STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265841	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Heights	505 Couch Avenue Kirkwood, MO 63122

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation and interview, the facility failed to ensure staff followed their abuse and neglect policy when a resident (Resident #3) told a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) a black fellow beat him/her up. Neither the CNA or the RN reported the resident's allegation to the facility Administrator and/or Director of Nursing (DON). Six residents were sampled. The census was 34.Review of the facility Prohibition of Any Form of Abuse policy, last revised on 8/7/25, showed:-Any report of potential abuse, neglect or misappropriation of resident property must be reported to the Executive Director (Administrator)/DON or health care administrator immediately;-Policy: Residents have the right to be free from verbal, sexual, and physical and mental abuse;-It is the responsibility of employees to promptly report to community management any occurrence of neglect or resident abuse from other residents, staff, family or visitors, including injuries of unknown source and theft or misappropriation of resident property;-Staff are mandated reporters and must comply with state and federal regulations regarding reporting a suspected occurrence of neglect or resident abuse;-All reports of resident verbal, sexual, physical and mental abuse are promptly and thoroughly investigated by community management;-Allegations of abuse, neglect will be thoroughly investigated and reported by community management personnel, and corrective action will be taken depending on the results of the investigation.Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 4/14/25, showed:-Speech Clarity: Clear speech, distinct intelligible words;-Makes Self Understood: Usually understood;-Ability to Understand Others: Usually understands;-Moderately impaired cognition.Review of the resident's medical diagnoses, located in the electronic medical record (EMR), showed a diagnosis of severe dementia and senile degeneration of the brain.Review of the resident's care plan, located in the EMR and dated 4/28/25, showed:-Focus: Impaired cognitive function/dementia and impaired thought processes; -Goal: The resident will be able to communicate basic needs on a daily basis; -Interventions/Tasks: Ask yes/no questions in order to determine the resident's needs. Communicate with the resident/family/caregivers regarding residents' capabilities and needs;-Focus: Activities of daily living (eating, dressing, grooming, walking, etc.) deficit related to limited mobility; -Goal: Will maintain activities of daily living; -Interventions/Tasks: Dependent for bathing and bed mobility. Hoyer lift (a machine used to transfer residents unable to bear weight) for transfers with 2 people. Review of the resident's progress note, located in the EMR and dated 6/30/25 at 3:05 P.M., showed staff completed a Brief Interview for Mental Status (BIMS, a cognitive assessment) which showed the resident had severe cognitive impairment.Observation on 8/14/25 at 1:31 P.M., showed CNA A and RN B transferred the resident from the Broda chair (a reclining chair) to the bed using a Hoyer lift. After the resident was in bed, he/she looked at CNA A and said a young black fellow beat him/her up. RN B, who was standing on the opposite side of the resident's bed asked the resident How did that happen? You have a camera in your room. The resident did not respond to the question and RN B did not ask any more questions before (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leaving the room.During an interview on 8/15/25 at 10:54 A.M., RN B said he/she did not report the resident's allegation to the Administrator or DON because the resident was confused, and staff check on the resident frequently. He/She did not believe the allegation occurred. He/She had been in-serviced on the facility abuse and neglect policy and he/she should have reported the resident's allegation.During an interview on 8/15/25 at 11:48 A.M., Certified Medication Technician G said if a resident told him/her a resident or staff member beat them up he/she would report it right away to the charge nurse, DON or Administrator. He/She would report regardless of if the resident was confused or not.During an interview on 8/15/25 at 11:55 A.M. CNA F said if a resident, even a confused resident, told him/her a resident or staff member had beat them up, he/she would report the allegation immediately to the charge nurse or any supervisor available. During an interview on 8/15/25 at 10:00 A.M., both the Administrator and DON said neither CNA A nor RN B reported anything to them about what the resident told them yesterday. The facility did have black male employees. The RN and CNA should have reported the resident's allegation to them immediately and they would have begun an immediate investigation. They expected staff to follow the facility's policy.