

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 06/25/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to follow their policy on reporting allegations of abuse to the state agency immediately, but no later than two hours after the allegation was made for one resident (Resident #1), in a review of eight sampled residents. Resident #1 reported an allegation of abuse to Certified Nurse Aide (CAN) A on 06/15/25. CNA A reported the allegation to his/her charge nurse, Licensed Practical Nurse (LPN) D, who also reported the allegation to Registered Nurse (RN) B. No staff reported the allegation to the Director of Nursing (DON) or the Administrator until four days later. Additionally, when the administrator became aware of the allegation on 06/19/25 at 10:45 A.M., she did not notify the state agency of the allegation until 1:12 P.M. (greater than two hours). The facility census was 65.</p> <p>Review of the facility policy for Abuse, Neglect and Reporting Reasonable Suspicion of a Crime, with a revision date of 02/13/25, 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>-Sexual Abuse is defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault;</p> <p>-Reporting Abuse/Neglect:</p> <p>c. Reporting to Department of Health and Senior Services (DHSS) following the Guidelines for Facility Self-Reporting for Certified Facilities, the Administrator, Director of Nursing (DON) or Human Resources (HR) Director will call the Department of Health and Senior Services (DHSS) and make the necessary self-report immediately, but not later than two (2) hours after the allegation is made;</p> <p>d. If the report is made after office hours or on a weekend to a Unit Supervisor or Charge Nurse, they must contact the Administrator, DON or HR Director at their emergency number (numbers are listed on the Emergency Telephone Numbers list located at each Nurses Desk) to immediately report the abuse;</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's rights employee orientation, dated 2025, showed residents have the right to be free from verbal, sexual, physical, financial, mental abuse, and involuntary seclusion by anyone. This includes, but isn't limited to nursing home staff, other residents, consultants, volunteers, staff from other agencies, family members or legal guardians, friends, or other individuals. If you witness or suspect abuse or neglect is happening to anyone in the facility, please contact the Human Resources Director or Director of Nursing or Administrator immediately.</p> <p>1. Review of Resident #1's face sheet showed his/her diagnoses included paraplegia (a condition characterized by paralysis of the lower half of the body, typically including the legs and sometimes the torso).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 05/20/25 showed the following:</p> <ul style="list-style-type: none"> -The resident had the ability to make self-understood and able to understand others; -Brief Interview for Mental Status (BIMS-a brief, standardized assessment used to quickly screen for cognitive impairment, focusing on orientation, short-term memory, and attention, often used in long-term care facilities) with a score of 9 (moderate cognitive impairment); -No hallucinations or delusions; -No behaviors; -He/She was dependent on staff for toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfer, and tub/shower transfer. <p>During an interview on 06/25/25 at 12:53 P.M., the resident said the following:</p> <ul style="list-style-type: none"> -He/She had not been comfortable with CNA G; -Certified Nurse Aide (CNA) G stroked his/her hair and said he/she liked his/her hair; -He/She saw CNA G holding women's underwear and he/she had been stroking the underwear between his/her fingers. <p>2. Review of a facility abuse investigation, dated 06/25/25, showed the following:</p> <ul style="list-style-type: none"> -On Thursday, June 19, 2025, CNA A reported to the administrator when he/she worked on June 15, 2025, Resident #1 confided in him/her that CNA G had done something sexually abusive to him/her but he/she wouldn't go into detail; -CNA A said he/she reported the allegation to Registered Nurse (RN) B, Licensed Practical Nurse (LPN) C, LPN D, LPN E and RN F. <p>3. During an interview on 06/25/25 at 12:25 P.M., CNA A said the following:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-In May the resident told him/her he/she did not want CNA G in his/her room and would not tell him/her the reason;</p> <p>-The resident said he/she saw CNA G rubbing women's silk underwear between his/her fingers in the hallway outside of his/her room;</p> <p>-The resident said this was not the reason he/she did not want CNA G in his/her room, but that CNA G sexually assaulted him/her;</p> <p>-The resident would not tell him/her anymore and did not want him/her to report the sexual abuse allegation;</p> <p>-He/She told the resident he/she had to report the sexual abuse allegation;</p> <p>-He/She reported the sexual abuse allegation to his/her supervisor, LPN D on June 15, 2025.</p> <p>During an interview on 06/25/25 at 2:13 P.M., LPN D said the following:</p> <p>-About one to two weeks ago, CNA A reported the resident said CNA G did something sexual to him/her;</p> <p>-He/She immediately reported the allegation to RN B;</p> <p>-Two days later (on June 17th), he/she followed up with the DON and she had not received an abuse allegation report from RN B.</p> <p>During an interview on 06/25/25 at 3:34 P.M., LPN E said the following:</p> <p>-He/She and LPN D had been on orientation and working together on June 15, 2025;</p> <p>-LPN D had come to the nurses' station and told RN B he/she needed to have a private conversation with him/her about something disturbing that the resident had reported to CNA A;</p> <p>-LPN D said the resident reported CNA G had made inappropriate moves on him/her and pulled out a pair of women's silk panties from his/her pocket rubbed them. This was something that needed to be reported to the staff supervisor. The chain of command was the CNA would report to the LPN and the LPN would report to the charge nurse;</p> <p>-LPN D reported what CNA A reported to him/her to RN B;</p> <p>-LPN D said he/she would follow up and make sure the allegations had been reported to the DON.</p> <p>During an interview on 06/25/25 at 2:22 P.M. and 4:47 P.M., RN B said the following:</p> <p>-He/She was the nursing supervisor on June 15th;</p> <p>-LPN D told him/her the resident was supposedly sexually assaulted;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Abuse allegations should be reported to the state agency within two hours;</p> <p>-When abuse allegations are made, the facility is to report it to the state agency and start an investigation immediately;</p> <p>-The allegations of abuse should have been reported to the State immediately.</p> <p>During an interview on 06/25/25 at 11:00 A.M., 4:38 P.M. and 5:05 P.M., the Administrator said the following:</p> <p>-On 06/19/25 at 10:45 A.M., CNA A reported to her he/she had reported the sexual abuse allegation to his/her supervisor, LPN D, on June 15th;</p> <p>-On June 19th, she asked the DON if the allegation had been reported to her and the DON said no sexual abuse allegation had been reported to her;</p> <p>-She thought the DON had already completed a prior investigation regarding the resident and CNA G which had been unfounded; the prior allegation was not related to a sexual abuse;</p> <p>-She did not recognize this as an additional concern being reported;</p> <p>-She would expect her staff to contact her and report any abuse allegations immediately;</p> <p>-The resident's abuse allegation should have been reported to the state agency within two hours of getting the report from CNA A on June 15th.</p> <p>MO256136</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to provide evidence that allegations of abuse were thoroughly investigated, per facility policy, for one resident (Resident #1), in a review of eight sampled residents. The facility census was 65.</p> <p>Review of the facility policy for Abuse, Neglect and Reporting Reasonable Suspicion of a Crime, with a revision date of 02/13/25, 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>-Sexual Abuse is defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault;</p> <p>-Investigations of Abuse/Neglect:</p> <p>a. The facility will ensure that all alleged reports of mistreatment, neglect or abuse, injuries of unknown source and misappropriation of resident property are investigated;</p> <p>b. The Human Resources Director is responsible for investigations of alleged abuse by an employee or staff member;</p> <p>h. The documented contents of the investigation will include:</p> <p>a. specific description of the incident, people involved, date, time and location of the incident;</p> <p>b. relevant information from the resident's medical record;</p> <p>d. personal information for all staff involved in the incident;</p> <p>e. written, signed statements by all people involved in incident;</p> <p>f. documentation of interviews conducted by facility staff;</p> <p>h. a summary of the investigation including corrective action taken;</p> <p>i. any other relevant information to the incident.</p> <p>1. Review of Resident #1's face sheet showed his/her diagnoses included paraplegia (a condition characterized by paralysis of the lower half of the body, typically including the legs and sometimes the torso).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 05/20/25, showed the following:</p> <p>-The resident had the ability to make self-understood and able to understand others;</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Brief Interview for Mental Status (BIMS-a brief, standardized assessment used to quickly screen for cognitive impairment, focusing on orientation, short-term memory, and attention, often used in long-term care facilities) with a score of 9 (moderate cognitive impairment);</p> <p>-No hallucinations or delusions;</p> <p>-No behaviors.</p> <p>During an interview on 06/25/25 at 12:53 P.M., the resident said the following:</p> <p>-He/She had not been comfortable with Certified Nurse Aide (CNA) G;</p> <p>-CNA G had stroked his/her hair and said he/she liked his/her hair;</p> <p>-He/She had seen CNA G holding women's underwear and he/she had been stroking the underwear between his/her fingers.</p> <p>2. Review of the facility's abuse investigation, dated 06/25/25 and signed as completed by the administrator, showed the following:</p> <p>-On Thursday, June 19, 2025, CNA A reported to the administrator when he/she worked on June 15, 2025, the resident confided in him/her CNA G had done something sexually to him/her but he/she wouldn't go into detail;</p> <p>-CNA A said he/she reported the allegation to Registered Nurse (RN) B, Licensed Practical Nurse (LPN) C, LPN D, LPN E and RN F;</p> <p>-The administrator went to the resident's room and asked the resident about the incident with CNA G;</p> <p>-The resident refused to talk with the administrator about the incident;</p> <p>-The administrator called the staff members who had been reported as aware of the situation and requested statements be sent to her;</p> <p>-Seven statements were included in the investigation, including statements provided from Registered Nurse (RN) B, Licensed Practical Nurse (LPN) C, LPN D, LPN E, RN F and the DON;</p> <p>-The administrator contacted the local police department;</p> <p>-The administrator contacted the next of kin.</p> <p>3. During an interview on 06/25/25 at 4:09 P.M., CNA G said he/she had not been contacted by the facility in reference to an abuse allegation.</p> <p>During an interview on 06/25/25 at 2:13 P.M., LPN D said the following:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-About one to two weeks ago, CNA A reported the resident said CNA G did something sexual to him/her;</p> <p>-He/She immediately reported the allegation to his/her charge nurse, RN B;</p> <p>-He/She did not talk with the resident about the allegation, he/she thought the Director of Nursing (DON) should have spoken with the resident;</p> <p>-He/She had not begun a facility investigation into this allegation.</p> <p>During an interview on 06/25/25 at 2:22 P.M., and 4:47 P.M., RN B said the following:</p> <p>-On June 15th, LPN D told him/her that the resident was sexually assaulted;</p> <p>-He/She was the nursing supervisor during that time;</p> <p>-He/She had not begun a facility investigation into this allegation;</p> <p>-He/She tried to talk with the resident, but he/she would not talk with him/her.</p> <p>During an interview on 06/25/25 at 3:20 P.M., the Assistant Director of Nursing (ADON) said the following:</p> <p>-About four to five weeks ago, a CNA came to her and said the resident was having problems with CNA G being in his/her room. She interviewed the resident and asked if there was anything that needed looked into or anything that needed to be addressed and the resident said, no, he/she just had not liked how CNA G took care of him/her;</p> <p>-She did not know the resident reported an additional concern that he/she had been sexually abused;</p> <p>-No report of sexual abuse had been reported her.</p> <p>During an interview on 06/25/25 at 11:38 A.M., the DON said the following:</p> <p>-About five weeks ago a CNA (did not remember who) reported to her, Resident #1 did not want CNA G in his/her room;</p> <p>-During the previous investigation she did not talk with staff about Resident #1 not wanting CNA G in his/her room;</p> <p>-She did not know how the present administrator would like abuse investigations to be conducted;</p> <p>-The old administrator would have the Social Service director (SSD) conduct resident interviews;</p> <p>-She had not conducted resident interviews regarding Resident #1's abuse allegation of 06/19/25.</p> <p>During an interview on 06/25/25 at 4:06 P.M., the DON said the following:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-She was responsible for the duties of Human Resources and had been for the past four months;</p> <p>-She did not remember LPN D asking her or telling her about CNA A reporting the resident's sexual abuse allegations;</p> <p>-She would have been responsible for telling the administrator and she did not tell the administrator about CNA A reporting Resident #1's sexual abuse allegations;</p> <p>-When abuse allegations are made, the facility should start an investigation immediately;</p> <p>-When the investigation is finished, the facility faxes it to the state agency;</p> <p>-During an abuse investigation, the facility should talk with the resident first and statements are gathered from anyone involved;</p> <p>-On Monday June 19, 2025, the administrator informed her about the resident's abuse allegations;</p> <p>-She had not begun a facility investigation into this allegation;</p> <p>-She had not interviewed any other resident's during the facility investigation of this allegation.</p> <p>During an interview on 06/25/25 at 11:00 A.M., 4:38 P.M., 5:05 P.M. and 07/10/25 at 8:23 A.M., the Administrator said the following:</p> <p>-On 06/19/25 at 10:45 A.M., CNA A reported to her the resident said he/she had been sexually assaulted by CNA G;</p> <p>-She thought the DON had already completed a prior investigation regarding the resident and CNA G which had been unfounded;</p> <p>-She did not speak with CNA G, regarding the new allegation as he/she no longer worked at the facility;</p> <p>-She would not have expected LPN D or RN B to have spoken to the resident because it had been an ongoing issue the DON had already investigated;</p> <p>-There are cameras in the hallways;</p> <p>-She had not viewed the camera footage for any observation of CNA G standing outside the resident room rubbing silk underwear between his/her fingers;</p> <p>-The resident's abuse allegation investigation, dated 06/25/25, consisted of staff statements, calling the police, talking with the resident and the next of kin;</p> <p>-The abuse investigation had not included any other resident interviews;</p> <p>-All the supervisors would be involved during an abuse investigation;</p> <p>(continued on next page)</p>		

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