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	07/09/2025

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when another resident (Resident #2) open handed slapped the resident, in the face three times. Resident #2 said Resident #1 had behaviors that bothered him/her and hit Resident #1 repeatedly. Resident #1 sustained contusions, redness, and swelling to the right side of his/her face and was sent to the Emergency Department (ED) by ambulance. The facility census was 103.Review of the facility's policy titled, Abuse, Neglect and Exploitation, 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. Review of Resident #1's medical record showed:The resident was own responsible party;Diagnoses of major depressive disorder (a mental disease characterized by persistent sadness), post traumatic stress disorder (PTSD - a mental health condition that can develop after experiencing or witnessing a traumatic event), Alzheimer's disease (a progressive disease causing loss of cognitive function), traumatic brain injury (TBI - a brain injury caused by physical force or a blow to the head that can affect a person's cognitive function), and paranoid schizophrenia (a mental disorder characterized by disruptions in thought, perception and behavior. Specifically marked by symptoms of paranoia, delusions and hallucinations). Review of the resident's Physician Order Sheet (POS), dated July 2025, showed:An order for Geodon (an antipsychotic medication - used to treat mental health conditions characterized by psychosis) 40 milligram (mg) two times daily, dated 06/05/24;An order for lorazepam (an antianxiety medication) 1 mg three times daily, dated 06/05/25;An order for risperidone (an antipsychotic medication) 2 mg two times daily, dated 12/18/23;An order for venlafexine (an antidepressant medication) 75 mg two times daily, dated 06/05/25. Review of the resident's Care Plan, dated 07/09/25, showed:Requires a supervised environment and supervision with all activities of daily living (ADL) care;Will become physically and verbally aggressive when not getting what he/she asks for and will scream when staff attempt to de-escalate;Psychiatry to follow up and prescribe/manage medications;Smokes and will yell when wanting to smoke if not allowed to do so, this is his/her repetitive behavior;Has intellectual disabilities;Will ask others for money or cigarettes, including staff and other residents;The care plan did not address interventions to manage the resident's escalating behaviors. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/12/25, showed:Some cognitive inabilities; Behaviors of agitation and cursing when upset;Required supervision with all ADLs. Review of the resident's ED medical record, dated 07/06/25, showed:Was treated for assault;Had contusions to the face and right side of the head;Received a new order for Tylenol for pain as needed. Review of Resident #2's medical record showed:The resident had a guardian;Diagnoses of major depressive disorder, schizoaffective disorder bipolar type (a mental disorder characterized by both schizophrenia and a mood disorder - meaning a person may experience psychotic symptoms like hallucinations or delusions along with episodes or mania or depression), impulse disorder (a mental health condition that makes it difficult to control or resist urges which can cause harmful or socially unacceptable behaviors), and anxiety. Review of the resident's POS, dated July 2025, showed:An order for risperidone 4 mg daily at bedtime, dated 04/04/25;An order for Zyprexa (an antipsychotic medication) 10 mg twice daily, dated 04/04/25. Review of the resident's Care Plan, dated 07/04/25, showed:Has a history of racing thoughts, mood instability, agitation, impulse anger issues, paranoia and assaultive behaviors;Has a history of destroying things when getting upset;Has a history of striking other residents;Incarcerated a number of times due to aggressive behaviors;Intervention of staff to attempt to de-escalate the situation and give one-on-one visits and education on coping skills. Review of the resident's annual MDS, dated [DATE], showed:Has a history of disorganized thinking and illogical flow of ideas; Poor judgement and decision making;Delusional and aggressive when upset;Would destroy things when upset. Review of the facility's investigation for the incident on 07/06/25 showed:Resident #1 ran up to Licensed Practical Nurse (LPN) A and said he/she had been struck in the face multiple times by Resident #2. Resident #2 ran up and told LPN A Resident #1 had been asking for money and he/she had gotten tired of it and hit Resident #1;The incident was unwitnessed by any staff;Resident #1 had a red swollen face and was