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	09/11/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review and interview the facility failed to provide adequate supervision for one of three sampled residents. Resident #1 was assessed as needing 24-hour supervision for safety and had a history of making suicidal threats/ideations and aggression towards others and staff. The resident exited the facility's secured behavioral unit without staff knowledge and was gone for approximately 12 hours. Facility staff failed to implement the facility policy for rounding and making observations of residents. While away from the facility, the resident used a broken piece of glass and attempted suicide by inserting it into her skull. The facility census was 100.The administration was notified on 09/11/25 of the Past Non-Compliance Immediate Jeopardy (IJ) which occurred 09/06/25. Upon notification of the elopement on 09/06/25, the facility administration immediately started an investigation and notified the Department of Health and Senior Services of the elopement. The facility installed new window modifications to prevent residents from removing the glass and in-serviced all staff on the facility's policy and procedures for making rounds. The IJ was corrected on 09/06/25. Review of the facility's Rounding Policy, dated 02/24/24, showed:- All residents have the right to be cared for in a safe environment. Rounding will be ensured all resident needs are being addressed and proper supervision is occurring;- Rounds are completed every two hours unless directed by the charge nurse;- Rounds must be made at the beginning and ending of each shift ensuring physically walking into each room and physically seeing each resident;- To be proactive in our care, staff need to be rounding each hour, so the residents use the call lights less, you have less interruptions during your day and the residents are much happier. 1. Review of Resident #1's Level II Preadmission Screening and Resident Review (PASRR) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated 03/02/23, showed:- Requires 24-hour supervision for safety, fall risk;- History of physical behaviors;- Monitoring of behavioral symptoms;- Provision of behavioral support;- Assess and plan for the level of supervision required to prevent harm to self and others;- History of suicidal threats and ideations. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated 04/24/24 showed:- Diagnoses of schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia, such as hallucinations and delusions, with symptoms of a mood disorder, like bipolar disorder or depression), personality disorder (personality disorder is a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), impulse disorder (a mental health condition where a person cannot resist the urge to perform an act that is harmful to themselves or others), major depressive disorder (a mood disorder characterized by persistent feelings of sadness, hopelessness, or a loss of interest or pleasure in daily activities, lasting for at least two weeks), and anxiety (excessive fear, worry, and related behavioral disturbances that interfere with daily life);- Cognition intact;- Supervision of staff for activities of daily living;- Rejection of care and evaluation 4-6 days a week;- Ambulates independently. Review of the resident's Care Plan dated 01/21/24, showed:- Resident has a history of making suicidal threats and ideations related to depression;- History of refusals to eat, take medications, or be assessed;- History of verbal and physical aggression towards others and staff;- History of delusions. Review of the facility Self-Report form, dated 09/09/25 regarding Resident #1, showed: - On 09/06/25, police arrived at the building at approximately 8:30 A.M. responding to another resident situation. As Licensed Practical Nurse (LPN) A was walking the police to D Hall secured unit, he/she received a call about a person that was found on the outside of a local store. The officer's exact words he/she has been here (at the store) all night. LPN A asked the officer the name of the individual that had been found, and the officer responded with Resident #1's name. LPN A confirmed that he/she was a resident of facility. LPN A immediately checked Resident #1's room. LPN A contacted the Assistant Director of Nursing (ADON) that Resident #1 had exited the facility sometime the previous night. The ADON contacted the Administrator. Resident #1 had eloped from the facility. Staff initiated a head count on D-hall and the entire building which determined Resident #1 was missing and all other residents were accounted for. The ADON confirmed with the responding officer that Resident #1 arrived at a local liquor store via security camera footage at 3:24 A.M. on 09/06/25. The resident slept on the concrete in-front of the building. The store clerk arrived at 7:00 A.M. The store clerk went back outside at 8:00 A.M. to speak with the resident. The store clerk contacted local police who arrived at the liquor store at approximately 8:24 A.M. Resident #1 informed the police that he/she broke out of the facility to go for a walk and had been walking around the area for a while, before arriving at the liquor store.