STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265839	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY SENIOR HEALTH	206 NORTH MAIN STREET O FALLON, MO 63366

(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 ensure one resident (Resident # 1) in a review of eleven residents was free from verbal and mental abuse when Dietary Aide E threw a ceramic dinner plate towards the resident, hitting the wall behind the resident, shattering the plate and called the resident a fucking bitch. The facility census was 50. On 12/19/24 at 11:00 A.M. the administrator was notified of the past non-compliance which occurred on 12/15/24. On 12/15/24 the administrator identified Dietary Aide E verbally and physically abused Resident #1. Upon discovery, staff suspended Dietary Aide E, conducted an investigation and notified appropriate parties. Staff reviewed the abuse and neglect policies, and all facility staff was educated on the facility abuse and neglect policies. Dietary Aide E was terminated. The deficiency was	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin/CEO | (X6) DATE 1-8-25

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 corrected on 12/16/24. Review of the facility abuse policy, dated July 2017, showed the following: -It was the policy of the facility that all residents are to be free from abuse or neglect of a physical, emotional, verbal or sexual nature and from misappropriation of property; -Upon hiring and annually, employees will be trained on identifying resident abuse and neglect and how to go about reporting an incident; -All claims of resident neglect, abuse or misappropriation of property should be reported to the Administrator/delegate immediately; -The Administrator will promptly investigate all such claims; -The resident shall be protected throughout the investigation by removing the individual involved in the incident; -If there is evidence of any of the above, the individual involved will be immediately suspended without pay. The Administrator shall immediately notify the Department of Health and Senior Services (DHSS) and if necessary, local law enforcement. An investigation will then be conducted; -If the complaint was found to be true, the individual involved will be immediately terminated from employment; -Abuse is defined as any physical or mental injury or sexual assault inflected upon a resident other than by accidental means in a facility. Abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical, mental, emotional pain or anguish; -Verbal abuse is any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or	F 600		

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F 600	Continued From page 2 within their hearing distance to describe residents, regardless of their age, ability to comprehend, or disability; -Physical abuse is hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment; -Mental abuse is defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services. 1. Review of Resident #1's undated Face Sheet showed diagnoses of heart failure, arthritis, pain in shoulder and knee, diseases of the respiratory system, abnormal posture, and depression. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument, completed by facility staff), dated 10/7/24, showed the following: -Cognitively intact; -No hallucinations or delusions; -No behaviors directed towards others; -Mobile with walker with staff assistance or with motorized wheelchair independently; -Required set up help with eating, transfers and personal hygiene. Review of the resident's Care Plan, revised 10/18/24, showed the following: -Required assistance with Activities of Daily Living (ADLs). Staff should allow the resident to express feelings of frustration and inadequacy, assume unhurried manner and allow ample time for tasks, encourage the resident to complete tasks as able with assist from staff only as needed to promote independence; -Alert and oriented and cognitively intact. Staff should allow the resident to make choices	F 600		

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pertaining to care, offer reminders when meals occurred, supervise and assist with decision making as needed and talk to the resident during care and explain procedures;
-Right to a dignified existence and treated with respect, dignity and freedom from abuse.

Review of the resident's Nurses' Note, dated 12/15/24 at 12:03 P.M., showed the Director of Nursing (DON) documented the resident was in the dining room. Dietary staff was in the dining room and was asked by the resident not to throw away a banana peel and also some salsa. Dietary staff stated he/she needed to throw away the items or the items could cause bugs if not thrown out. The resident stated he/she did not want the items thrown out and that he/she would use those in the garden for compost. Dietary staff became angry and threw a plate at the wall causing the plate to shatter and fall to the floor. Dietary staff also went over and told the resident he/she was a fucking bitch.

Review of the facility's Allegation of Abuse Summary report, dated 12/15/24, showed the following:
-On 12/15/24 at approximately 9:10 A.M. dietary staff was in the dining room serving breakfast to Resident #1. Dietary Aide E went over to clear the garbage off the table which consisted of two banana peels and an individually portioned salsa container. Resident #1 requested Dietary Aide E not throw these items out so the resident could use the salsa again and the banana peels could be used in the garden compost. Dietary Aide E became upset and walked away from Resident #1 after telling the resident he/she would not be allowed to keep the banana peels. The banana peels could cause bugs in the facility and protocol

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F 600	Continued From page 4	F 600		

stated he/she must throw the banana peels away. Dietary Aide E then stated to Resident #1 the salsa had to be thrown out because it was opened. Dietary Aide E came back out of the kitchen area and threw a plate at the wall directly behind Resident #1. Dietary Aide E went over to the resident's table and called the resident a fucking bitch and then left the floor;
-On 12/16/24 Dietary Aide E was terminated.

Review of Dietary Aide E's written statement, obtained by the DON, dated 12/15/24 at 11:30 A.M., showed Dietary Aide E said he/she was serving Resident #1 and was getting a little fed up, the recycling thing was getting out of hand. Resident #1 told Dietary Aide E not to throw away the salsa and Dietary Aide E got upset, and really angry and so mad that he/she threw a plate against the wall in the dining room. Dietary Aide E threw away the bananas and was upset, he/she told Resident #1 it caused flies and bugs. Dietary Aide E admitted he/she called Resident #1 a bitch.

During an interview on 12/18/24 at 11:00 A.M. the DON said Registered Nurse (RN) A heard the plate hit the wall and came quickly. Two Certified Nurse Assistant (CNA) staff heard the plate hit the wall also and came to the dining room quickly. Dietary Aide E admitted he/she threw the plate and called Resident #1 a fucking bitch.

During an interview on 12/18/24 at 2:17 P.M. the Human Resources Director said he/she saw the video recorded on 12/15/24 of Resident #1 in the dining room. The resident sat in a wheelchair eating. Dietary Aide E walked into view of the camera from the small kitchen area and Resident #1 sat directly in front of Dietary Aide E. Dietary

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F 600	Continued From page 5 Aide E picked up a ceramic plate from the serving area and threw the plate overhand, hit the wall behind the resident and the plate shattered. The video did not contain audio. The video footage was no longer available to view. During an interview on 12/19/24 at 9:01 A.M. CNA B said on 12/15/24 he/she was in the assist dining room and heard something break followed by, "I can't stand you, you fucking bitch". CNA B went immediately to the main dining room and Dietary Aide E was shouting at Resident #1. The plate had shattered against the wall directly behind the resident, who sat in a wheelchair at a dining room table in the center of the room. Glass was all over the floor. Dietary Aide E had to have thrown the plate hard for it to shatter like that. The plate went directly over the resident's head. During an interview on 12/19/24 at 9:10 A.M. Registered Nurse (RN) A said on 12/15/24 at about 9:30 A.M. he/she was at the nurses' desk near the main dining room and heard a crash. RN A saw Dietary Aide E near the food serving area and he/she was angry and yelled bitch toward Resident #1 who sat in a wheelchair at the dining room table. Resident #1 was directly in front of Dietary Aide E when Dietary Aide E threw the ceramic plate over the resident's head and hit the wall behind the resident. Ceramic glass went everywhere. Dietary Aide E threw the plate hard, and it shattered and sprayed all over the dining room floor. Resident #1 said the plate flew over his/her head. RN A heard Dietary Aide E call the resident a bitch and was looking at Resident #1. Dietary Aide E abused the resident. During an interview on 12/19/24 at 9:45 A.M. CNA C said on 12/15/24 he/she was in the assist	F 600		

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dining room and heard a crash and then heard, "I hate you, you fucking bitch". CNA C went immediately to the main dining room and Dietary Aide E stood at the kitchen area and yelled at Resident #1. CNA C asked Dietary Aide E if he/she called the resident a fucking bitch and Dietary Aide E said yes. Resident #1 said Dietary Aide E threw the plate at him/her and the plate went over his/her head and missed hitting the resident. The glass plate shattered everywhere. Dietary Aide E abused the resident.

During an interview on 12/18/24 at 12:25 P.M. Resident #1 said during breakfast time on 12/15/24 the resident was at the table. Dietary Aide E took his/her plate and the resident asked to keep the two banana peels for the garden compost. Dietary Aide E said no, it was rubbish and took the resident's plate. Then Dietary Aide E took the resident's small cup of salsa and was going to through it away. The resident asked Dietary Aide E to save it for the following day. Dietary Aide E said no and threw the salsa away. Resident #1 asked Dietary Aide E if he /she wanted the resident to tell his/her supervisor and Dietary Aide E then threw a plate over the resident's head and hit the wall behind the resident. The plate shattered. The plate was a ceramic dinner plate. Dietary Aide E threw the plate hard to shatter it like that. The resident did not know the plate was coming or that Dietary Aide E was angry. Dietary Aide E must have gotten angry when the resident asked if he/she should tell Dietary Aide E's supervisor about the banana peels and salsa. Resident #1 did not hear Dietary Aide E say anything.

During an interview on 12/19/24 at 11:45 A.M. the Administrator said he was notified of the abuse

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F 600	Continued From page 7 allegation on 12/15/24. Dietary Aide E was terminated for abuse of Resident #1. Dietary Aide E's behavior was abusive. MO00246640	F 600		