of aggression and throwing urine on others; - The resident had impaired cognitive thought processes; - The resident resided on a secured behavior unit until 02/06/25; - The resident may exhibit behaviors such as throwing himself/herself onto the floor when he/she does not get their way. Interventions included Social Services working with the resident one on one, staff redirecting resident when he/she is impatient and remind the resident of his/her coping skills when he/she is angry; - The resident has a history of elopement attempts from the locked unit. Interventions included staff will accompany the resident to and from destination if the resident needs to be off the locked unit, staff will notify the resident's psychiatric doctor and resident will be put on one on one monitoring or 15 minute checks to ensure safety; - The resident is resistive to care and treatments at time. Interventions included allowing resident time to make decisions and explaining processes slowly and leaving the situation and coming back 5-10 minutes later and approach again. Review of Resident #2's PASRR, dated 04/07/22, showed the resident meets requirements for short term nursing facility placement. The resident required: - A behavioral support plan; - A structured environment; - Crisis intervention services; - Discharge planning; - Medication therapy and monitoring; - ADL assistance. Review of Resident #2's face sheet showed: - Diagnoses of Autistic Disorder (a lifelong disorder affecting how a person communicates, interacts with others and behaves), Schizophrenia (a mental health disease affecting how a person thinks including delusions, paranoia and hallucinations), and delusional disorder (a serious mental illness causing unshakeable false beliefs). Review of Resident #2's annual MDS, dated [DATE], showed the resident: (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Cognitively intact; - Exhibited hallucinations (the perception of the presence of something that is not actually there, involving one or more of the five senses, and delusions are fixed, false beliefs not shared by others that the resident holds even in the face of evidence to the contrary) and delusions (a fixed, false belief that the resident holds, even in the face of evidence to the contrary); - Exhibited physical behaviors (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) one to three day during the 7 day look back observation period; - Exhibited verbal behaviors (threatening others, screaming at others, cursing at others) one to three days during the 7 observation period; - The resident's behaviors put others at a significant risk and significantly disrupt the care environment. Review of Resident #2's care plan, updated 03/05/25, showed: - On 11/8/24 the resident had a resident to resident altercation and was placed on one on one monitoring. The care plan was updated on 12/10/24 to include the resident has delusions at times and will strike staff and other residents without warning. Interventions included remaining on one on one monitoring, informing the resident's physician of the behaviors and reminding the resident to use his/her coping skills; - The resident frequently becomes fixated on his/her medication administration and will follow CMTs around. The resident also has a history of hitting staff and staff equipment if he/she does not get his/her medications when he/she asks for them. Interventions included directing CMTs to give Resident #2 his/her medication first on his/her hall of residence and for the resident to seek assistance if he/she can't use his/her coping skills. Review of Resident #2's Care Plan for Behaviors, dated 11/14/24, showed: - The resident has a history of delusions with suspicious thoughts and impulsive behaviors which include medication non-compliance, poor hygiene, hitting head when distressed, consumption of non food items (i.e. paint chips), consumption of large quantities of food, rocking, strange postures, staring episodes, and startling easily per level II PASRR. - The resident also becomes distressed by loud noises, exhibits threatening behavior towards his/her father, fixation on particular items, abnormal thought process, and withdrawn; - Interventions included: - Administer medications as ordered; - Ascertain causes for symptoms; - Conduct intervention matching causes of symptoms, preferences include music therapy, orientation training, exercise and/or art cognitive activity; (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Observe for effectiveness of medications; - Offer tea or [NAME] Aid as way to promote calmness; - Engage conversations with me about my musical preferences; - Refer resident to activities of choice, like watching TV; - Engage resident in conversations regarding baseball, or find a game on TV; - Offer resident his/her PAD. I enjoy playing games/using my PAD; - Staff will monitor for consumption of non-food items and report any abnormal findings to physician. Review of the facility's investigation, dated 02/06/25, showed: - On 02/06/25, Resident #2 asked Certified Medication Technician (CMT) A for medications; - CMT A informed Resident #2 it was too early for the medications; - Resident #2 was on one on one with a designated staff member, Certified Nurse Aide (CNA) B, due to a history of aggressive behaviors; - The resident became agitated and started to walk down the hallway; - CMT A was afraid of Resident #2 and locked himself/herself in a clean linen closet; - CNA B and Licensed Practical Nurse (LPN) C, followed Resident #2 halfway down the hall and stopped two rooms away; - Resident #2 went to the end of the hallway and stared into Resident #1's room for a few minutes; - CNA B and LPN C watched as Resident #2 raised his/her arms up and ran into Resident #1's room. Resident #2 ran into the room and hit Resident #1 on the left side of the head; - Resident #1 sustained a hematoma to the left side of the head (damaged blood vessels surrounding the tissue). (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/25/25 at 2:00 P.M., CMT A said he/she is agency staff and had been with the facility as needed since July 2024. CMT A said that in the past he/she had received education and training on working with mental health residents. CMT A said on 02/06/25, Resident #2 asked for his/her medications too early. The CMT said he/she told Resident #2 it was not time for his/her medications yet. CMT A said getting his/her medications is a trigger for Resident #2 and he/she became very threatening toward the CMT after he/she told the resident he/she was unable to provide the medications. CMT A said he/she removed himself/herself from the situation by hiding in the closet. CMT A said he/she did not know if CNA B and LPN C would be able to handle Resident #2 if he/she escalated in behaviors, because Resident #2 is large and can be very aggressive. CMT A said he/she hid in hopes to de-escalate the resident by removing himself/herself from the situation quickly. CMT A said he/she peeked out of the closet and saw Resident #2 enter Resident #1's room. CMT A heard Resident #1 yelling for help. LPN C and CNA B stood at least two room doors away and did not attempt to stop Resident #2 from entering Resident #1's room. CMT A said the only intervention in place for Resident #2 was the one on one monitor, other than that he/she would attempt to redirect the resident. CMT A had never seen a care plan for a resident. During an interview on 02/25/25 at 3:15 P.M., LPN C said CNA B had been assigned to monitor Resident #2 in a one on one capacity due to the resident's history of aggressive behaviors toward other residents. Resident #2 asked CMT A for a medication and CMT A told the resident it was too early. Resident #2 became agitated. When Resident #2 started to walk down the hallway, he/she and CNA B followed. LPN C said they watched Resident #2 standing at the doorway to Resident #1's room and they stood back down the hall to provide the resident space and not approach him/her. LPN C said they were hoping if Resident #2 had some space he/she would de-escalate. LPN C did not know what interventions Resident #2 was care planned for. They were two rooms behind Resident #2 observing, when Resident #2 ran into Resident #1's room and hit Resident #1. LPN C said he/she and CNA B then ran toward Resident #1's room and stopped Resident #2 from hitting Resident #1 again. LPN C said when Resident #2 had become agitated the staff should have intervened to protect Resident #1 by attempting to redirect Resident #2 away from Resident #1's room. LPN C said he/she had received training on de-escalating a resident. LPN C did not say why he/she did not intervene and attempt to de-escalate Resident #2 before he/she struck Resident #1. LPN C said he/she did not try to engage Resident #2 in any conversation about his/her favorite things or other interventions from the resident's behavioral care plan. During an interview on 02/25/25 at 4:20 P.M., CNA B said he/she is an employee of the facility and not agency staff. CNA B said he/she had been assigned to monitor Resident #2 one on one, on 2/06/2025 due to the resident's history of hitting other residents in the head. Resident #2 was agitated due to not getting the medication he/she requested. Resident #2 started down B Hall while he/she and LPN C followed, but not too closely. He/she said they stood about two rooms away hoping Resident #2 would step back and away from Resident #1's room. CNA B said Resident #2 stood at the doorway of Resident #1's for awhile then raised his/her arms and took off toward Resident #1 striking him/her in the head. CNA B said he/she and LPN C then ran toward Resident #1's room and heard him/her screaming. They intervened and stopped Resident #2 from striking the resident again. He/she did not say why they were not closer to Resident #1. CNA B said he/she had received training on redirection and de-escalation, but did not use any verbal redirection with Resident #2. CNA B did not say why he/she or LPN C did not attempt to stop Resident #2 from striking Resident #1 the first time nor did he/she say why he/she did not attempt any of the interventions listed in the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265704	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Perryville, Llc, The	430 North West Street Perryville, MO 63775

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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/25/25 at 9:45 A.M., the Administrator (ADM) said facility staff receive training on de-escalation methods twice monthly. However, the facility currently has in house staffing issues and rely on agency staff. The ADM said he cannot force agency staff to participate in facility training. The ADM said they have invited the agency staff to all trainings, but they do not come. He said that he had called the agency to see if they could be made to attend and no one returned the call. He would expect all staff to protect the residents. The ADM said he expected the staff, CNA B and LPN C, to have stopped Resident #2 from hitting Resident #1. CNA B and LPN C are not agency staff and should have called for assistance if they felt they could not handle Resident #2. The ADM said on 02/06/25, Resident #2 was already being monitored one on one for previous aggressive behaviors. He was unsure what other interventions were in place for Resident #2. The ADM said they were doing the best they could, but staff seemed to be scared of Resident #2. The ADM said he was unsure how care plan information was shared with staff. 2. Review of the facility's investigation, dated 02/08/25, showed: - Resident #1 was removed from the B Hall after an incident involving Resident #2; - Resident #1 did not want to leave B Hall and went back to B Hall during the evening hours to go to his/her old room; - Staff members LPN D and CNA E approached the resident and attempted to get Resident #1 redirected to his/her new hall; - Resident #1 sat in the floor and refused to get up; - Resident #1 continued to refuse to leave the B hall and laid in the floor while staff attempted to pull him/her to a standing position; - LPN D then placed a blanket on the floor and physically rolled Resident #1 onto the blanket; - LPN D and CNA E dragged the blanket and Resident #1 on the floor down B hall, through the lobby to his/her new room on A Hall. During an interview on 3/6/2025 at 10:20 A.M., CNA E said he/she was an agency staff member. CNA E said prior to arriving at the facility, he/she had no idea he/she would be assigned to a behavior hall. CNA E said he/she did not know the names of any other staff. He/she received no training or policies on the Behavior Hall, a secured unit. During the evening, Resident #1 came onto the B hall and said his/her room was there. The other staff members on the hallway told the resident that he/she needed to return to the A hall where the resident had been relocated to earlier that day. The resident sat on the floor and wanted to remain there. The resident was not causing any problems or having any behaviors. The resident did refuse to go to his/her new room and was wanting to return to the old room he/she had been in prior to the relocation. The charge nurse, LPN D, came to the B hall and told the resident he/she had to leave. CNA E said he/she requested multiple times to allow the resident to just remain on the floor and calm down and then redirect. LPN D got a blanket to put on the floor, rolled the resident onto the blanket and instructed CNA E to grab a corner and pull. LPN D drug the resident through the hallway to the A hallway. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265704	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of Perryville, Llc, The	430 North West Street Perryville, MO 63775

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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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/6/2025 at 11:30 A.M., LPN D said he/she was agency staff brought in with no information regarding working a behavior unit. He/she was not given any policies or protocols, and did not have time to become familiar with residents prior to starting job duties. LPN D did not know Resident #1 had only been moved earlier that day and did not know the resident was at risk for elopement. On 02/06/2025 Resident #1 left his/her current hall and entered B hall. Staff from B hall called him/her to assist with Resident #1. Resident #1 was sitting in the hallway asking to go in his/her old room. Staff on B hall, unknown to LPN D, were attempting to get the resident to stand up and the resident laid in the floor. LPN D said he/she tried to redirect. The B hall staff said the resident had been attacked earlier by another resident who still was on B hall and it was not safe for Resident #1 to be there. LPN D said he/she attempted to reach the facility's Director of Nurses and on call staff and no one answered. He/she decided that the resident needed to be moved to ensure his/her's safety. He/she used the fireman blanket transfer (a blanket used to transfer people in emergency situations safely) to move the resident safely. The resident was rolled onto the blanket. LPN D then had CNA E assist in dragging the blanket from the unit on Hall B, through the lobby to A hall. The resident was anxious and appeared nervous, after being drug through the facility but was not yelling or being aggressive. LPN D felt it was the only way to ensure the resident was safe. During an interview on 02/25/25 at 9:45 A.M., the ADM said the facility currently has in house staffing issues and rely on agency staff. The facility has requested the agency staff to attend in-servicing but they have in the past refused. The two staff who put Resident #1 on a blanket and drug him/her through the facility were agency staff. The ADM did not know how their policies were communicated to agency staff. The ADM said in this situation, he would expect staff to attempt to redirect and if not possible to sit with the resident until they calm down. Complaint #MO249378 NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).