STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive Saint Louis, MO 63136

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the Department of Health and Senior Services (DHSS) as required within a two-hour timeframe following a physical altercation between two residents (Residents #3 and #4), in which one resident sustained an eye injury. The sample was four. The census was 73. Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the Department of Health and Senior Services (DHSS) as required within a two-hour timeframe following a physical altercation between two residents (Residents #3 and #4), in which one resident sustained an eye injury. The sample was four. The census was 73. Review of the facility's Abuse, Neglect and Exploitation Policy, dated 4/8/24, showed the following:-Policy: Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property. 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 serving the resident, family members, legal guardians, friends or other individuals;-Policy Explanation and Compliance Guidelines:--Physical Abuse includes, but not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment;-Facility Abuse Prevention Plan:-Response and Reporting of Abuse, Neglect and Exploitation:--Anyone in the facility can report suspected abuse to the abuse agency hotline--When abuse, neglect or exploitation is suspected, the Licensed Nurse should:---Respond to the needs of the resident and protect them from further incident (document);---Notify the Administrator and Director of Nursing (DON) (document).-The policy failed to specify that allegations of abuse must be reported to the State Survey Agency immediately, but not later than two hours after the allegation is made, in accordance with federal regulations. Review of Resident #3's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/25/26, showed the following:-No cognitive impairment;-No mood or behaviors exhibited;-Diagnoses included anxiety disorder and depression. Review of the resident's care plan, dated 2/28/26, showed the following:-Problem: The resident was involved in a physical altercation with another resident related to poor impulse control, hitting a resident, and noncompliance with facility smoking rules;-Interventions: Reeducate the resident on the facility's smoking rules. Reinforce the use of coping strategies such taking deep breathing, verbalizing concerns before escalations. Review of the resident's nurse's note, dated 2/28/26 at 9:50 P.M., showed it was reported to this writer that this resident struck another resident in the eye. This writer did go and asked the resident what happened. The resident said that the other resident was trying to take his/her cigarette when he/she drooled on him/her. This resident was placed on 15-minute checks for behaviors. During an interview on 3/4/26 at 12:35 P.M., the resident said he/she and another resident were smoking a cigarette in the smoking area. Resident #4 came over and drooled on him/her and tried to take his/her cigarette. He/She pulled Resident #4 to the ground and punched him/her in the nose. Review of Resident #4's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-No moods or behaviors (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: 265712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exhibited;-Diagnoses included high blood pressure, stroke, seizure disorder, anxiety, and depression. Review of the resident's care plan, dated 3/1/26, showed the following:-Problem: The resident was involved in a resident-to-resident altercation;-Interventions: Monitor the resident for sign of agitation and emotional distress. Provide emotional support as needed. Separate the residents involved when necessary to reduce conflict. Review of the resident's nurse's notes showed the following:-On 2/28/26 at 9:28 P.M., staff documented the resident had walked up on another resident trying to take his/her cigarette. When he/she drooled on the other resident, he/she was hit in the eye by the other resident. The resident's left eye discolored black and purple under the orbit (a bony, pyramid-shaped cavity in the skull);-On 2/28/26 at 10:26 P.M., staff documented a message was left for the resident's psychiatrist, the Assistant Director of Nursing (ADON) and the Director of Nursing(DON) were notified. Observation on 3/4/26 at 11:04 A.M., showed the resident ambulated throughout the facility. The resident had a dark purple area under his/her left eye. An attempt was made to interview the resident without success. The resident was pleasantly confused. Review of the facility's Complaint/Incident Investigation Report, submitted to DHSS on 3/2/26, showed the facility reported a physical altercation between Residents #3 and #4 occurred on 2/28/26. During an interview on 3/4/26 at 1:16 P.M., the ADON said the charge nurse called him/her regarding the altercation between the residents. It was reported that Resident #4 had redness under his/her left eye. The ADON did not read either resident's notes or see the residents until Monday, 3/2/26. During an interview on 3/4/26 at 1:08 P.M., the Administrator said the ADON called her about the incident between Residents #3 and #4 and she read Resident #4's nurse's notes regarding his/her black eye. She wanted to see Resident #4's eye before reporting to DHSS. She should have notified DHSS of the allegation of abuse within the two-hour timeframe, per regulatory requirements. The incident happened on 2/28/26 but was not reported to DHSS until 3/2/26. She was not aware the facility's policy did not include the required reporting timeframes. 2791646