| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265839 | A. Building<br>B. Wing | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Abbey Senior Health | 206 North Main Street<br>O Fallon, MO 63366 |

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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to communicate transfers and/or discharges to the State Long-Term Care Ombudsman (a trained advocate, often a volunteer, who works to protect the rights and improve the quality of life for residents in long-term care facilities, such as nursing homes and assisted living facilities) for three residents (Resident #44, #70 and #34), in a review of 14 sampled residents, and for two discharged residents (Residents #4 and #38). The facility census was 49. Review of the undated facility policy, Transfer and Discharge from the Facility, showed the following:-The facility forwards a copy of all discharge notices to the Office of the State Long-Term Care Ombudsman;A. Facility staff will document in the residents' record:iv. Date copy of the notice was sent to the representative of the Office of the State Long-Term Care Ombudsman per requirements.1. Review of email communication from the State Long-Term Care Ombudsman, dated 06/05/26 at 4:14 P.M. and 06/08/26 at 11:20 A.M., showed the following:-The facility did not send a monthly log of residents transferred to the hospital for June 2025 through January 2025 to the Ombudsman program;-The Ombudsman's office stopped accepting notices of transfer and discharge in February 2026. The facility should submit the notices through the state Ombudsman's reporting platform;-She didn't see any submissions to the Ombudsman's reporting platform (February 2026 to May 2026) from the facility. 2. Review of Resident #44's face sheet showed he/she was his/her own responsible party. Review of the resident's progress note, dated 04/18/26 at 12:30 P.M., showed the resident was sent to the emergency department (ED) with complications of his/her urinary catheter (device inserted into the bladder to drain urine). Review of the resident's medical record showed no documentation staff notified the Ombudsman of the resident's transfer to the hospital on [DATE]. Review of resident's Minimum Data Set (MDS), discharge assessment, a federally mandated assessment to be completed by the facility, dated 05/12/26, showed the resident discharged to the hospital on [DATE]. Review of the resident's progress note, dated 05/06/26 at 5:00 P.M., showed the resident returned to the facility after treatment for cystitis (inflammation of the bladder). Review of the resident's medical record showed no documentation staff notified the Ombudsman of the resident's transfer to the hospital on [DATE]. 3. Review of Resident #70's progress note, dated 06/03/26 at 10:16 A.M., showed the following:-The resident complained of nausea with dry heaving;-No output in ostomy (a surgically created opening in the abdomen that allows stool or urine to exit the body when natural function is impaired) this morning;-Left lower quadrant (LLQ) distended with mild pain (normal non-distended without pain);-The resident was transferred to the hospital. Review of the resident's medical record showed no documentation facility staff notified the Ombudsman of the resident's transfer to the hospital on [DATE]. Review of the resident's progress note, dated 06/09/26 at 10:11 A.M., showed the following:-This morning at 7:30 A.M., day shift staff found the resident kneeling beside his/her bed on his/her right knee;-The resident was alert and oriented times two and slow to respond;-The resident was also weak and unsteady;-Nurse practitioner gave orders to send the resident to the hospital for further evaluation. Review of the resident's medical record showed no documentation facility staff notified the Ombudsman of the<br>(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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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident's transfer to the hospital on [DATE]. 4. Review of Resident #34's progress note, dated 05/17/26 at 6:13 A.M., showed the following:-Noticed dark red blood (normal no blood) in the resident's incontinence brief, looks to be from the rectum but hard to tell and has a foul odor (normal no odor);-Received a return call from the resident's physician to send the resident to the emergency room for evaluation and treatment. Review of the resident's medical record showed no documentation the facility staff notified the Ombudsman of the resident's transfer to the hospital on [DATE]. 5. Review of Resident #38's face sheet showed he/she was his/her own responsible party. Review of the resident's progress note, dated 05/24/26 at 3:50 P.M., showed the resident left the facility and said he/she would not be returning and was against medical advice (AMA). Review of the resident's medical record showed no documentation staff notified the Ombudsman when the resident discharged from the facility on 05/24/26. 6. Review of Resident #4's progress note, dated 05/15/26 at 11:11 A.M., showed the resident was discharged from the facility back to private home with home health services. Review of the resident's medical record showed no documentation facility staff notified the Ombudsman of the resident's discharge to the community on 05/15/26. 7. During an interview on 06/10/26 at 11:35 A.M., the Social Service Director (SSD) said the following:-She used to email a list of discharged residents directly to the Ombudsman, but currently didn't know who the Ombudsman was and forgot about sending the transfer/discharge list to the Ombudsman;-She had not sent a list of transfers and/or discharges to the Ombudsman's office for quite some time;-She was unaware transfer/discharge notifications were now submitted through the Ombudsman reporting platform. During an interview on 06/11/26 at 9:55 A.M., the Director of Nursing said nursing staff did not notify the Ombudsman when residents were transferred or discharged . During an interview on 06/11/26 at 10:05 A.M., the Administrator said the following:-The facility did not notify the Ombudsman of all transfers and discharges because they did not know it was required;-The facility policy said the facility would only notify the Ombudsman of immediate discharges, such as behaviors;-He was not aware of the change in the requirement to notify the Ombudsman of all transfers and discharges and the use of the Ombudsman reporting platform. |