STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately assess resident falls by ensuring residents received treatment and care in accordance with acceptable standards of practice when staff failed to accurately complete neurological (neuro) evaluations (pulse (P), respiration (R), and blood pressure (BP) measurements; assessment of pupil size and reactivity; and equality of hand grip strength) if the fall was unwitnessed or if the resident had an incident in hitting their head, for three of three residents sampled. In addition, the facility failed to adequately assess resident falls by ensuring residents received treatment and care in accordance with acceptable standards of practice and the facility's policy when staff failed to complete incident follow up (IFU) documentation for 72 hours post fall in the progress notes each shift, for three of three residents sampled (Residents #1, #2 and #3). The census was 73.Review of the facility's Accident and Incident Report policy and procedure, revised 2/6/18, showed:-Procedure:-1. Resident: -a. The charge nurse will fill out the incident report, in detail, noting cause or probable cause of the incident; -b. Administer first aid as indicated; -c. Notify family/responsible party of incident; -d. Notify physician;-4. In All Cases: -a. Give exact description of the circumstances surrounding the accident; -b. Obtain statement from the resident, employee or visitor, if possible; -c. Chart the resident's incident in the nursing notes; -d. Submit the completed accident report to the nursing office. 1. Review of Resident #1's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/14/25, showed:-Severe cognitive impairment;-Always incontinent of bowel and bladder;-Falls since admission/entry or reentry or the prior assessment, Yes; -No injury, two or more; -Injury (except major), two or more;-Diagnoses included high blood pressure, Alzheimer's disease (progressive and irreversible brain disorder that causes memory loss, cognitive decline, and behavioral changes), Parkinson's disease (a progressive, chronic brain disorder that primarily affects movement), anxiety disorder, depression and lower back pain. Review of the resident's care plan, in use during the survey, showed:-Problem: Resident is at risk for falls;-Goal: Resident safety will be maintained through next review date;-Interventions: Neuro checks for 72 hours. Review of the resident's progress notes, showed:-On 7/27/25 at 7:49 A.M., Resident was found on the floor beside his/her bed after rolling out of bed. Resident has an 8-centimeter (cm) X 2 cm abrasion with swelling on his/her right cheek area. Nurse put a cold compress on the swelling. Notified physician and family member. Neuros started. Resident denied pain;-On 7/27/25 at 3:35 P.M., incident follow up (IFU) due to recent fall. No signs or symptoms of infection noted to abrasion to right cheek. Slight edema noted to right cheek, no bleeding or drainage noted. Resident denies pain or discomfort. No changes in level of care for resident;-On 7/27/25, Night shift (7:00 P.M. to 7:00 A.M.): No IFU documentation;-On 7/28/25 at 1:49 P.M., Resident remains on observation. No c/o pain or discomfort noted at this time. No distress noted at this time;-On 7/29/25 at 5:35 A.M., Remains on IFU. No signs or symptoms (s/s) of distress noted. Resting in bed with eyes closed at this time. Voices no complaints of pain or discomfort;-On 7/29/25, Day shift (7:00 A.M. to 7:00 P.M.): No IFU documentation;-On 7/29/25, Night shift: No IFU documentation. Review of the resident's Neurological Evaluation, dated 7/27/25, showed:-On 7/28/25, Day shift, not completed;-On 7/29/25, Night shift, not completed. Review of the resident's progress notes, showed:-8/11/25 at 5:50 P.M., Roommate notified nurse that the resident rolled out of bed. When entered room, observed resident lying face down on fall mat to the left of head of bed. Bed was in lowest position and fall mats on both sides of bed. Staffed assisted resident to bed. Resident has small cut on bridge of nose. Nose and cheek red. Provide first aid. Range of motion (ROM, extent of movement possible at a joint) within normal limits (WNL) for resident. Notified physician and family. Notified Hospice. Resident is up in geri chair (supportive recliner with wheels designed for individuals with limited mobility) for dinner. Will continue to monitor.-On 8/11/25, Night shift: No IFU documentation;-On 8/12/25, Day shift: No IFU documentation;-On 8/12/25, Night shift: No IFU documentation;-On 8/13/25, Day shift: No IFU documentation;-On 8/13/25 at 7:01 P.M., Resident continues on IFU charting. Resident with no new injury from previous fall. Denies pain or discomfort. Review of the resident's Neurological Evaluation, dated 8/11/25, showed:-8/13/25, Day shift, not completed;-8/13/25, Night shift, not completed;-8/14/25, Day shift, not completed. Review of the resident's progress notes, showed:-On 8/14/25 at 10:06 A.M., Resident rolled out of bed this morning. Bed was in lowest position and fall mats were in place. No signs of injury and no reports of pain. Vital signs stable. Hospice, physician and family have been notified. Bolsters have been added to the bed;-On 8/14/25, Night shift: No IFU documentation;-On