STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026

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 0552

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are fully informed and understand their health status, care and treatments.

Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, before beginning psychotropic medications (medications that affect the mind, emotions, and behavior) for 11 residents (Residents #2, #3, #4, #6, #8, #13, #30, #49, #59, #73, and #90) out of 20 sampled residents. The facility census was 98. Review of the facility's policy titled, Use of Psychotropic Drugs, reviewed 08/24/24, showed:

- Residents who have not used antipsychotic (medication primarily used to manage psychosis (a mental disorder with a severe loss of contact with reality)) drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record;

- Residents who use antipsychotic drugs will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue use of these drugs;

- With the physician as the leader, and in collaboration with a pharmacist and other members of the interdisciplinary team, each resident's drug regimen will be reviewed on a monthly basis, taking into consideration of the dose, duration of use, indications for use, presence of adverse consequences which indicate the dose should be reduced or discontinued, and non-pharmacological interventions (such as behavioral interventions);

- Each resident will receive the lowest possible dose and for the shortest period of time necessary for treating his or her condition or to improve the target symptoms being monitored;

- After initiating or increasing the dose of an antipsychotic drug, the behavioral symptoms will be reevaluated at least quarterly during the review to determine the effectiveness of the antipsychotic drug and the potential for reducing or discontinuing the dose based on target symptoms and any adverse effects or functional impairment;

- If the antipsychotic drug is identified as probably causing or contributing to adverse consequences, risks and benefits will be considered in the decision-making process regarding the continuation, reduction or discontinuation of the antipsychotic drug;

- Decisions and rationale will be documented in the medical record.

1. Review of Resident #2's medical record showed:

- An admission date of 05/10/23;
(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: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Estates of Perryville, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), major depressive disorder (a serious mental health condition characterized by at least two weeks of persistent, pervasive low mood, loss of interest, and low self-esteem), anxiety disorder (common, treatable mental health conditions characterized by excessive, persistent fear or worry that interferes with daily life), impulse disorder (mental health conditions characterized by an inability to resist urges, resulting in repetitive, harmful behaviors like gambling, stealing, or violence), and schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia (a chronic brain disorder with symptoms that can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation) symptoms such as hallucinations, delusions, and disorganized thinking, and a major mood disorder); - An order for Risperdal (an antipsychotic medication) 4 milligrams (mg) by mouth at bedtime for schizoaffective disorder, dated of 12/29/25; - An order for Zyprexa (an antipsychotic medication) 10 mg by mouth every morning and at bedtime for schizoaffective disorder, dated of 12/29/25; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Risperdal and Zyprexa. 2. Review of Resident #3's medical record showed: - An admission date of 09/26/20; - Diagnoses of schizoaffective disorder, major depressive disorder, and generalized anxiety disorder; - An order for quetiapine (an antipsychotic medication) 50 mg by mouth three times a day for major depressive disorder, dated of 02/04/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the quetiapine. 3. Review of Resident #4's medical record showed: - An admission date of 02/19/26; - Diagnoses of major depressive disorder, dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs); - An order for bupropion (an antidepressant medication) 12 hour extended release (ER) 200 mg by mouth in the morning for depression, dated 02/20/26; - An order for Zyprexa 5 mg 1.5 tablet by mouth at bedtime for bipolar disorder and agitation, dated 02/19/26; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for trazodone (an antidepressant medication) 100 mg by mouth at bedtime for depression, dated 02/19/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the bupropion, Zyprexa, and trazodone. 4. Review of Resident #6's medical record showed: - An admission date of 08/16/22; - Diagnoses of schizophrenia, generalized anxiety disorder, and Parkinson's disease (a movement disorder of the nervous system that worsens over time); - An order for haloperidol (an antipsychotic medication) 1 mg by mouth every eight hours as needed for generalized anxiety disorder, dated of 02/13/26; - An order for Zyprexa 15 mg by mouth at bedtime for schizophrenia, dated 03/08/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the haloperidol and Zyprexa. 5. Review of Resident #8's medical record showed: - An admission date of 04/04/25; - Diagnoses of attention deficit hyperactivity disorder (a common developmental disorder marked by persistent inattention, hyperactivity, and impulsivity that begins in childhood and can continue into adulthood), schizophrenia, narcissistic personality disorder (a mental health condition marked by an excessive sense of self-importance, a deep need for admiration, and a profound lack of empathy for others), autistic disorder (a condition related to brain development that affects how people see others and socialize with them), and bipolar type schizoaffective disorder; - An order for Zyprexa 5 mg by mouth two times a day for depression, dated of 03/10/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Zyprexa. 6. Review of Resident #13's medical record showed: - An admission date of 11/03/25; - Diagnoses of schizophrenia, anxiety, and cerebral infarction (lack of blood flow to brain); - An order for Risperdal 1 mg by mouth one time a day related to schizophrenia and anxiety, dated 11/04/25; (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Keppra (an antiseizure medication also used as a mood stabilizer) 750 mg two tablets by mouth two times a day related to schizophrenia and cerebral infarction (stroke), dated 11/03/25; - An order for quetiapine 25 mg by mouth two times a day related to schizophrenia and anxiety, dated 11/03/25; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Keppra and quetiapine. 7. Review of #30's Physician Order Sheet (POS) showed: - An admission date of 02/16/26; - Diagnoses of suicidal ideations, insomnia, and major depressive disorder, recurrent, severe, with psychotic symptoms; - An order for aripiprazole (an antipsychotic medication used to treat depression) 5 mg by mouth in the morning related to major depressive disorder, recurrent, severe with psychotic symptoms, dated 03/04/26; - An order for Remeron (an antidepressant medication) 15 mg by mouth in the evening for major depressive disorder, recurrent, moderate, dated 02/16/26; - An order for trazodone 50 mg 0.5 tab by mouth at bedtime for insomnia, dated 02/16/26; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the aripiprazole, Remeron, and trazodone. During an interview on 03/08/26 at 12:30 P.M., Resident #30 said he/she did not recall the staff explaining the risks and benefits of his/her medications to him/her. 8. Review of Resident #49's medical record showed: - An admission date of 12/14/23; - Diagnoses of traumatic brain injury (a disruption in brain function caused by a blow, jolt, or penetrating head injury), major depressive disorder, anxiety, migraines, post-traumatic stress disorder (PTSD – a psychological distress following a traumatic event), cerebral infarction, and falls; - An order for Zyprexa oral tablet 10 mg by mouth at bedtime for bipolar disorder, dated 02/06/24; - An order for amitriptyline (an antidepressant medication) 25 mg by mouth at bedtime related to major depressive disorder, dated 02/05/26; - An order for Lamictal (an antiseizure medication also used as a mood stabilizer) 100 mg by mouth one time a day related to impulsiveness and unspecified convulsions (define), dated 04/15/23; (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Zoloft 50 mg by mouth one time a day related to major depressive disorder, dated 11/07/25; - An order for divalproex (an antiseizure medication also used as a mood stabilizer) delayed release 500 mg two tablets by mouth twice a day for seizures and mood, dated 02/06/24; - An order for Keppra 750 mg by mouth two times a day related to convulsions, dated 11/01/23; - An order for gabapentin (an antiseizure medication) 600 mg by mouth three times a day related to diseases of the nervous system, dated 04/15/23; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the amitriptyline, Lamictal, Zoloft, divalproex, Keppra, and gabapentin. 9. Review of Resident # 59's medical record showed: - An admission date of 02/03/25; - Diagnoses of schizophrenia, mild intellectual disability, intermittent explosive disorder (define), bipolar disorder, anxiety, visual hallucinations, agitation and restlessness; - An order for Uzedy (an antipsychotic medication) 125 mg/0.35 milliliters (ml) 125 mg subcutaneously (injection under the skin) one time a day every 28 days related to schizophrenia, 08/13/25; - An order for olanzapine 20 mg by mouth one time a day related to schizophrenia, dated 01/17/25; - An order for paroxetine (an antidepressant medication) 40 mg by mouth one time a day related to bipolar disorder, dated 04/24/24; - An order for lorazepam (an antianxiety medication) 1 mg by mouth three times a day for anxiety, dated 10/06/25; - An order for valproic acid (an antiseizure medication also used as a mood stabilizer) 250 mg/5ml 5ml by mouth three times a day related to visual hallucinations, dated 04/24/24; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the Uzedy, olanzapine, paroxetine, lorazepam, and valproic acid. 10. Review of Resident #73's medical record showed: - An admission date of 11/05/25; - Diagnosis of depressive type schizoaffective disorder; - An order for haloperidol 10 mg by mouth three times a day for schizoaffective disorder, dated of 11/06/25; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for Invega (an antipsychotic medication) 234 mg/1.5 ml inject intramuscularly (an injection into the muscle) in the afternoon monthly on the 25th for schizoaffective disorder, dated 11/25/25; - An order for Invega extended release 9 mg by mouth in the morning for schizoaffective disorder, dated 11/06/25; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the haloperidol and Invega. 11. Review of Resident #90's medical record showed: - An admission date of 11/14/22; - Diagnoses of delusional disorder (a psychiatric condition characterized by a person having one or more fixed false beliefs), bipolar disorder, dementia, and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs); - An order for divalproex 125 milligram (mg) by mouth three times a day related to bipolar disorder, dated 01/03/23; An order for fluoxetine (an antidepressant medication) 20 mg by mouth one time a day related to bipolar disorder, dated 01/03/23; An order for olanzapine 5 mg by mouth one time a day related to bipolar disorder, dated 01/19/23; - No documentation of consents or education of risks and benefits were provided to the resident and/or their representative for the divalproex, fluoxetine, and olanzapine. During an interview on 03/11/26 at 1:30 P.M., Resident #90 said he/she did not remember anyone reviewing the risks and benefits of his/her medications with him/her. During an interview on 03/11/26 at 4:05 P.M., Licensed Practical Nurse (LPN) A said the nurse practitioner would review risks and benefits of a medication with a resident. He/She had never had a resident sign anything saying they understood the risks or benefits of a medication. During an interview on 03/11/26 at 4:25 P.M., LPN C said he/she told the residents the risks and benefits of their medication if they asked, but the doctor or nurse practitioner reviewed that with the resident before they prescribed a new medication. He/She never had residents sign anything stating they understood the risks or benefits of a medication. During an interview on 03/11/26 at 5:56 P.M., the Director of Nursing (DON) and the Administrator said they would expect residents and/or the resident representatives be informed of the risks and benefits of their medications and have informed consents for the psychotropic medications.

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NAME OF PROVIDER OR SUPPLIER Estates of Perryville, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for two residents (Residents #11 and #13) out of 20 sampled residents and for one resident (Resident #88) outside the sample. The facility census was 98. Review of the facility's policy titled, MDS Policy, reviewed 08/02/24, showed: - The Resident Assessment Instrument (RAI) Manual serves as the policy by which the facility follows the process of completing MDS assessments. Review of the RAI Manual, dated October 2025, showed: - J1400: Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services; - Code all high-risk drug class medications according to their pharmacological classification, not how they are being used; - Code any type of CPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized through a mask or other device continuously or via electronic cycling throughout the breathing cycle. 1.Review of Resident #11's medical record showed: - admitted on [DATE]; - Diagnosis of atrial fibrillation (a heart condition that causes an irregular heartbeat, increasing risks of blood clots); - An order for apixaban (an anticoagulant medication used to prevent and treat blood clots) 5 milligrams (mg) by mouth two times per day for atrial fibrillation; - No order for an antiplatelet (a class of medication used to prevent blood clots). Review of the resident's admission MDS, dated [DATE], showed: - No use of an anticoagulant; - Routine use of an antiplatelet. 2. Review of Resident #13's medical record showed: - admitted on [DATE]; (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of obstructive sleep apnea (condition causing difficulty breathing or periods of not breathing at times); - An order for continuous positive airway pressure (CPAP - medical equipment to assist with breathing and a non-invasive mechanical ventilator) machine at bedtime, dated 11/04/25. Review of the residents quarterly MDS, dated [DATE], showed: - The resident did not require a non-invasive mechanical ventilator. 3. Review of Resident #88's medical record showed: - admitted on [DATE]; - No order for hospice. Review of the resident's annual MDS, dated [DATE], showed: - Resident received hospice. During an interview on 03/11/26 at 4:24 P.M., the MDS Coordinator said the MDS assessment should accurately reflect the resident's current condition at the time of the assessment. Resident #13 should have been coded for the non-invasive mechanical ventilation. Anticoagulants should have been coded on the MDS correctly for Resident #11, and Resident #88 was never on hospice. During an interview on 03/11/26 at 6:00 P.M., the Administrator and the Director of Nursing (DON) said they would expect the MDS to accurately reflect the resident's condition at the time of the assessment.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive care plan with specific interventions tailored to meet individual needs for two residents (Residents #4 and #13) out of 20 sampled residents. The facility census was 98.Review of the facility's policy titled, Care Plan and Care Plan Conference, dated 08/24/24, showed:- A care plan shall be used in developing the resident's daily care routine and will be available to the team for review to ensure the best person-centered care is provided to our residents; - A comprehensive care plan will be generated through collaboration with the interdisciplinary team, resident, and responsible party, to be completed by the 21st day of admission;- The care plan will reflect a problem, goal, and interventions to guide the interdisciplinary team to assist the resident in achieving the desired outcome for a specific problem. 1. Review of Resident #4's medical record showed:- admitted on [DATE];- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), bipolar (a mental disorder that causes unusual shifts in mood), major depressive disorder (MDD - a long-term loss of pleasure or interest in life), and asthma (condition making breathing more difficult);- History of self-harm/suicide attempts. Review of the resident's Care Plan, last revised 03/02/26, showed:- Did not address the history of self-harm/suicide attempts with specific goals and interventions;- Did not address dementia with specific goals and interventions;- Did not address bipolar with specific goals and interventions;- Did not address asthma with specific goals and interventions. During an interview on 03/10/26 at 3:10 P.M., Resident #4 said he/she had attempted suicide three times in the past. During an interview on 03/11/26 at 10:46 A.M., Certified Nurse Aide (CNA) B said he/she did not know about Resident #4's past or any interventions in place. During an interview on 03/11/26 at 10:35 A.M., Licensed Practical Nurse (LPN) A said he/she did not know about Resident #4's past. 2. Review of Resident #13's medical record showed:- admitted on [DATE];- Diagnosis of obstructive sleep apnea (condition causing difficulty breathing or periods of not breathing at times);- An order for continuous positive airway pressure (CPAP - medical equipment to assist with breathing) machine at bedtime. Review of the resident's Care Plan, revised 01/07/26, showed:- Did not address obstructive sleep apnea with use of a CPAP. During an interview on 03/11/26 at 6:05 P.M., the Director of Nursing (DON) and the Administrator said anything pertinent to a resident's care should be included in the care plan, and that the care plan should be revised as needed, but at least quarterly.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders when administering medications for five residents (Residents #4, #17, #30, #49, and #86) out of 12 residents. The facility census was 98.Review of the facility policy titled, Physician Orders, dated 08/24/24, showed: - Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Medication Technicians (CMT) are expected to review orders prior to administering medications and/or performing a treatment; - The RNs, LPNs, and CMTs are to follow the orders as written. 1. Review of Resident #4's medical record showed: - admitted on [DATE]; - Diagnosis of hypertension (high blood pressure); - An order for clonidine (a blood pressure medication) 0.1 milligrams (mg) by mouth four times a day for hypertension. Hold for a systolic blood pressure (SBP - the top number in a blood pressure reading, measuring the force against artery walls when the heart contracts) less than 120. Hold for a diastolic blood pressure (DBP - the bottom/lower number in a blood pressure reading, measuring pressure in the arteries while the heart relaxes between beats) lower than 80, dated 02/20/26. Review of the resident's Medication Administration Record (MAR), dated February 2026 - March 2026, showed: - For February 2026, the clonidine was not administered correctly according to the physician orders on 02/22/26 at 8:00 A.M. - 146/76 (administered), 02/22/26 at 12:00 P.M. - 142/72 (administered), 02/22/26 at 9:00 P.M. - 132/70 (administered), 02/28/26 at 8:00 A.M. - 100/74 (administered), and 02/28/26 at 12:00 P.M. - 100/74 (administered); - For March 2026, the clonidine was not administered correctly according to the physician orders on 03/03/26 at 9:00 P.M. - 126/76 (administered), 03/04/26 at 4:00 P.M. - 117/63 (administered), 03/06/26 at 12:00 P.M. - 112/68 (administered), 03/06/26 at 4:00 P.M. - 102/64 (administered), 03/07/26 at 12:00 P.M. - 96/56 (administered), and 03/09/26 at 9:00 P.M. - 133/81 (withheld); - A total of 11 doses the medication was administered incorrectly out of 72 doses. During an interview on 03/11/26 at 10:35 A.M., LPN A said if a resident's SBP or the DBP was inside the ordered parameters, then the medication should be given as ordered. If the SBP or the DBP was outside of the ordered parameters, then the medication should be withheld as ordered. If a resident's order did not have parameters and the staff had a blood pressure medication to administer with a questionable blood pressure, then staff would be expected to hold the medication and talk to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

nurse to see if the medication still needed to be held or if the physician needed to be contacted for further instructions.

2. Review of Resident #17's medical record showed:

- An admission date of 11/03/25;

- Diagnoses of congestive heart failure (a chronic, progressive condition where the heart cannot pump blood efficiently, causing fluid buildup in the lungs and body) and essential hypertension (high blood pressure without a single known medical cause);

- An order to monitor the blood pressure prior to the blood pressure medication administration. Hold if the SBP less than 90 or the DBP less than 60, dated 11/04/25;

- An order for losartan (a blood pressure medication) 25 mg by mouth in the morning for hypertension, dated 11/04/25;

- An order for metoprolol (a blood pressure medication) 25 mg 0.5 tablet by mouth two times a day for hypertension, dated 11/05/25.

Review of the resident's MAR, dated December 2025 – March 2026, showed:

- For December 2025, the losartan and metoprolol were not administered correctly according to the physician orders on 12/03/25 morning doses - 121/73 (withheld), 12/04/25 morning doses - 125/80 (withheld), 12/05/25 morning doses - 106/70 ; (withheld) 12/09/25 morning doses - 114/77 (withheld), 12/10/25 morning doses - 112/71 (withheld), 12/14/25 morning doses - 122/77 (withheld), 12/15/25 morning doses - 117/77 (withheld), 12/21/25 morning doses - 112/63 (withheld), and 12/25/25 morning doses - 94/69 (administered);

- For January 2026, the losartan and metoprolol were not administered correctly according to the physician orders on 01/16/26 morning doses - 120/84 (withheld), 01/19/26 morning doses - 108/68 (withheld), 01/20/26 morning doses - 122/70 (withheld), 01/21/26 metoprolol morning dose - 121/89 (withheld), 01/23/26 morning doses - 123/81 (withheld), 01/26/26 morning doses - 94/60 (withheld), 01/27/26 morning doses - 135/93 (withheld), 01/28/26 morning doses - 113/69 (withheld), and 01/30/26 morning doses - 100/64 (withheld);

- For February 2026, the losartan and metoprolol were administered incorrectly according to the physician orders on 02/01/26 morning doses - 115/60 (withheld), 02/04/26 morning doses - no blood pressure documented (withheld), and 02/26/26 metoprolol evening dose - 132/81(withheld);

- For March 2026, the losartan and metoprolol were not administered correctly according to the physician orders on 03/01/26 morning doses – 116/92 (withheld) and the metoprolol evening dose – 116/93 (withheld), 03/05/26 metoprolol evening dose - 111/74 (withheld), and 03/11/26 morning doses - 134/83 (withheld);

- A total of 45 doses the medications were administered incorrectly out of 302 doses.
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Estates of Perryville, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #30's medical record showed: - admitted [DATE]; - Diagnosis of hypertension; - An order for lisinopril (a blood pressure medication) 20 mg by mouth in the morning, hold if SBP less than 90 or DBP less than 60, dated 02/04/25. Review of the resident's MAR, dated January 2026 - March 2026, showed: - For January 2026, the lisinopril was not administered correctly according to the physician orders on 01/02/26 - 121/72 (withheld), 01/05/26 - 115/68 (withheld), 01/08/26 - 132/85 (withheld), 01/09/26 - 96/68 (withheld), 01/12/26 - 120/77 (withheld), 01/14/26 - 135/93 (withheld), 01/16/26 - 114/70 (withheld), 01/18/26 - 136/89 (withheld), - 131/74 (withheld), 01/20/26 - 134/82 (withheld), 01/26/26 - 114/82 (withheld), 01/28/26 - 119/79 (withheld), and 01/30/26 for - 131/82 (withheld); - For February 2026, the lisinopril was not administered correctly according to the physician orders on 02/01/26 - 133/66 (withheld), 02/04/26 - 134/84 (withheld), 02/11/26 - 123/85 (withheld), 02/12/26 - 112/72 (withheld), 02/13/26 - 117/68 (withheld), 02/16/26 - 121/69 (withheld), 02/17/26 - 111/68 (withheld), 02/24/26 - 117/69 (withheld), and 02/26/26 - 123/69 (withheld); - For March 2026, the lisinopril was not administered correctly according to the physician orders on 03/03/26 - 115/75 (withheld), 03/04/26 - 120/75 (withheld), 03/05/26 - 131/76 (withheld), 03/09/26 - 117/75 (withheld), and 03/11/26 - 116/84 (withheld); - A total of 27 doses the medication was administered incorrectly out of 70 doses. 4. Review of Resident #49's medical record showed: - admitted on [DATE]; - Diagnosis of hypertension; - An order for propranolol (a blood pressure medication) 10 mg by mouth two times a day. Hold if SBP less than 90, DBP less than 60, or the heart rate is less than 60, dated 01/15/25 and discontinued 02/10/26; - An order for propranolol 10 mg by mouth one time a day, dated 02/06/26; - An order to monitor the blood pressure prior to the blood pressure medication administration. Hold the medication for a SBP less than 90 or a DBP is less than 60. Monitor the blood pressure three times a day for low blood pressure, dated 01/08/26. Review of the resident's MAR, dated December 2025 - March 2026, showed: (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	03/11/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For January 2026, the propranolol was not administered correctly according to the physician orders on 01/24/26 at 9:00 A.M. - 90/60 (withheld), 01/25/26 at 9:00 A.M. - 98/60 (withheld), 01/26/26 at 9:00 A.M. - 99/62 (withheld), 01/27/26 at 9:00 A.M. - 101/71 (withheld), 01/30/26 at 6:00 P.M. - 96/70 (withheld), and 01/31/26 at 6:00 P.M. - 96/60 (withheld); - For February 2026, the propranolol was not administered correctly according to the physician orders on 02/01/26 at 9:00 A.M. - 98/61 (withheld), 02/04/26 at 6:00 P.M. - 89/65 (administered), 02/05/26 at 6:00 P.M. - 99/64 (withheld), 02/06/26 at 6:00 P.M. - 144/102 (withheld), 02/09/26 at 9:00 A.M. - 112/68 (withheld), 02/10/26 at 9:00 A.M. - 119/88 (withheld), 02/11/26 at 9:00 A.M. - 111/86 (withheld), 02/12/26 at 9:00 A.M. - 114/66 (withheld), 02/13/26 at 9:00 A.M. - 99/68 (withheld), 02/16/26 at 9:00 A.M. - 116/67 (withheld), 02/17/26 at 9:00 A.M. - 111/89 (withheld), 02/18/26 at 9:00 A.M. - 115/84 (withheld), and 02/22/26 at 9:00 A.M. - 100/66 (withheld); - For March 2026, the propranolol was not administered correctly according to the physician orders on 03/01/26 at 9:00 A.M. - 108/70 (withheld) and 03/02/26 at 9:00 A.M. - 111/75 (withheld); - A total of 21 doses the medication was administered incorrectly out of 202 doses. 5. Review of Resident #86's medical record showed: - An admission date of 12/02/22; - Diagnosis of essential hypertension; - An order to monitor the blood pressure prior to blood pressure medication administration, hold if SBP less than 90 or DBP less than 60, dated 03/12/25; - An order for atenolol 25 mg by mouth daily for essential hypertension, dated 08/27/24 and discontinued 12/15/25; - An order for atenolol 25 mg 0.5 tablet daily for essential hypertension, dated 12/16/25. Review of the resident's MAR, dated December 2025 – March 2026, showed: - For December 2025, the atenolol was not administered correctly according to the physician orders on 12/02/25 - 108/72 (withheld), 12/05/25 - 108/68 (withheld), 12/09/25 - 118/68 (withheld), 12/12/25 - 105/91 (withheld), 12/14/25 - 90/75 (withheld), 12/15/25 - 119/82 (withheld), 12/16/25 - 105/70 (withheld), 12/17/25 - 101/81(withheld), 12/19/25 - 127/81(withheld), and 12/30/25 - 98/76 (withheld); - For January 2026, the atenolol was not administered correctly according to the physician orders on 01/01/26 - 117/73 (withheld), 01/03/26 - 110/71 (withheld), 01/08/26 - 123/77 (withheld), 01/09/26 - 132/91 (withheld), 01/13/26 - 124/75 (withheld), 01/16/26 - 100/68 (withheld), 01/21/26 - 98/78 (withheld), 01/23/26 - 118/83 (withheld), 01/26/26 - 113/93 (withheld), and 01/30/26 - 137/77 (withheld); - For February 2026, the atenolol was not administered correctly according to the physician orders on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/01/26 - 117/64 (withheld), 02/02/26 - 122/73 (withheld), 02/03/26 - 94/69 (withheld), 02/04/26 - 121/87 (withheld), 02/11/26 - 121/80 (withheld), 02/13/26 - 124/77 (withheld), 02/17/26 - 126/60 (withheld), and 02/27/26 - 117/68 (withheld); - For March 2026, the atenolol was not administered correctly according to the physician orders on 03/04/26 - 118/78 (withheld), 03/09/26 - 126/78 (withheld), and 03/10/26 - 130/76 (withheld); - A total of 31 doses the medication was administered incorrectly out of 100 doses. During an interview on 03/11/26 at 8:06 A.M., CMT D said blood pressure medications should not be given if the SBP was less than 135 or the DBP was less than 80. It also depended on how active the resident was or if they smoke. During an interview on 03/11/26 at 9:38 A.M., CMT E said the parameters for each resident was listed under the medication administration screen. He/She said the parameters for most residents was to hold if the SBP was under 90 or the DBP was under 60. During an interview on 03/11/26 at 9:45 A.M., LPN C said a medication should not be held without an order and if a CMT thought a blood pressure was too low, the CMT was to inform the nurse assigned, and they would contact the physician if needed. During an interview on 03/11/26 at 5:56 P.M., the Director of Nursing (DON) said blood pressure medications should be held when they were outside the parameters. The physician should be called before holding medications that did not have parameters ordered. During an interview on 03/11/26 at 5:56 P.M., the Administrator said she would expect physician orders to be followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Estates of Perryville, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 36 opportunities with two errors made, for an error rate of 5.56%, which affected two residents (Residents #17 and #86) out of six sampled residents. The facility census was 98.Review of the facility policy titled, Administering Medication Policy, dated 10/07/24, showed:- Medications will be administered in a safe and timely manner, and as prescribed (ordered by a qualified practitioner);- Medications must be administered in accordance with the orders, including any required time frame;- If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing the medication shall contact the resident's physician or if a Certified Medication Technician (CMT), the charge nurse to discuss the concerns;- Vital signs must be checked or verified to each resident prior to administering medication;- If a medication is withheld, refused or given at a time other than the scheduled time, the individual administering the medication will document the rationale. 1. Review of Resident #17's Physician Order Sheet (POS), dated 03/11/26, showed:- An order to monitor the blood pressure prior to blood pressure medication administration. Hold if systolic (the top number in a blood pressure reading, measuring the force against the artery walls when the heart contracts and beats) is less than 90 or diastolic (the bottom number in a blood pressure reading, measuring the pressure in arteries when the heart rests between beats) is less than 60, dated 11/04/25;- An order for losartan (a blood pressure medication) 25 milligrams (mg) by mouth in the morning for hypertension (high blood pressure), dated 11/04/25. Observation on 03/11/26 at 7:56 A.M. of the resident's medication administration showed:- CMT D took the resident's blood pressure with a reading of 134/83;- CMT D did not administer the losartan. During an interview on 03/11/26 at 7:56 A.M., CMT D said he/she did not give the resident's losartan because the resident's blood pressure was too low. 2. Review of Resident #86's POS, dated 03/10/26, showed:- An order to monitor the blood pressure prior to blood pressure medication administration. Hold if systolic is less than 90 or diastolic is less than 60, dated 03/12/25;- An order for atenolol (a blood pressure medication) 25 mg 0.5 tablet by mouth one time a day for hypertension, dated 12/16/25. Observation on 03/10/26 at 8:26 A.M. of the resident's medication administration showed:- CMT D took the resident's blood pressure with a reading of 130/76;- CMT D did not administer the atenolol. During an interview on 03/10/26 at 8:26 A.M. CMT D said he/she did not give the resident's atenolol because the resident's blood pressure was too low. During an interview on 03/11/26 at 8:06 A.M. CMT D said he/she would hold the blood pressure medication if the resident's systolic was less than 135 or diastolic was less than 80. He/She also considered if the resident was active or a smoker. During an interview on 03/11/26 at 5:56 P.M., the Director of Nursing (DON) said she would expect medication orders to be followed, and medications held only when they fall outside the parameters set by the physician. During an interview on 03/11/26 at 5:56 P.M., the Administrator said she would expect the facility's medication error rate to be less than five percent.

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	03/11/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide palatable, attractive food at safe and appetizing temperatures for four residents (Residents #7, #25, #57, and #73) out of 20 sampled residents. This deficient practice had the potential to affect all residents in the facility. The facility's census was 99. Review of the facility's policy titled, Food Temperature Control, dated February 2024, showed:- All potentially hazardous foods will be stored, prepared, held, and served at proper temperatures;- Food temperatures will be monitored, documented, and corrective action taken when necessary;- Temperature standards for hot food: greater than or equal to 140 degrees Fahrenheit (F). Review of Resident Council Minutes dated 12/30/25, 01/27/26, and 02/24/26, showed:- No complaints regarding cold food;- Residents complained the food was overcooked, didn't like the menus, and meals were served late. During an interview on 03/08/26 at 10:14 A.M. Resident #73 said the food was not good and it was sometimes served cold. During an interview on 03/08/26 at 10:15 A.M., Resident #57 said the food was always undercooked and cold which would make him/her have to use the bathroom. During an interview on 03/08/26 at 10:53 A.M., Resident #7 said the food tasted dreadful and was always cold. During an interview on 03/08/26 at 11:11 A.M., Resident #25 said the food was often cold when it should be hot. Observation on 03/08/26 at 1:34 P.M. of the delivery of the hall trays to the D Hall from the kitchen showed:- The trays were delivered on an uncovered and unheated rolling cart;- Each plate was covered by an insulated plate cover. Observation on 03/10/26 at 1:15 PM of the delivery of the hall trays to the C Hall from the kitchen showed:- The trays were delivered on a closed and heated rolling cart;- Each plate was covered by an insulated plate cover. Observation on 03/11/26 at 9:05 A.M. of the breakfast meal test hall tray showed:- The meal tray removed from the heated rolling cart;- The meal tray was the last tray on the heated rolling cart;- The plate was covered with an insulated plate cover and the temperature of the food was:- Two poached eggs with a temperature of 94 F;- A bowl of oatmeal with a temperature of 110 F. During an interview on 03/11/26 at 3:14 P.M., the Dietary Manager said the residents had complained to her when she attended the February 2026 Resident Council meeting that the food was not hot enough. The complaints about the cold food were not documented on the February 2026 Resident Council meeting minutes. She did check the steam table temperatures and educated the staff on turning the steam table on at least an hour before putting food on it. The residents had complained the fries and tater tots were cold on the hall trays, but she didn't know what to do about that because those foods cooled off quickly. During an interview on 03/11/26 at 5:56 P.M., the Director of Nursing (DON) and the Administrator said they would expect food to be served at safe and appetizing temperatures.