STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265437	A. BUILDING _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VIEW HEALTH AND WELLNESS	1200 WEST COLLEGE STREET LIBERTY, MO 64068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect one resident's (Resident #1) right to be free from physical abuse when Resident #2 hit Resident #1 in the back. Resident #1 was noted to have redness to his/her back. The facility census was 108. On 4/2/25 the Administrator was notified of the past noncompliance which began on 3/24/25. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented. The noncompliance was corrected on 3/24/25. Review of the facility's Abuse, Neglect and Exploitation policy, dated 8/22/2022, showed: -It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 4/15/25

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.

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F 600	Continued From page 1 prevent abuse, neglect, exploitation and misappropriation of resident property; -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish; -Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment; -Identification of Abuse, Neglect and Exploitation: Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse. 2. Physical marks such as bruises, patterned appearances such as a hand print, belt or rink mark on a resident's body. 3. Physical injury of a resident, of unknown source. 6. Physical abuse of a resident observed. 1. Review of Resident #1's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 3/6/25, showed: -The resident has the diagnoses of dementia with agitation (a group of thinking and social symptoms that interferes with daily functioning), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), , low back pain, mood disorder (a mental health condition characterized by persistent and pervasive change in a person's emotional state) and dysphagia (difficulty	F 600		

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F 600	Continued From page 2 swallowing); -He/She has adequate hearing, clear speech, understands other and is able to make self understood; -He/She scored 3 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). This score indicates severely impaired cognitive abilities; -He/She has displayed no behaviors. Review of Resident #1's comprehensive care plan, dated 3/24/25, showed: The resident has a behavior issue related to wandering and rummaging in peer's rooms. He/She had a resident-to-resident altercation on 3/24/25. He/She requires staff supervision during meals. Staff to intervene as necessary to protect the rights and safety of others. Approach and speak to the resident in a calm manner. Divert the resident's attention. Remove the resident and take him/her to an alternate location as needed. Assess the resident for pain, hunger, thirst, care needs. 2. Review of Resident #2's quarterly MDS, dated 2/12/25, showed: -The resident has the diagnoses of aphasia (a language disorder that affects a person's ability to communicate), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) , seizures (a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations or states of awareness), mild cognitive impairment (the in-between stage between typical thinking skills	F 600		

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F 600	Continued From page 3	F 600		

and dementia), dementia;
-The resident has adequate hearing, clear speech, usually understands others and usually makes self understood;
-He/She scored zero on the BIMS, indicating severely impaired cognitive abilities;
-He/She displays verbal behaviors.

Review of Resident #2's comprehensive care plan, dated 3/31/25, showed:
-The resident has potential to be physically aggressive (hitting, breaking things) related to anger. He/She had a resident-to-resident altercation on 3/24/25. Staff will administer medications to the resident as ordered. Analyze times of day, placed, circumstances, triggers and what de-escalates behavior. Staff will provide physical and verbal cues to alleviate anxiety. Staff will assess and anticipate the resident's needs. When the resident becomes agitated, staff will intervene before agitation escalates, guide them away from the source of distress, engage calmly in conversation.

Review of the facility investigation, dated 3/24/25, showed:
-On 3/24/25 at 7:50 A.M., Certified Medication Technician (CMT) A notified the charge nurse, Licensed Practical Nurse (LPN) A of a physical altercation between Resident #1 and Resident #1. CMT A stated that Resident #2 was seated at a table in the dining area and Resident #1 walked by. Resident #2 yelled at Resident #1 to go away and then reached out and hit Resident #1 on the back. CMT A intervened, separated the residents and notified the charge nurse. Both residents were assessed, and Resident #1 was noted to have redness to his/her back;
-During interviews conducted shortly after the

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F 600	Continued From page 4 altercation, neither resident could recall the incident. Both residents responded that they feel safe in the facility. - Summary of actions taken include, residents assessed and monitored, physician and responsible parties were notified, environmental changes were implemented to reduce future incidents including: Increase staff support at meal times, staff to observe resident participation in table clearing after meal service, laminated Spanish reminder placement for Resident #1 before cleaning. - Trauma Informed Care interventions were completed for both residents. - Evaluation completed by mental health professional services, medications reviewed and care plans updated accordingly. During an interview on 4/2/25 at 145 P.M. CMT A said: -CMT A was in the dining room, helping residents get ready for breakfast and passing medication. Resident #2 was sitting at the dinning table, waiting for breakfast. Resident #1 walked by Resident #2's table. Resident #2 yelled at Resident #1 to "go away" and then reached out and hit Resident #1 on the back; -CMT A immediately separated the two residents and notified the charge nurse. During an interview on 4/2/25 at 2:40 P.M., LPN A said: -At approximately 7:50 A.M., CMT A told LPN A that there was an altercation between Residents #1 and #2. Resident #2 yelled at and hit Resident #1 in the back when he/she walked by Resident #2's table. CMT A separated the residents and notified the charge nurse; -LPN A assessed both residents. Resident #2	F 600		

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F 600	Continued From page 5 had no injuries. There was redness noted to Resident #1's back. LPN A notified the Director of Nursing (DON), physician, and responsible parties. During an interview on 4/2/25 at 2:12 P.M., the Administrator said: -Resident #1 has a history of working as a housekeeper and server. He/She frequently walks around the memory care unit, attempting to tidy up rooms, clear tables and other housekeeping tasks. He/She often needs redirection at mealtime to avoid cleaning tables before other residents are done; -Resident #2 has a history of being a registered nurse and a Director of Nursing at a long-term care facility. He/She frequently reverts to his/her previous occupation, attempting to oversee and direct staff and other residents. He/She enjoys assisting with small tasks and prefers everything to be well organized; -Staff education involving de-escalation, abuse and neglect, and intervention strategies was started and completed on 3/24/25; -Meal schedules on the memory care unit were re-evaluated to provide increased staffing support during meal times; -Staff are supporting and assisting Resident #1 in clearing tables after meals; -Laminated placemats have been placed on the tables, with a note in Spanish, to cue Resident #1 in asking for staff assistance before clearing tables. MO251626	F 600		