

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Maple Lawn Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 West Line Street Palmyra, MO 63461	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49528</p> <p>Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of nine sampled residents, was free from verbal abuse. The resident reported staff (Licensed Practical Nurse (LPN) D) raised his/her voice and told the resident to come on, come on while the resident tried to wheel himself/herself to the bathroom in a wheelchair. Resident #1, who had a diagnosis of aphasia (language disorder that affects a person's ability to communicate effectively), tried to communicate specific needs to LPN D, and when LPN D was not understanding what the resident was trying to say, the resident reached out to touch LPN D's hand so he/she would listen to the resident. LPN D continued to yell at the resident and threaten to call the police. The resident said the verbal abuse made him/her upset and scared of LPN D. The facility census was 63.</p> <p>Review of the facility policy for Abuse, Neglect and Reporting Reasonable Suspicion of a Crime, with a revision date of 02/03/22, showed the following:</p> <p>-It is the policy of this facility to protect the rights of all residents to be free from mistreatment, abuse, neglect, injuries of unknown sources and misappropriation or stealing of resident property or money;</p> <p>-Verbal Abuse is defined as any use of oral, written or gestured language that includes belittling and derogatory remarks of resident or families, or within the hearing distance of residents, regardless of their age, ability to comprehend, or disability;</p> <p>-All employees will be trained in this Abuse/Neglect policy and in the Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility policy at New Hire Orientation and an annual review will be done at the mandatory in-service training.</p> <p>1. Review of Resident #1's face sheet showed diagnoses included cerebral infarction due to embolism of left middle cerebral artery (a stroke where a blood clot in the brain blocks blood flow and causes the brain tissue to die off due to lack of oxygen resulting in a brain infarction (tissue damage) in the affected area), aphasia from cerebra vascular accident, and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/03/24, showed the following:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Intact cognition;</p> <p>-Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time;</p> <p>-Understands others-clear comprehension;</p> <p>-Partial/moderate assistance with toilet transfer and toileting hygiene;</p> <p>-Independent with wheelchair mobility, able to wheel 50 feet with two turns;</p> <p>-No rejection of cares;</p> <p>-No behaviors.</p> <p>Review of the resident's care plan, last updated 01/30/25, showed the following:</p> <p>-Altered ability to make self-understood secondary to aphasia from cerebral vascular accident (CVA - stroke);</p> <p>-Allow increased time for the resident to respond;</p> <p>-Encourage the resident to speak slowly and clearly;</p> <p>-Speak slowly and clearly while facing the resident in a well lit area.</p> <p>During an interview on 03/04/25 at 10:43 A.M. and 2:30 P.M., the resident said the following:</p> <p>-The incident happened on Saturday morning, 03/01/25;</p> <p>-LPN D was trying to tell the resident how to wheel into the bathroom; he/she tried to tell LPN D that was not how he/she did it and LPN D became agitated;</p> <p>-LPN D said several times come on; he/she (the resident) tried to tell LPN D to wait a minute;</p> <p>-He/She (the resident) tried to touch LPN D's hand to get LPN D to listen to him/her;</p> <p>-LPN D jerked his/her hand away and said he/she was going to call the cops;</p> <p>-Another resident down the hall heard the incident;</p> <p>-He/She felt upset and scared of LPN D;</p> <p>-He/She was tearful during the interview and said, I don't know what I did wrong;</p> <p>-He/She said he/she did not grab LPN D's shirt.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 03/04/25 at 10:55 A.M., the resident's family member said the resident called him/her on Saturday morning (03/01/25) upset and crying about a nurse yelling at him/her. He/She has requested LPN D not work with the resident anymore due to the resident being upset and scared of the nurse.</p> <p>2. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Intact cognition; -Understands others-clear comprehension. <p>During an interview on 03/04/25 at 10:57 A.M., the resident said the following:</p> <ul style="list-style-type: none"> -He/She heard yelling from his/her room, two doors down from Resident #1's room on Saturday morning (03/01/24) and came out into the hallway; -LPN D was screaming at the top of his/her lungs, saying he/she was going to have Resident #1 arrested; -Someone at the nurses station asked LPN D why, and he/she said because he/she (referring to Resident #1) grabbed me; -Resident #1 was one of the nicest people in the facility and was depressed the rest of the day as a result of the interaction. <p>During an interview on 03/04/25 at 11:05 A.M., Certified Medication Technician (CMT) C said the following:</p> <ul style="list-style-type: none"> -The resident's family member called his/her personal phone on 03/01/25 at 9:52 A.M. and asked him/her to have the resident call the family member; -He/She was not working, so he/she called the facility and asked LPN D to have the resident call his/her family member; -LPN D was agitated and said, I'm not doing this, I don't need you to tell me how to do my job. I've been doing this for [AGE] years; -He/She told LPN D he/she was not telling him/her what to do, but that he/she just need him/her to give a message to the resident; -He/She then asked LPN D to just have a Certified Nurse Assistant (CNA) help the resident to call his/her family member. <p>During an interview on 03/04/25 at 10:20 A.M., LPN B said the following:</p> <ul style="list-style-type: none"> -On Saturday March 1st, LPN D came to C and D hall stating Resident #1 was being rude and grabbed his/her shirt and Resident #1 needed to keep his/her hands to him/herself or he/she would call the cops; <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Resident #1 has aphasia due to a stroke but is alert and oriented and knows what is going on;</p> <p>-He/She has never had any problems with Resident #1 when he/she has worked with the resident;</p> <p>-Resident #1 has always been pleasant and cooperative.</p> <p>During an interview on 03/04/25 at 10:05 A.M., RN Supervisor A said the following:</p> <p>-He/She was the supervisor on call and was working in the facility on Saturday March 1st;</p> <p>-He/She made his/her rounds to the other halls to see how things were going when LPN D said Resident #1 gave him/her attitude a few days prior and then later told him/her that he/she (LPN D) could not do it any more and that he/she would not take care of the resident due to the resident's behaviors; LPN D said the resident grabbed his/her shirt, and if the resident came at him/her again, he/she would call the cops;</p> <p>-He/She went to Resident #1's room to see what happened and the resident would not tell him/her what happened.</p> <p>During an interview on 03/04/25 at 2:15 P.M., the ADON said the following:</p> <p>-Resident #1's family member came to her office this morning to discuss the incident that happened over the weekend;</p> <p>-The family member said the resident called and was upset on 03/01/25, so he/she came to the facility today to check on the resident and found out the resident was upset with nursing staff that yelled at him/her on 03/01/25;</p> <p>-The family member requested LPN D not work with Resident #1.</p> <p>During an interview on 03/04/25 at 1:10 P.M. and 2:55 P.M., the DON said the following:</p> <p>-She would have considered it abuse and/or a dignity and respect issue;</p> <p>-She would expect staff to treat residents with dignity and respect;</p> <p>-She would not expect staff to raise their voice or yell at a resident no matter what;</p> <p>-She would not expect staff to threaten to call the cops on a resident.</p> <p>During an interview on 03/04/25 at 1:55 P.M. and 3:25 P.M., the administrator said the following:</p> <p>-She was unaware of the allegation until the state surveyor arrived today;</p> <p>-She started her investigation, and with the information she received from staff, the resident and the state surveyor, she would consider the incident abuse;</p> <p>-All staff are trained on resident rights, dignity, respect and abuse upon hire and annually;</p> <p>(continued on next page)</p>		

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