STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265237	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	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)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided adequate nutrition, monitored consumption, monitored or identify weight loss, completed assessments or notified the resident's provider or dietitian of weight loss, and did not evaluate the resident's care plan or initiate interventions to prevent further weight loss for one resident (Resident #14) in a sample of 17 residents. Review of the resident's weight records showed the resident lost 21.8 lbs. since 06/04/25, which was an 11.86 percent (%) weight loss in six months. The resident lost 15.2 lbs. since 10/01/25 (no weight for November documented) which was an 8.5% weight loss in two months. The resident experience significant weight loss with no staff identification, evaluation, notification, or intervention. The facility census was 59. Review of the facility's policy Documentation for weights, undated, showed:-Upon admission all residents will have their weight obtained and recorded in their medical record for four weeks if not otherwise ordered;-If not ordered per physician differently the resident will have their weight obtained and documented prior to the 7th of each month;-Some residents may have daily or weekly weights ordered per physician or due to weight loss;-These weights should be obtained prior to breakfast using the same scale each time;-The charge nurse will be responsible to make sure the weight is done;-Document in progress notes any weight changes, notification of Dr, any new orders received and notification of family;-The information will be faxed to the attending physician on a monthly basis after the weight committee has met and given any recommendations for change in plan of care. Review of the undated facility policy, Nutrition and Hydration, showed the following:-The facility will ensure that all residents receive adequate nutrition and hydration to maintain the highest practicable physical, mental, and psychosocial well-being;The facility will provide a nutritionally adequate diet, appropriate hydration, and necessary assistance based on each resident's assessed needs, preferences, cultural considerations, and clinical condition;-Nutrition and hydration services are resident centered, interdisciplinary and continuously evaluated;-Definition of adequate nutrition: Intake sufficient to meet assessed caloric, protein, vitamin and mineral needs;-Definition of clinically significant weight loss: Unplanned weight loss per facility parameters and clinical judgment;-Definition of therapeutic diet: Diet ordered by a practitioner to treat or manage a medical condition;1. Assessment-Nutrition and hydration status is assessed: a. On admission; b. With each comprehensive assessment; c. With any significant change in condition;d. Upon noted weight change, poor intake, or dehydration risk;-Assessments include: a. Height, weight, body mass index (BMI) b. Diet order and food preferences; c. Swallowing status; d. Hydration risk factors; e. Ability to eat/drink independently;2. Care Planning:-A person centered care plan is developed and updated by the interdisciplinary team (IDT);-Care plans address:a. Diet type and texture; b. Fluid goals; c. Adaptive equipment or feeding assistance; d. Meal location and timing preferences; e. Cultural and religious considerations;3. Diets and Meals:-Menus meet current Dietary Reference Intakes (DRIs) and are approved by a qualified dietitian;-Residents are offered: a. Regular and therapeutic diets as ordered; b. Texture modified diets when clinically indicated; c. Substitutions and alternatives when meals are refused;-Residents may refuse a therapeutic diet after informed consent; refusals are documented and care planned;5. Feeding Assistance: Residents who require (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Actual harm Residents Affected - Few	assistance will receive timely and adequate help during meals;6. Monitoring and Documentation:-Intake is monitored based on resident risk level;-Weights are obtained per facility protocol or physician order;-The IDT reviews: a. Weight trends; b. Intake patterns; c. Lab values when indicated;-Significant findings are communicated to the practitioner and documented;7. Weight Loss and Nutritional Risk:-Unplanned weight loss triggers: a. IDT review; b. Root cause analysis; c. Care plan revision;-Interventions may include: a. Diet changes; b. Supplements; c. Enhanced feeding assistance; d. Medical evaluation;8. Refusals and Preferences:-Resident preferences are honored whenever possible;-Persistent refusals are: Investigated, documented and care planned;-Residents are not force fed or coerced;9. Advance Directives and End of Life Care:-Nutrition and hydration decisions respect advance directives, physician orders, and resident or legal representative choices;-Comfort focused approaches are used when appropriate.Staff Responsibilities:1. Nursing:-Monitor intake, hydration, and weight;-Implement care plan interventions;-Notify the provider and IDT of concerns;2. Dietary Services:-Plan and prepare nutritionally adequate meals;-Honor resident preferences;-Participate in IDT reviews;3. Medical Provider:-Order diets, supplements, and evaluations;-Review significant changes;4. Administration:-Ensure staff training and compliance;-Conduct audits and quality improvement activities. Review of the undated facility policy, Weight Loss / Poor Intake Trigger Flowchart, showed the following:-To provide a clear, survey-ready decision pathway for identifying, assessing, and responding to unplanned weight loss or poor oral intake in nursing home residents, consistent with federal requirements and interdisciplinary best practice.-STEP 1: Trigger Identification:Initiate the flowchart when ANY of the following occur:-Greater than or equal to (ˆ) 5 percent (%) weight loss in 30 days;- ˆ 7.5% weight loss in 90 days;-ˆ 10% weight loss in 180 days;-Poor intake (<75% of meals for 3 consecutive days);-Refusal of meals or fluids;-Signs of dehydration;-Change in condition affecting intake (illness, cognition, swallowing, mood);-STEP 2: Immediate Nursing Actions (Within 24 hours):-Verify weight accuracy (same scale, time, clothing);-Initiate or increase meal and fluid intake monitoring;-Assess for:Pain;Nausea/vomiting;Constipation;Dental/oral issues;Swallowing difficulty;Depression or behavioral changes;-Notify charge nurse/supervisor;-STEP 3: Physician/Practitioner notification:Notify provider if:-Weight loss meets trigger thresholds;-Poor intake persists > 3 days;-Dehydration suspected;Provider may order:-Diet change or texture modification;-Supplements;-Labs or diagnostic testing;-Medication review/changes;-STEP 4: Interdisciplinary Team (IDT) Review:IDT Members: Nursing, Dietary, Provider, Therapy, Social Services (as indicated)IDT evaluates:-Root cause(s) of weight loss/poor intake;-Food preferences and meal satisfaction;-Assistance needs and meal environment;-Cultural, psychosocial, and end-of-life considerations;-STEP 5: Interventions:Implement and document individualized interventions, such as:-Diet liberalization or resident-preferred foods;-Oral nutritional supplements;-Enhanced feeding assistance or cueing;-STEP 6: Care Plan update:-Update care plan with identified problems, goals, and interventions;-Include resident/representative preferences and consent;-Document education and discussion;-STEP 7: Monitoring and Re-evaluation:-Monitor intake daily (or per risk level);-Reweigh per protocol or provider order;-Evaluate effectiveness of interventions;If improvement noted: ˆ Continue interventions and routine monitoringIf NO improvement or continued decline: ˆ Reassess root cause ˆ Re-notify provider ˆ Revise interventions. 1. Review of Resident #14's face sheet showed the following:-Diagnoses included Alzheimer's disease, dementia, anxiety, and high blood pressure;-The resident had a healthcare proxy who was his/her emergency contact. Review of the resident's Care Plan, dated 10/25/23, showed the following:-Nutritional Status: Resident is on a consistent carbohydrate diet with thin liquids;-Goals: Resident will maintain optimal nutrition as evidenced by absence of significant weight loss through the next review;-Resident has a diagnosis of diabetes (inability to regulate blood sugar) and currently takes oral medications to control blood sugar;-Resident consistently asks for between meal snacks numerous times even right after eating a meal; -Resident was currently above ideal body (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	weight;-Resident goes to the dining room for most meals. Review of the resident's December 2025 Physician Orders, showed the following:-Monitor weight monthly;-Regular, consistent carbohydrate diet (initiated 12/11/23). Review of the resident's annual Nutritional Assessment, dated 05/12/25, showed the Registered Dietitian documented the following:-Resident weighs 186 pounds (lbs.), usual body weight is 185 lbs.;-The resident's estimated nutritional needs are 1664 calories, 67 grams of protein and 2536 milliliters of fluid;-Resident has a wound;-Weight stable;-Overweight;-Goal to maintain weight or gradual weight loss. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 05/22/25, showed the following:-Moderate cognitive impairment;-No behaviors, hallucinations, delusions, or rejection of care;-It was very important to the resident to have snacks between meals; -Set up or clean up assistance from staff for eating; -Weighs 186 lbs., therapeutic diet;-The resident's MDS triggered an alert that the resident was at risk for alterations in nutrition and the facility indicated a care plan would be initiated for nutrition. Review of the resident's Physician Orders, dated May 2025, showed the resident continued monitoring of monthly weights and a regular, consistent carbohydrate diet. Review of the resident's weight record, showed facility staff obtained and documented the resident's weight as follows:-On 06/04/25, 183.8 lbs.;-On 07/02/25, 183.6 lbs.;-On 08/07/25, 184.4 lbs. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Alzheimer's and Dementia diagnosis;-184 lbs.;-New antipsychotic medication. Review of the resident's Progress Notes, dated 8/25/25 at 2:40 P.M., showed the following: -Quarterly nutrition review;-Consistent carbohydrate, regular diet; -Meal intake varied, does like snacks; -2500 ml fluid restriction; -Labs: 08/06/25: basic metabolic panel (BMP - a common blood test that checks your body's chemical balance, metabolism, and kidney function) all within normal limits, except glucose (blood sugar) 176 (history of diabetes) (normal glucose range on a BMP is 70 - 100); -Skin: No pressure injuries; -Height: 64 inches, weight 184.4 pounds;-Weight stable/no significant changes in the past quarter;-Diet order remains appropriate and adequate to meet needs;-No changes advised continue plan of care. Review of the resident's Nurses Notes, dated 09/09/25, at 1:33 A.M., showed the resident's appetite varied from 25% to 100%. The resident fed self and liked snacks. Review of the resident's weight record, showed facility staff obtained and documented the resident's weight as follows:-On 09/10/25, 180.8 lbs.;-On 10/01/25, 177.2 lbs.;-On 10/02/25, 177.6 lbs. a 2% weight loss in one month, 4.5% weight loss in six months. Review of the resident's Nurses Notes showed staff documented the following:-10/07/25 at 2:00 P.M., the resident has refused both meals again this shift. He/She sleeps most of the shift and is not asking for snacks;-10/07/25 at 6:25 P.M., the resident has refused supper again this shift. Education given to resident;-10/08/25 at 2:35 P.M., staff instructed to give the resident snacks when he/she asked even if he/she doesn't eat meals;-10/08/25 at 9:52 P.M., the resident asked for ice cream and water numerous times and was redirected. The resident refused all three meals today;-10/12/25 at 9:56 P.M., (3:00 P.M. to 11:00 P.M. shift) the resident was very demanding and verbal this shift, constantly asking for snacks and drinks;-10/13/25 at 10:20 P.M., the resident refused to eat his/her supper, then after the trays were removed, resident started asking for snacks. The resident asked for ice cream, but this nurse offered him/her a sandwich instead. Resident said he/she did not want a sandwich and that he/she already ate supper. Resident reminded he/she didn't eat supper and asked if he/she would eat a sandwich before ice cream. Resident agreed and ate the sandwich. Resident given ice cream. Resident came back to this nurse immediately after eating ice cream and asked for more. Resident informed they were currently out of ice cream and the snack drawer was also empty. The resident was angry and walked back to his/her recliner;-10/17/25 at 8:19 P.M., the resident approached the nurses station asking for another snack. Reminded he/she just received a snack. Resident picked up a fly swatter, swung it at nurse and said, I'll smack you. Resident approached the nurses station about every ten minutes asking for snacks and drinks repeatedly. Snacks and drinks provided, but resident continued to request more, even after just receiving a snack and drink;-10/25/25 at 9:00 P.M., the resident approached this nurse asking for another snack. Snack just (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	provided a few minutes prior. When the resident was reminded he/she just had a snack, the resident smacked this nurse in the back;-11/01/25 at 11:35 A.M., the resident was encouraged to come to the dining room for meals. Appetite remains poor to fair. Continues to request a snack as soon as he/she gets up from the table;-11/10/25 at 9:22 P.M., the resident has been asking all staff for water refills and snacks all shift. Resident would argue if he/she was told no. Resident asked for a snack every 30 minutes and argued when informed he/she just had one. Review of the resident's Registered Dietician's Progress Notes, dated 11/13/25 at 3:13 P.M., showed the following: -Quarterly nutrition review;-Consistent calorie, regular diet;-Meal intake varies, likes snacks;-2500 ml fluid restriction;-Labs: 11/12/25: Hemoglobin A1C (a blood test measuring your average blood sugar (glucose) over the past 2-3 months) 7.7% (indicates a blood sugar average of 169 to 183;-Skin: No pressure injuries;-Height: 64 inches, weight 177.6 pounds;-No significant weight changes in the past quarter, weight is trending down, but not of concern at this time, will continue to monitor;-Diet order remains appropriate and adequate to meet needs;-No changes advised, continue plan of care. Review of the resident's weight record showed no evidence of staff obtaining the resident's weight for November 2025. Review of the resident's Nurses Notes showed staff documented the following:-11/16/25 at 10:06 P.M., the resident was speaking in a very hateful manner to staff, demanding drinks and snacks;-11/19/25 at 8:01 P.M., the resident refused to get up from recliner for supper. Resident refused to go to the dining table, yelled at nurse and rammed nurse with her walker when attempting to talk to resident about eating. Day shift reports resident has refused all meals today. Snack provided with bedtime medications;-11/25/25 at 9:40 P.M., the resident refused supper tonight and has not asked for snacks;-11/28/25 at 9:30 P.M., the resident refused supper then requested several snacks;-11/30/25 at 9:05 P.M., the resident refused supper then continued to ask for snacks. Review of the resident's weight record, showed staff obtained and documented the resident's weight on 12/01/25 as 162 lbs. Review of the resident's weight records showed resident lost 21.8 lbs. since 06/04/25, which was an 11.86 % weight loss in six months and had lost 15.2 lbs. since 10/01/25 (no weight for November documented) which was an 8.5% weight loss in two months. Review of the resident's Physician Orders, dated December 2025, showed the resident continued monthly weight monitoring, and regular, consistent carbohydrate diet. Review of the resident's Care Plan showed no evidence new interventions or evaluation of the resident's nutrition goals after his/her weight loss in December. The last update to the care plan was 11/13/25 for psych med side effect monitoring, 12/5/25 for wound care related to two new pressure ulcers, and 12/8 honeycomb cushion pressure reduction for chair Review of the resident's medical record showed no documentation the resident's physician, dietician, IDT or resident's representative were notified of the resident's weight loss (per facility policy). Further review showed no assessment was completed upon the noted weight change. There was no documentation of an IDT review, root cause analysis or care plan revision being completed per facility policy. Review of the resident's Nurses Notes, dated 12/04/25 at 1:33 P.M., showed the resident had two new wounds to the coccyx (bony part of lower back/buttocks) area measuring 1.5 centimeters (cm) x 1 cm and 1cm x 1cm. Observation on 12/08/25 from 12:00 P.M. to 1:10 P.M. (continuous observation from the time the meal tray cart was opened until most residents left the dining area), showed the resident in a recliner with his/her legs elevated in the resident's television viewing area (common area with 18 recliners) The resident's eyes were closed during all observations. Staff served meal trays and offered assistance to other residents. No staff attempted to wake the resident or offer the resident a meal tray. The resident's mouth and lips were dry, flaky and cracked. Observation on 12/10/25 at 8:43 A.M., showed the resident in a recliner in the television viewing area with his/her legs elevated. Staff served meal trays and offered feeding assistance to other residents. Staff asked the resident if he/she wanted to eat breakfast, and the resident said no. Staff did not bring a tray to the resident or snack foods and only made a verbal offer. Staff did not serve any food to the resident. The resident had a pitcher of water beside him/her, but no staff offered the resident fluids, and the resident did not attempt to reach them him/herself. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's medical record showed no documentation of the resident'spersistent refusal of meals was investigated or care planned per facility policy. Observation on 12/10/25 at 11:50 A.M. to 12:20 P.M., showed the resident in a recliner in the television viewing area with his/her legs elevated and his/her eyes closed. Staff served meal trays and offered feeding assistance to other residents. No staff attempted to wake the resident or offer the resident a tray. During the survey process from 12/08/25 through 12/11/25 and 12/15/25, when the state agency (SA) was on the locked dementia unit where the resident resided, the resident had a drink beside him/her but never attempted to get the drink and provide him/herself with fluids and never had food offered or in front of him/her during the time the SA staff did observations. All other residents had multiple meals during those times. During a telephone interview on 12/18/25 at 12:40 P.M., the resident's family representative said the following: -He/She was the resident's emergency contact and made decisions for the resident;-The facility did not notify him/her of the resident's weight loss;-He/She expected staff to try to get the resident to eat, and if he/she did not, staff should give the resident snacks, a shake, or something;-The facility had not notified him/her the resident was refusing meals or had varying intakes;-He/She felt like the facility was giving the resident too much medication and all the resident did was sleep; -He/She would prefer the resident not be so drugged up all the time, and maybe then the resident could eat. During an interview on 12/15/25 at 3:15 P.M., Licensed Practical Nurse (LPN) A said the following: -She usually worked on the Special Care Unit (dementia unit);-Weights for residents were reviewed by the charge nurse the first week of the month;-He/She did not work the first week of December and he/she was not sure who would have worked;-He/She did not know the resident had a significant weight loss, but the resident had not been eating well; -The resident will eat oatmeal cream pies;-The resident has not been on any supplements, and had no orders for extra snacks or anything that he/she knew of;-He/She was not sure why the resident did not have a weight in November;-If a resident had weight loss, the charge nurse was responsible to contact the physician;-The charge nurse was responsible to alert nursing administration when a weight loss was found. During an interview on 12/23/25, at 3:54 P.M., the Care Plan Coordinator said the following:-If a resident has a weight loss or gain the first thing staff are expected to do is reweigh the resident to ensure accuracy;-The charge nurse should have reported the resident's weight on 12/01/25, after they got a reweigh;-When there is a weight loss the charge nurse was expected to notify the physician, dietitian and get orders for supplements or an intervention;-The resident's fluid restriction was ordered when the resident had a low sodium last summer;-She was on a 2000cc fluid restriction for the low sodium level, then in June her physician increased her fluid allowance to 2500ml, which wasn't much of a restriction; the resident doesn't come close to drinking that much. During an interview on 12/15/25, at 4:43 P.M. the Director of Nursing (DON) said the following:-Staff are expected to weigh residents monthly;-When she started, staff said there had been a weight loss committee, but the meetings stopped;-There was no current IDT weight loss committee;-The charge nurses are expected to notify the physician and dietitian of any weight loss; -If weight loss was identified, staff would be expected to monitor the resident more closely by initiating weekly weights, monitoring intake, re-evaluate the care plan to find the root cause of the weight loss, and implement interventions to help the resident's weight to stabilize;-Staff are expected to physically bring food to every resident;-A resident with dementia may eat if food was placed within reach;-Staff did not make her aware of the resident's weight loss. She did not think anyone was monitoring weights like they needed to be monitored. During an interview on 12/18/25 at 9:10 A.M., the Registered Dietitian said the following:-The facility had not contacted her about weight loss for the resident;-There had been many changes to the administration at the facility and she had only been going to the facility for a few months. The facility did not seem to have someone in charge of evaluating the weights and communicating issues to her;-She comes to the facility once a month, so she expects the staff to notify her of a significant weight loss in between visits so a resident does not continue to lose weight;-She expected staff to start nutritional supplements, assist residents with eating or call her to (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	discuss options until her next visit;-She documented on the last visit the resident had some gradual weight loss and to monitor, but they did not notify her that the resident had a significant weight loss on 12/01/25;-Weight loss can cause many health issues including skin breakdown, weakness, falls, and low blood sugars;-This resident had wounds that had just healed. She was also not notified the resident's wounds had reopened;-Communication and early interventions can improve outcomes with weight loss;-If staff had contacted her, she would have talked to the staff and made a recommendation for a supplement or something to start (based off their answers) until she could do a formal assessment. During an interview on 12/19/25, at 8:50 A.M., the resident's physician (Physician R) said the following:-She was not made aware of the resident's weight loss until she visited the facility on 12/18/25;-If a resident experienced significant weight loss, she expected staff to notify her and the dietitian as soon as weight loss was identified so interventions could be attempted;-She would expect communication for a weight loss with the family to see if they wanted aggressive or conservative interventions to be made;-She expects the facility to attempt to find the root cause of the weight loss, such as needed assistance, a dental issue, or some other issue contributing to the weight loss;-If staff had reported to her, she would try to find out what the family's goals were to determine if they wanted conservative or aggressive measures;-With conservative measures, they can attempt snacks, supplements like nutrition shakes, attempts to cue and assist a resident to eat;-If a family wanted more aggressive measure, they could look at appetite stimulants and more aggressive interventions;-Significant weight loss can lead to other health concerns so efforts should be made to slow weight loss down and stabilize a resident's weight if possible;-The resident was not on diuretics, he/she had issues with a low sodium in the past;-2500 ml wasn't much of a fluid restriction, just to make sure if his/her psychiatric medications cause him/her to be thirsty he/she isn't excessively drinking.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility staff failed to ensure a resident with dementia (Resident #14), in a review of 17 sampled residents received high-quality, compassionate, and individualized care that supports his/her dignity, well-being, and independence, while addressing the unique challenges posed by dementia. The facility failed to find the root cause and triggers for a resident's behavior and initiate non-pharmacological Interventions, use effective communication strategies, and provide appropriate guidance to staff for managing behavioral symptoms. The resident experienced lethargy, weight loss, physical altercations, agitation, and new skin breakdown. The facility census was 59. Review of the facility's policy, Dementia Care for Long-Term Care Facility, undated, showed the following:-The purpose of this policy is to ensure that all residents with dementia in this long-term care facility receive high-quality, compassionate, and individualized care that supports their dignity, well-being, and independence, while addressing the unique challenges posed by dementia;-This policy applies to all residents diagnosed with dementia or related conditions such as Alzheimer's disease, vascular dementia, and other neurodegenerative diseases in this facility. It is intended for use by all staff members, including nursing, medical, therapy, dietary, and activity staff, to guide the provision of care for residents with dementia.-Person-Centered Care Approach:The facility is committed to providing person-centered care for all residents, with special emphasis on those with dementia. This approach recognizes and respects the individuality of each resident and seeks to maintain their dignity, autonomy, and quality of life. Care plans will be developed in partnership with the resident, their family members, and/or legal representatives.-Key Components of Person-Centered Care:Individualized Care Plans: Each resident will have a personalized care plan that addresses their specific needs, preferences, and abilities. This plan will be updated regularly to reflect changes in the resident's condition and abilities.Resident Preferences: Care plans will incorporate the resident's history, preferences, likes, and dislikes, including their previous lifestyle, routines, and cultural practices.Involvement of Family and Caregivers: Family members and caregivers will be encouraged to participate in the care planning process and ongoing decision-making. They will also be provided with educational resources and support regarding dementia care.-Staff Training and Education:Staff members involved in the care of residents with dementia will receive ongoing training on best practices for dementia care. The training will cover, but not be limited to, the following:Understanding Dementia: Types, stages, symptoms, and progression of dementia.Non-Pharmacological Interventions: Techniques for managing behavior without the use of medications, including redirection, environmental modifications, and structured activities.Communication Strategies: Methods to improve communication with residents who have cognitive impairments, including using simple language, non-verbal communication, and patience.Managing Behavioral Symptoms: How to address common dementia-related behaviors, such as wandering, aggression, agitation, and sundowning, in a safe and respectful manner.Person-Centered Care Practices: Ensuring that care is individualized, consistent, and compassionate;-Staff will undergo this training upon hire and at regular intervals, and training will be updated as new best practices or evidence-based approaches emerge.-Behavioral and Pharmacological Interventions:The facility will focus on non-pharmacological interventions to manage dementia-related behaviors, in line with CMS guidelines. When behavioral interventions are insufficient, medications may be considered, but only as a last resort and in accordance with the following:Behavioral Interventions First: Staff will prioritize non-medication approaches, such as redirection, individualized activity programs, and modifications to the environment, to address behaviors like agitation or aggression.Minimizing Medication Use: Antipsychotic medications and other sedatives will not be used as a primary method of managing dementia symptoms unless (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	1410 West Line Street Palmyra, MO 63461

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F 0744 Level of Harm - Actual harm Residents Affected - Few	absolutely necessary. When medication is prescribed, it will be closely monitored for effectiveness and side effects, and dosage will be minimized.Regular Review: The use of medications, particularly antipsychotics, will be regularly reviewed by a physician and a multidisciplinary team to ensure they are still necessary and that non-pharmacological interventions are being utilized.-Resident and Family Rights:Residents with dementia have the same rights as other residents, including:Right to Autonomy: To the extent possible, residents will be allowed to make choices about their care and daily activities. Staff will encourage participation in decision-making, even if the resident cannot fully express themselves.Right to Privacy and Dignity: Residents will be treated with dignity and respect at all times. This includes respecting their personal space and ensuring confidentiality regarding their medical and personal information.Right to Participate in Care Planning: Family members and legal representatives will have the opportunity to participate in care planning and review. Any changes to care plans will be communicated to families regularly.Right to a Safe Environment: The facility will provide a safe and supportive environment that is free from abuse, neglect, and mistreatment. All allegations of mistreatment will be promptly investigated.-Evaluation and Continuous Improvement:The facility will continuously assess the effectiveness of its dementia care practices. This will include:Regular Care Plan Reviews: Care plans for residents with dementia will be reviewed and updated at least quarterly, or more frequently if needed.Resident and Family Feedback: The facility will actively solicit feedback from residents and their families about their satisfaction with the care provided. This input will be used to refine care practices and ensure that the facility is meeting residents' needs.Quality Assurance and Audits: The facility will conduct regular audits of care practices, safety procedures, and resident outcomes to ensure compliance with this policy and best practices in dementia care. Review of the facility's policy, Dementia Behavioral Symptom Flowchart, undated, showed the following:Step 1: Identify Behavior:Examples: Agitation, aggression, wandering, shouting, refusal of care, repetitive actions, sleep disturbances.Document behavior: type, frequency, severity, triggers.Step 2: Ensure Safety:Immediate risk to resident or others?Yes: Intervene to prevent harm, remove hazards, call for assistance.No: Proceed to Step 3.Step 3: Assess for Causes / Triggers (ABC Approach)A - Antecedent: What happened before the behavior? (environment, interaction, unmet needs);B - Behavior: Describe the behavior objectively;C - Consequence: How did staff or others respond?Common Triggers to Evaluate:Pain, hunger, thirst, fatigue;Infection, constipation, urinary retention;Environmental overstimulation or under stimulation;Change in routine or caregivers;Emotional needs (loneliness, anxiety).Step 4: Implement Non-Pharmacological Interventions First:Redirection, reassurance, and calm communication;Structured activities, music, or reminiscence therapy;Adjust environment (lighting, noise, seating, personal items);Offer comfort measures (hydration, snack, toileting, repositioning).Step 5: Evaluate Effectiveness:Behavior improved?Yes: Document interventions and continue monitoring;No: Proceed to Step 6.Step 6: Consider Medical / Pharmacologic Evaluation:Consult nurse or physician for potential medical causes (infection, pain, medication side effects);Medications for behavior only if non-pharmacologic interventions fail, with:Physician order;Monitoring plan;Documentation of rationale.Step 7: Update Care Plan:Record behavior, interventions, triggers, and outcomes in the resident's care plan;Share updates with interdisciplinary team and family;Revise strategies as needed.Key Notes:Always prioritize safety and dignity.Use consistent documentation for regulatory compliance.Involve family in care planning whenever possible. Review of drugs.com shows the following:-Risperidone, an antipsychotic medication, is used to treat schizophrenia (chronic brain disorder that disrupts how a person thinks, feels, and behaves, causing them to lose touch with reality (psychosis) through symptoms like hallucinations (hearing voices/seeing things), delusions (false beliefs), disorganized speech, and unusual motor behavior), bipolar (a mental health condition causing extreme mood swings between emotional highs (mania/hypomania) and lows), and agitation related to autism (neurodevelopmental disorder effecting social interaction and communication). Risperidone carries a warning for increased risk of death in elderly patients with dementia-related psychosis. Risperidone is (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	not approved for use in older adults with dementia-related psychosis.-Seroquel, and atypical antipsychotic medication, is used to treat schizophrenia, mania or manic disorders, depression with bipolar disorder. Seroquel warnings include Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis.-Haloperidol, and atypical antipsychotic medication, is used for schizophrenia, to treat motor control and speech ticks for Tourette's Syndrome (neurologic disease that presents with multiple tics). Warnings include Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Haloperidol injection is not approved for the treatment of patients with dementia-related psychosis. 1. Review of Resident #14's face sheet shows the resident had diagnoses of Alzheimer's, dementia, and anxiety. Review of the resident's Physician's Orders, dated 09/16/24, showed an order for Lexapro (an antidepressant medication) 10 mg daily for anxiety disorder. Review of the resident's Care Plan, last updated 11/13/24, showed the following:-The resident has cognitive deficits related to diagnosis of dementia;-Goal: maintain cognitive levels for Activities of Daily Living (ADLs), safety and quality of life through next review;-Encourage resident to attend activities so he/she can socialize with other residents;-Ask one question at a time and give him/her time to respond before asking another question;-Encourage him/her to come to the dining room for meals;-Psychotropic drug use: Potential for Adverse Drug Reactions:-Resident is on medication for anxiety;-Goals: Resident will not experience adverse reaction to medication thru next review.-Interventions:-Encourage verbalization of feelings;-Monitor for changes in behavior and mood (e.g., lethargy, change in gait or balance problem);-Observe for any signs of decline in functional or cognitive status, notify nurse of any findings;-Significant side effects of psychotropic drug therapy may include any of the following: low blood pressure, uncontrolled mouth movements, continual body movements, cognitive and behavioral changes. Report to nurse any declines with activities of daily living (ADLs) or mental status;-Report increased sleeping or restlessness;-Monitor for side effects of psychotropic medication to include any of the following: Drowsiness, dizziness, dry mouth, blurred vision, tiredness, nausea, constipation, weight gain, trouble sleeping or muscle or nervous system problems (anxiety, agitation, jitteriness, drooling, trouble swallowing, restlessness, shaking or stiffness). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 05/22/25, showed the following:-Moderate cognitive impairment;-No behaviors, hallucinations, delusions, or rejection of care;-Snacks between meals was very important to the resident;-Walker use;-Weighs 186 pounds (lbs.), therapeutic diet;-Independent with transfers, and ambulation 150 feet;-Set up or clean up assistance from staff for eating; -Antidepressant medication daily. Review of the resident's Physician's Orders, dated 07/17/25, showed an order for Seroquel (an antipsychotic medication for hallucinations and delusions) 25 milligrams (mg) daily for anxiety disorder. (Anxiety is not an approved use for Seroquel and is not approved for elderly residents with dementia. Review of the resident's Care Plan, updated 08/11/25, showed the following:-Behavior Management program:-Resident requires ongoing redirection, monitoring and structured activities to alter behavior problems;-Smacks staff and peers on buttocks, hits staff on arms, and goes into linen room for washcloths numerous times;-Refuses to go to meals at times and then wants snacks and fluids;-Refuses incontinent care at times;-Resident takes handfuls of napkins out of holders and puts them in his/her pants;-Resident will respond to redirection from staff when behavior occurs thru next review;-Resident will engage in on and off unit programs to maintain current sensory awareness thru next review;-Encourage family involvement in care and visits;-Provide structured programs appropriate for the resident's cognitive status;-Social Service intervention and evaluation as needed;-Prompt resident to not smack or hit staff;-Re-approach with refusal of incontinent care and meals by different staff members;-Medication changes;-Gentle approaching and re-direction;-Staff will monitor the resident closely when around peers;-Moved into a room by himself/herself due to (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	resident-on-resident altercations. The care plan did not include staff evaluated the root cause of the resident's behaviors and interventions were planned as a result of this evaluation. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Physical behavioral symptoms directed towards others one to three days;-Diagnosis of Alzheimer's/dementia;-New Antipsychotic medication daily;-Antidepressant medication daily;-Weighs 184 lbs.;-No pressure ulcers. Review of the resident's Progress Notes, dated 8/25/2025 at 2:40 P.M., showed the following: -Quarterly Registered Dietitian nutrition review;-Consistent carbohydrate, regular diet; -Meal intake varies, does like snacks; -2500 ml fluid restriction; -Labs: 08/06/25: basic metabolic panel (BMP - a common blood test that checks your body's chemical balance, metabolism, and kidney function) all within normal limits, except glucose (blood sugar) 176 (history of diabetes) (normal glucose range on a BMP is 70 - 100); -Skin: No pressure injuries; -Height: 64 inches, weight 184.4 pounds;-Weight stable/no significant changes in the past quarter;-Diet order remains appropriate and adequate to meet needs;-No changed advised continue plan of care. Review of the resident's Nurses Note, dated 09/03/25, at 8:29 A.M., showed staff received a fax back from the physician about increased behaviors and the physician increased Seroquel to 25 mg twice daily. Review of the resident's medical record, including nurses' notes and resident documents, did not identify what behaviors were reported or what interventions had been attempted and failed related to the resident's behaviors. Review of the resident's Physician's Orders, dated 09/03/25, showed an order to increase Seroquel) 25 mg daily to two times per day, diagnosis of dementia. (dementia is not an approved use for Seroquel). Review of the resident's Nurses Note, dated 09/04/25, at 10:03 P.M., showed the resident continues obsession with hoarding of napkins and washcloths. Becomes aggressive with staff intervention. Resident smacked a staff member on his/her bottom. When resident told to keep his/her hands to himself/herself, he/she laughed. Review of the resident's medical record showed no documentation staff attempted to find the root cause of the resident hoarding napkins and washcloths, or provide accommodations to the resident to address the behavior (providing own supply of napkins etc. Review of the resident's Nurses Note, dated 09/07/25, at 10:15 A.M., showed the resident continues with behaviors such as yelling and hitting staff while attempting to get him/her up to use the restroom. After numerous attempts made to get him/her to use restroom finally used restroom but refused his/her breakfast. Review of the resident's medical record showed no documentation staff attempted to determine the root cause of the resident not wanting to use the bathroom, but showed staff repeatedly attempted to get the resident to use the bathroom which triggered physical and verbal behaviors. when the resident refused breakfast; the record showed no attempts by staff to offer alternatives like snacks to ensure the resident received nutrition. Review of the resident's Nurses Note, dated 09/08/25, at 9:00 P.M., showed the resident continues obsession with hoarding of napkins and washcloths. Has smacked and shoved staff three times so far this shift. Currently has multiple napkins and washcloths shoved in the side of his/her recliner and in the cup holder next to recliner. Review of the resident's weight record, dated 09/10/25, showed the resident weighed 180.8 lbs. Review of the resident's Nurses Note, dated 09/13/25, at 8:45 P.M., showed at supper the resident walked by a peer and pulled his/her hair unprovoked. Immediate staff intervention and separation of residents. Resident then re-approached the peer's table and was bothering them while they were trying to eat, again requiring staff intervention. At this time the resident swung at a nurse, attempting to hit her. Resident was very difficult to redirect and has been aggressive each time with staff intervention. Review of the resident's medical record showed staff no documentation staff attempted to identify what triggered the resident's physical behaviors, or what interventions were attempted besides redirection when redirection was not successful (i.e. pain, thirst, hunger, boredom). Review of the resident's Nurses Note, dated 09/17/25, at 8:06 P.M., showed the resident smacked the nurse when the nurse took his/her cup from his/her walker. The nurse had just provided 1/2 cup of ice water five minutes prior, and the resident took cup to the bathroom and filled it with water. Explained to the resident that he/she was on a fluid restriction and staff had to keep track of (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	his/her intake. Review of the resident's medical record showed no evidence the resident was consuming a fluid amount contrary to his/her restriction. Staff documented this triggered the resident's behavior. Staff confronted the resident than adding the amount to the resident's intake and adjusting later if needed. Review of the resident's Nurses Note, dated 09/18/25, at 10:23 P.M., showed the resident was not cooperative with staff during this shift. He/She made repeated efforts to take napkins out of the holders and hide them. He/She continued to try to put the shades down, although the other residents asked him/her not to do so. He/She yelled at another resident (about taking the napkins when the other resident tried to stop him/her). He/She made repeated attempts to obtain beverages and would not take redirection (including trying to pour water from the pitcher on the med cart). At approximately 10:00 P.M., he/she sat in a recliner near the television and appeared to calm down. Review of the resident's medical record showed no evidence staff attempted to identify what triggered the resident's hoarding of napkin, or why the resident was closing the shades. When the resident was taking fluids from other resident's and the medication cart, staff did not document what interventions were attempted to alleviate the resident's thirst. Review of the resident's Nurses Note, dated 09/24/25, at 4:07 P.M., showed the resident refused breakfast or to get up to the bathroom. At lunchtime he/she screamed at staff numerous times. Once he/she was up he/she was obsessed with getting wash cloths and napkins which he/she put inside his/her incontinence brief, so he/she did not have to get up to go to the bathroom. The resident gets angry at staff when he/she was redirected and will hit staff. Updated physician on the resident's behaviors. Review of the resident's Nurses Note, dated 09/26/25, at 6:02 P.M., showed the physician's response to the fax about behaviors was I just increased Seroquel last week, gently redirect for now. Review of the resident's Nurses Note, dated 09/28/25, at 10:35 A.M., showed notified by staff this resident was becoming physically aggressive toward other residents. This resident was noted to bend another resident's left index finger back after the resident placed his/her hand over the napkin dispenser on his/her table to prevent this resident from taking it. This resident smacked another resident in the face on the left side. Resident hits staff unprovoked when he/she passes by them. Resident was unable to be redirected. Call placed to on call nurse practitioner to update on behavior. Requested order to possibly send to emergency room for evaluation. Order received for Haldol (antipsychotic medication) 5mg IM one time if resident continues to be physically aggressive toward other residents. Review of the resident's Physician's Orders, dated 09/28/25, showed an order for haloperidol lactate (an antipsychotic medication for hallucinations and delusions) 5 mg/milliliter (ml), inject intramuscularly (IM) for one dose for dementia. (dementia is not an approved use for haloperidol). Review of the resident's Nurses Note, dated 09/28/25, at 1:20 P.M., showed the resident continued to be physically aggressive toward staff and raised a hand to slap another resident again when the resident stopped this resident from removing napkins from his/her tray. Staff intervened and no contact made between residents. Haloperidol 5 mg given IM in right gluteal (muscle in the buttocks). Review of the resident's Nurses Notes, dated 09/28/25, at 4:55 P.M., showed staff updated the resident representative about the resident's behaviors and administration of Haldol today. Resident's representative states what am I supposed to do about it? Informed him/her we will be talking to the resident's primary care physician about resident behaviors and other possible interventions and will keep him/her updated. Review of the resident's Nurses Note, dated 09/28/25, at 7:06 P.M., showed at 5:30 P.M. the resident was walking back from the bathroom and approached a staff member. Resident shoved his/her walker into the back of staff very hard. Resident said he/she will do what he/she wants. Review of the resident's Nurses Note, dated 09/28/25, at 7:07 P.M., showed the resident again rammed his/her walker into a staff member. Review of the resident's medical record showed staff did not identify what possibly triggered the resident or the root cause of the behavior. The staff also did not document attempted interventions to alleviate the resident's triggers. Review of the resident's Nurses Note, dated 09/28/25, at 7:17 P.M., showed resident walked by a peer and smacked him/her on the bottom. Immediate staff intervention and separation of residents. Resident instructed to keep (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	his/her hands to himself/herself. The resident laughed and walked away. Review of the resident's Nurses Note, dated 09/28/25, at 8:25 P.M., showed the resident approached this nurse asking for a drink and another snack, chocolate milk provided to the resident. The resident asked for another cookie. The resident has had three cookies and a snack in the last two hours, when another snack was not provided, the resident smacked this nurse. Instructed to keep his/her hands to himself/herself. Review of the resident's medical record showed staff did not show any dietary restrictions or the resident had a limit on snacks. Review of the resident's Nurses Note, dated 09/29/25, at 3:41 P.M., showed a representative for the resident visited and was updated on resident's behaviors, i.e. taking wash cloths and napkins and putting in his/her pants and hitting staff. Resident moved to a different room to prevent resident to resident issues. Resident representative requested to test for urinary tract infection, fax sent to the primary physician. Review of the resident's Nurses Note, dated 10/01/25, showed the physician responded with an order for a urinalysis with a culture and sensitivity. Review of the resident's Nurses Note, dated 10/01/25, at 5:52 A.M., showed urine sample obtained. Review of the resident's Nurses Note, dated 10/01/25, at 2:39 P.M. showed the physician ordered Rocephin (antibiotic) 1 gram IM one time and Cefdinir (antibiotic) 300 mg, by mouth twice a day for 7 days for a urinary tract infection. Review of the resident's urinalysis dated 10/01/25, showed the resident was positive for nitrates and bacteria, which indicated a urinary tract infection. Review of the resident's weight record, dated 10/02/25, showed the resident weighed 177.6 lbs. (2% weight loss in one month, 4.5% weight loss in six months). Review of the resident's Nurses Note, dated 10/10/25, at 9:36 P.M., showed the resident taking napkins from the dining room and stuffing them down his/her pants. Review of the resident's care plan showed no evidence of review or added interventions to address the resident's dementia or behaviors. Review of the resident's Nurses Note, dated 10/12/25, at 9:56 P.M., showed the resident was very demanding and verbal this shift, constantly asking for snacks and drinks. He/She was not taking redirection well. He/She made numerous attempts to obtain wash cloths and napkins and became loud and belligerent when staff attempted to take them from him/her. Review of the resident's medical record showed staff did not identify any food restrictions, or that the resident drank over his/her fluid restriction. The resident expressed being hungry and thirsty and wanted washrags and napkins and had behaviors when the staff did not meet his/her needs. Review of the resident's Nurses Note, dated 10/17/25, at 8:19 P.M., showed the resident continued with fixation with collecting napkins and washcloths. Has been extremely aggressive with staff intervention. Resident smacked this nurse when caught in linen closet shoving five washcloths down his/her pants. Resident later walked by nurse and hit him/her on his/her bottom unprovoked. Resident picked up fly swatter, swung it at nurse and said, I'll smack you. Fly swatter taken from resident and resident retreated to his/her recliner in the common area. Review of the resident's Nurses Notes, dated 10/31/25, at 7:23 P.M., showed the resident swung at another resident but did not make contact. Review of the resident's weight record, dated November 2025, showed no weight was documented for the resident. Review of the resident's Nurses Note, dated 11/01/25, at 3:47 A.M., showed the following:-Resident request snacks and water when awake constantly;-Hides wash cloth and napkins in his/her recliner;-Hoarding wash cloths and napkins. Review of the resident's Nurses Note, dated 11/01/25, at 11:23 A.M., showed the following:-Resident cursing or verbally aggressive;-Scratching or hitting others;-Screaming. Review of the resident's medical record showed staff did not identify what possibly triggered the resident or the root cause of his/her verbal or physical behaviors There were no documented interventions to alleviate the resident's triggers and prevent physical harm to other residents. Review of the resident's Nurses Note, dated 11/02/25, at 3:46 A.M., showed the following:-Resident yells when awakened to go use the bathroom;-Hoarding napkins and washcloths. Review of the resident's Nurses Note, dated 11/03/25, at 3:29 A.M., showed the following:-Resident yells when awakened to go use the bathroom, yells I don't gotta go and is usually already incontinent;-Hoarding napkins and washcloths. Review of the resident's Nurses Note, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food service equipment/surfaces were appropriately cleaned under sanitary conditions in accordance with professional standards for food service safety. The facility census was 59.Record review of the facility's Guideline & Procedure Manual, 2011 Edition, showed the following:-Clean Equipment - All equipment used in food preparation is clean and sanitary. Equipment is washed, rinsed and sanitized after each use. Food contact surfaces are sanitized before they are used with a cleaning cloth that is stored in a sanitizer solution between uses;-Cleaning Rotation - Items cleaned daily (stove top), items cleaned weekly (hood/filters, shelves, ovens), Items cleaned monthly (walls);-Sanitation of Dining and Food Service Areas - The dining services manager will record the necessary cleaning and sanitation tasks for the department, all staff will be trained on the frequency of cleaning, a cleaning schedule will be posted for all cleaning tasks;-Cleaning Instructions (range) - Wipe the outside surface and burner knobs with a cloth soaked in hot, soapy water, scrub drip trays and the front, sides, and back of range with hot water and detergent, or degreaser, wipe the outside surface with a sanitizing solution and allow to air dry;-Cleaning Instructions (oven) - Wash outside of door, door handles and frame with hot, soapy water. 1. Observations in the kitchen on 12/8/25 between 10:05 A.M. and 1:40 P.M., and on 12/9/25 between 6:30 A.M. and 11:50 A.M., showed the following:-The top surface of the steamer oven, located next to the ice machine, had a moderate buildup of dust, debris, and oil;-The top surface of the upright four-door oven, located next to the four-burner stove top, had a moderate to heavy buildup of dust, debris and oil/grease coating;-The stainless-steel shelf above the four-burner stove top/griddle had a moderate buildup of dust, debris and oil;-Six range hood fire suppression nozzle cables, located above the four-door oven, four-burner stove top/griddle and deep fryer, had a moderate to heavy buildup of dust, debris and oil/grease coating;-A wall-mounted, metal electrical receptacle box and wire channel, located along and above a stainless-steel preparation table and behind a toaster and microwave oven, had a heavy buildup of dust, debris and oil/grease coating. During an interview on 12/8/25 at 1:15 P.M., [NAME] O said he/she had not noticed the identified areas with dust, debris, and oil/grease buildup. There was no set cleaning schedule for the identified areas. During an interview on 12/9/25 at 9:55 A.M., the Assistant Dietary Manager said the following:-She was not aware of the identified areas with a buildup dust, debris, oil, and grease. Some of the areas were on top of equipment and were more difficult to observe without a ladder;-The Dietary Manager and Assistant Dietary Manager monitored the kitchen daily. No logs are maintained for the identified areas;-She preferred the identified areas be kept clean. Staff working in those areas should clean the area after each meal. During an interview on 12/9/25 at 10:25 A.M., the Dietary Manager said the following:-The cooks and the Assistant Dietary Supervisor should monitor the identified areas weekly; -He was not aware of the identified areas having a dust, debris, and oil or grease;-He wanted the kitchen and identified areas to be clean and monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265237	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	1410 West Line Street Palmyra, MO 63461

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop complete policies and procedures to monitor the facility's water system and implement the facility policy to monitor for Legionella (a bacterium that can cause a serious type of pneumonia called Legionnaires' Disease (a bacterial disease commonly associated with water-based aerosols) in persons at risk) control that included specific control parameters based on Center for Disease Control and Prevention (CDC) and American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE)) standards. The facility failed to ensure staff performed proper infection control practices when providing care to one resident (Resident #32), in a review of 17 sampled residents sampled, and for one additional resident (Resident #56). The facility failed to handle linens in a way to prevent contamination. The facility census was 59. 1. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html). Environmental, clinical and epidemiological considerations for healthcare facilities are described in this toolkit;-Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system;-Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens;-Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Review of the facility's policy Legionella and Water Management Policy, dated 11/01/19 and reviewed 10/31/24, showed the following:-As part of the infection prevention and control program, our facility has a water management program, which is overseen by the maintenance department and the water management team;-The water management team includes the administrator, maintenance, director of nursing and the medical director;-The team is to identify areas in the water system where Legionella can grow and spread to reduce the risk of Legionnaire's disease;-The CDC water prevention toolkit and ASHRAE recommendations have been used in developing a water management program;-A detailed description and diagram of the water system in the facility will include: a. Water intake - comes from the city; b. Cold water delivery; c. Hot water delivery - Hot water heaters; d. Waste - out to sewer-Identification of areas in the water system that could encourage the growth and spread of Legionella include water heaters, filters, showerheads, hoses, personal humidifiers, medical machines such as a Continuous Positive Airway Pressure (CPAP) devices;-Measures used to control the spread of legionella: a. Diagram of where control measures are applied; b. Monitor control limits; c. Documentation of the program. Review of the facility's undated policy, Legionella Surveillance and Detection, showed the following:-Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella;-Legionnaire's disease will be included as part of our infection control program;-Clinical staff will be trained on signs and symptoms affiliated with pneumonia and Legionnaire's and when to notify physician in regard to testing: Cough, shortness of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	breath, fever, muscle aches, headache, and diarrhea, nausea and confusion associated with Legionnaires disease;-If pneumonia or Legionnaire's disease are suspected, the nurse will notify the physician immediately with an assessment of the resident's condition;-Physician will decide based on assessment if there is a need to test for Legionnaire's disease;-Depending on the severity of illness, a hospital transfer may be initiated;-If Legionella is detected in one or more residents: a. Initiate active surveillance for Legionnaires disease; b. Notify the local health department; and c. Notify the Administrator and Director of Nursing will contact the Department of Health and Senior Services;-The Water Management Team will investigate to possibly locate the source of contamination. Review of the facility policies did not include control limits, specific information for monitoring water temperatures, dead legs, flushing unused areas, monitoring for scaling, sediment, or biofilm within the water system or guidance on what to monitor and what actions to take if any findings were outside facility established parameters. The policies did not include what testing would be done if legionella was suspected. The facility did not implement a water management team or set parameters for the team to monitor. During an interview on 12/11/25, at 9:10 A.M., the Maintenance Director said the following:-He did not know much about Legionella;-He did not know what ASHRAE was or what it stood for;-The facility did not have a water management team or meetings to discuss Legionella;-He had never seen a water flow map in the facility, so he did not think the facility had one;-The facility did not have meetings to discuss anything related to water management. During an interview on 12/15/25, at 3:10 P.M., the Assistant Director of Nursing said she will be the primary Infection Preventionist. She did not know much about Legionella and had not heard about a water management team. During an interview on 12/15/25, at 4:43 P.M., the Director of Nursing said the following:-To her knowledge, the facility did not have a water management team;-To her knowledge, the facility did not screen residents with new cases of pneumonia for Legionella. -The facility did not currently monitor any residents for Legionella. During an interview on 12/15/25, at 4:30 P.M., the Administrator said he started in October 2025 and had not been able to fully evaluate the facility's water management program, however, he knew it was not being done properly. Review of the Centers for Disease Control and Prevention Legionella Environmental Assessment Form, undated, showed Legionella generally grew well between 77 degrees Fahrenheit (F) and 113 degrees F. The optimal growth range for Legionella is between 85 degrees F and 108 degrees F. Review of the facility's water temperature log, dated 04/01/25, showed the following hot water temperatures: -Dogwood Wing Central Bath 107.4 degrees F;-Dogwood Wing Clean Utility 89.7 degrees F;-Front Men's Bath 103.9 degrees F;-Front Women's Bath 96.4 degrees F. Review of the facility's water temperature log, dated 05/01/25, showed the following hot water temperatures:-Dogwood Wing Central Bath 107.6 degrees F;-Dogwood Wing Clean Utility 90.2 degrees F;-Therapy Bathroom [ROOM NUMBER] degrees F;-Front Men's Bath 86.5 degrees F;-Front Women's Bath 91.9 degrees F. Review of the facility's water temperature log, dated 06/15/25, showed the following hot water temperatures:-Ash Wing Clean Utility 81 degrees F;-Dogwood Wing Central Bath 106 degrees F;-Dogwood Wing Clean Utility 90 degrees F;-Therapy Bathroom [ROOM NUMBER].5 degrees F;-Front Men's Bath 88 degrees F;-Front Women's Bath 90 degrees F. Review of the facility's water temperature log, dated 07/18/25, showed the following hot water temperatures:-Ash Wing Clean Utility 80.5 degrees F;-Dogwood Wing Clean Utility 88 degrees F;-Therapy Bathroom [ROOM NUMBER].5 degrees F;-Front Men's Bath 79 degrees F;-Front Women's Bath 94 degrees F. Review of the facility's water temperature log, dated 08/27/25, showed the following hot water temperatures:-Ash Wing Clean Utility 82 degrees F;-Dogwood Wing Clean Utility 92 degrees F;-Therapy Bathroom [ROOM NUMBER] degrees F;-Front Men's Bath 82.5 degrees F;-Front Women's Bath 91 degrees F. Review of the facility's water temperature log, dated 09/17/25, showed the following hot water temperatures:-Ash Wing Clean Utility 79 degrees F;-Dogwood Wing Clean Utility 87.5 degrees F-Therapy Bathroom [ROOM NUMBER] degrees F;-Front Men's Bath 80 degrees F;-Front Women's Bath 95.5 degrees F; Review of the facility's water temperature log, dated 10/23/25, showed the following hot water temperatures:-Ash Wing Clean Utility 78.5 degrees (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F;-Dogwood Wing Clean Utility 90 degrees F;-Therapy Bathroom [ROOM NUMBER] degrees F;-Front Men's Bath 82.5 degrees F;-Front Women's Bath 96 degrees F. Review of the facility's water temperature log, dated 11/25/25, showed the following hot water temperatures below 108 degrees F.:-Ash Wing Clean Utility 83 degrees F;-Dogwood Wing Clean Utility 91.5 degrees F;-Front Men's Bath 78 degrees F. The facility provided no documentation showing monitoring of cold-water temperatures. Observation on 12/11/25, at 12:12 P.M. in the A hall Shower/Central bath showed the hot water temperature in the shower was 107.2 degrees F. Observation on 12/11/25, at 12:17 P.M. in the utility room, located around the corner from Dogwood Nurses Station, showed the water temperature was 91.5 degrees F when measured with a digital thermometer. Observation on 12/11/25, at 12:24 P.M. showed room the D hall shower faucet (round works hot and cold) turned to hot read 103.9 degrees F with a digital thermometer, and the faucet turned to the cold side read 80 degrees F with a digital thermometer. The sink in the D hall shower room faucet marked hot read 103 degrees F. Observation on 12/11/25, at 12:30 P.M. showed the C hall shower room sink faucet marked hot read 106.2 degrees F with a digital thermometer. The shower in C hall shower room with a round faucet turn same knob for cold and hot water, showed 101 degrees F for the hot side and 80 degrees F for the cold side. Observation on 12/11/25, at 12:40 P.M. showed room C-42 (occupied resident room) faucet marked hot read 104.7 degrees F with a digital thermometer, and faucet marked cold did not work, when the knob was turned no water came out. Observation on 12/11/25, at 12:44 P.M., in the C hall shower room showed the hot water temperature was 105 degrees F and the cold water temperature was 82 degrees F. During an interview on 12/11/25, at 9:10 A.M., the Maintenance Director said the following:-He did a chlorine test every month on the facility's hot water lines;-The water temperatures that he monitored were on the Water Temperature Log;-The maintenance department made sure the hot water was between 105 and 120 in resident rooms;-If the water temperatures were too low, they rechecked to make sure they were in range, but they did not document it anywhere;-The facility did not monitor any cold water temperatures. 2. Review of Resident #57's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/05/25, showed the following:-Required partial/moderate assistance for chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Required substantial/maximal assistance for shower/bathe, upper body dressing, and lower body dressing;-Dependent on staff for toileting hygiene, put on/take off footwear, and personal hygiene;-Frequently incontinent of bowel and bladder. Observation on 12/10/25, at 6:36 A.M., showed the following:-Certified Nurse Assistant (CNA) DD propelled the resident in his/her wheelchair into the shower room; -CNA DD and CNA E put on gloves without washing their hands; -CNA DD and CNA E transferred the resident from his/her wheelchair to the shower chair;-CNA DD finished undressing the resident;-CNA E picked up trash and soiled linen left from previous residents in the shower room, did not change his/her gloves, and picked up clean items and put them in the cabinet; -CNA E removed his/her gloves, rinsed his/her hands in the sink (less than five seconds), did not use soap, turned the water off touching the knobs, dried his/her hands with paper towels, and left the shower room;-CNA DD proceeded to shower the resident;-CNA E returned to the shower room with clean towels, did not wash hands, and put on gloves;-The resident had a bowel movement during the shower and there was feces on the floor;-CNA DD wiped up the feces on the floor with a washcloth he/she used on the resident. Staff did not disinfect the floor;-CNA DD did not change his/her gloves after cleaning up feces off the floor and washed the resident's perineal area with wash cloths. Feces were observed on the washcloths;-CNA DD rinsed his/her gloves with the shower nozzle and washed the resident's hair while wearing the same soiled gloves;-CNA E bagged the dirty linens and trash from the resident's shower, wiped up water that was going across the floor from the shower, then removed his/her gloves, and without washing hands left the room;-CNA DD dried the resident, dressed the resident, and combed his/her hair with the same gloves he/she used to give the resident a shower and clean feces off the floor and from the resident;-CNA E returned to the shower room, without washing hands, he/she donned gloves;-CNA DD and CNA E placed a gait belt around the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident, assisted the resident to stand, and transferred the resident to his/her wheelchair;-CNA DD and CNA E removed their gloves. CNA DD washed his/her hands and propelled the resident to the common area. CNA E did not wash his/her hands after removing his/her gloves and left the shower room. During an interview on 12/10/25, at 7:10 A.M., CNA E said staff should change their gloves when contaminated. Staff should wash their hands before and after providing care to a resident. Staff should change gloves if they were contaminated and wash their hands if dirty. During an interview on 12/10/25, at 7:12 A.M., CNA DD said staff should wash their hands before and after caring for a resident. Staff should wear gloves if there was any chance of contact with body fluids. Staff should change gloves and wash hands if they were contaminated. Staff should wash their hands when they remove their gloves if they were contaminated. 4. Review of Resident #32's quarterly MDS, dated [DATE], showed the following:-He/She required substantial/maximum assistance with toileting and personal hygiene;-He/She was always incontinent of bowel and bladder. Review of the resident's care plan, last revised on 11/24/25, showed the following:-He/She was incontinent of bowel and bladder;-He/She was at high risk for urinary tract infections (UTIs);-Staff instructed to maintain infection control practices through proper handwashing. Observation on 12/11/25 at 11:40 A.M. showed the following:-The resident sat in his/her recliner and was incontinent of bowel and bladder;-CNA S wore gloves and removed the resident's feces-soiled pants and threw them directly onto the floor. He/She removed his/her gloves, did not wash his/her hands, opened the door to the room, and exited the room;-Feces was smeared on the resident's back, trunk, legs, and was under the resident's fingernails;-CNA S returned to the room, and without washing or sanitizing hands, put on new gloves and cleaned feces from the resident's perineal area and legs with multiple passes with a soapy washcloth. CNA S did not change the surface of the feces soiled cloth with each wipe; -CNA S threw feces soiled linens in a bag on the floor;-While wearing the same soiled gloves he/she wore to provide incontinence care, CNA S dressed the resident, assisted the resident to stand by holding onto the gait belt, removed feces from the resident's back and buttocks with multiple passes with the same surface of a soapy washcloth, and threw feces soiled wash cloths onto the floor;-CNA S did not sanitize the floor after throwing soiled linens on the floor. -Staff cleaned the resident's hands with a disposable wipe, but did not clean under the resident's fingernails. During an interview on 12/11/25 at 12:00 P.M., CNA S said the following:-The bathroom was occupied, so he/she provided the resident's incontinence care in the recliner; -He/She did the best he/she could to clean the resident; -It was almost time for lunch, and he/she didn't have time to take the resident to the shower to properly clean him/her; -He/She tried to get the resident cleaned quickly; -He/She should not have touched clean items with contaminated gloves and should have removed his/her soiled gloves and washed his/her hands. During an interview on 12/15/25, at 4:43 P.M., the Director of Nursing (DON) said the following:-Staff should not perform perineal care while the resident sat in a recliner;-If the resident had extensive soiling, staff should take the resident to the shower to properly clean the resident;-She expected staff to wash the resident's hands if he/she had feces under his/her fingernails;-Soiled linens should never be on the floor;-She expected staff to wash their hands and change their gloves when they were contaminated with body fluids before they touched any other item or area;-She expected staff to wash their hands with every glove change;-Staff were to remove their gloves and wash their hands before leaving a room. 5. Review of the facility's undated policy, Handling Soiled Linen, showed the following:-Soiled Linen: Any linen contaminated with blood, body fluids, secretions, excretions, or visibly dirty materials;-All soiled linen is treated as potentially infectious;-Hands must be washed or sanitized immediately after glove removal;-Place linen directly into designated leak-resistant laundry bags;-Soiled linen must be stored in designated, secure areas separate from clean linen;-Clean linen must never be stored in areas where soiled linen is handled. 6. Observation on 12/08/25, at 12:55 P.M., showed the following:-Housekeeper FF rolled a dirty linen cart next to the dining room in the kitchenette area, the housekeeper had gloves on;-Housekeeper FF went to the cabinet drawer with clean clothing protectors (cloth bibs) and rearranged the drawer;-Housekeeper (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	FF removed unused clothing protectors from the tables and put them back in the drawer;-He/She then picked up soiled clothing protectors from the tables and placed them in the dirty linen barrel;-He/She did not remove his/her gloves or wash his/her hands and picked up unused clothing protectors that were on occupied tables but were still folded and put them in the drawer with other clean clothing protectors with the same soiled gloves; -The housekeeper picked up additional soiled clothing protectors and placed them in the dirty linen barrel;-He/She picked up more unused clothing protectors from other tables and placed them in the cabinet with clean clothing protectors with the same gloves. During an interview on 12/11/25, at 2:32 P.M., Housekeeper FF said clean linen had to be kept separate from dirty linen. Staff were to wear gloves when handling soiled linen. After he/she placed soiled linen in the dirty linen bin, he/she was supposed to remove his/her gloves and wash his/her hands. He/She should not put the unused clothing protectors from the tables in with clean linen. During an interview on 12/15/25, at 4:43 P.M., the Director of Nursing (DON) said the following:-Staff should remove their gloves and wash their hands after touching soiled linens and prior to touching clean linens;-Staff should re-launder unused clothing protectors left on the tables. Staff should not put the clothing protectors back into the drawer with the clean linens.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were awakened according to their preferences or according to how they were feeling that morning for one resident (Resident #57), in a review of 17 sampled residents, and three additional residents (Resident #14, #9 and #29). Per staff interview, for facility convenience, the facility had developed a get up list and early morning shower list for specific residents. This schedule was not consistent with the residents' plan of care. The facility census was 59. Review of the facility policy, Your Rights and Protections as a Nursing Home Resident, undated, showed the following:-As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need; -You have the right to make your own decisions;-At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident;-Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose; -You have the right to decide when you go to bed, rise in the morning, and eat your meals. Review of the facility's Willow/Walnut (Special Care Unit (SCU) halls) 11:00 P.M. to 7:00 A.M. Natural Awakening List, updated 12/10/25, showed the following:-Night shift staff are responsible to get up a specific list of residents, including Residents #29, #14, #57 and #9 (six other residents were listed);-Night shift shower schedule (early morning showers-before 7:00 A.M.) included a list of specific residents for specific days, including Resident #57 (four other residents were listed). 1. Review of Resident #57's Care Plan, last updated 06/23/25, showed the following:-Resident's Activities of Daily Living (ADLs): dependent on staff for showers, locomotion, toileting and eating; -Substantial/maximum assist from staff for dressing, oral/personal hygiene; -Partial/moderate assist for transfers, ambulation; supervision/touching assist for bed mobility;-Incontinent of bowel and bladder, and wears pull ups;-The resident prefers to awaken around 7:00 A.M. and go to bed around 10:00 P.M.;-The resident prefers his/her showers during the day;-When he/she is restless at bedtime, he/she is brought to the common area to a recliner, he/she then will fall asleep;-He/She can make position changes on his/her own. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 11/05/25, showed the following:-Severe cognitive impairment;-Resident was not able to complete the interview for daily preferences;-Walker and wheelchair use;-Requires supervision/touching assistance from staff members for roll right and left, sit to lying, lying to sitting on bed side, and sit to stand;-Requires partial/moderate assistance from staff for eating, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Requires substantial/maximal assistance from staff for shower/bathe, upper body dressing, and lower body dressing.-Dependent on staff for oral hygiene, toileting hygiene, put on/take off footwear, personal hygiene, wheeling wheelchair (50 and 150 feet);-Frequently incontinent of bowel and bladder. Observation on 12/10/25 at 6:30 A.M., showed the following:-Certified Nurse Assistant (CNA) E and CNA DD went into the resident's room;-The resident was in bed with his/her eyes closed;-CNA DD left the resident's room and said he/she would return;-CNA E attempted to wake the resident;-CNA E said the resident's name several times, rubbed the resident's arm, slightly shook the resident's hand, said the resident's name repeatedly and the resident did not respond in any way;-CNA DD returned to the resident's room and CNA E told CNA DD, I could not wake him/her (the resident) up, and when he/she made rounds at 3:00 A.M. the resident sat straight up, so he/she worried the resident may not be ready to get up this morning;-CNA DD said, let's sit the resident up and see if he/she wakes up;-CNA DD took the resident's upper body, shoulders and torso, and CNA E the resident's lower body, hips and legs, and sat the resident to the side of the bed;-The resident did not open his/her eyes;-CNA DD came over to the right side of the resident's bed and the CNA's put a gait belt on the resident, the resident's eyes remained closed;-CNA (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DD said, he/she is responding a little bit, let's go ahead and get him/her up;-CNA E and CNA DD grabbed the resident's gait belt and lifted the resident to a standing position;-The resident's feet shuffled without purpose while the CNA's guided the resident to his/her wheelchair and then the CNA's lowered the resident to his/her wheelchair;-CNA DD propelled the resident down the hall in his/her wheelchair, the resident's eyes remained closed. Observation on 12/10/25 at 6:36 A.M., showed the following:-CNA DD entered the shower room propelling the resident in his/her wheelchair, the resident's eyes remained closed;-CNA DD and CNA E transferred the resident from his/her wheelchair to the shower chair, the resident's eyes remained closed;-When the staff stood the resident up, the resident said, oh, no;-CNA DD finished undressing the resident;-CNA E left the shower room;-CNA DD proceeded to shower the resident;-CNA E came back into the shower room with clean towels;-CNA DD then rinsed his/her gloves with the shower nozzle and washed the resident's hair;-During the entire shower the resident's eyes remained closed;-CNA E left the room;-CNA DD dried and dressed the resident and combed his/her hair;-CNA E returned to the shower room;-CNA DD and CNA E placed a gait belt around the resident, stood the resident up, pulled his/her pants up, and pivot transferred the resident to his/her wheelchair;-CNA DD propelled the resident out to the common area, the resident still had his/her eyes closed. Observation on 12/10/25 at 6:45 A.M. showed staff transferred the resident to a recliner in the common area. The resident's eyes remained closed during the transfer and when he/she was placed in a recliner. During an interview on 12/10/25 at 6:35 and 6:45 A.M., CNA E said they had ten residents to get up on night shift and it was not optional because it was their assignment, per the list. Resident #57 was on the get up list and today they had to give him/her a shower, so he/she had to get up. Night shift usually had one to two showers to give for the morning. Sometimes the residents do not want to get up and they really fight staff. If the residents are awake, or awaken easily, all is good, but many times they must get residents up that do not want to get up, and that makes him/her uncomfortable. The charge nurse was During an interview on 12/10/25 at 6:45 A.M., CNA DD said there was a get up list and staff must start at 5:30 A.M. to get everyone up on time. 2. Review of Resident #29's Care Plan, dated 04/18/24, showed resident preferred to get up in the morning after 7:00 A.M. Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Uses a walker and wheelchair;-The resident requires set up and cueing for ADLs. Observation on 12/10/25 at 6:15 A.M., showed the resident up in a recliner in the common area, dressed and with his/her eyes closed. Observation on 12/10/25 at 6:45 A.M. showed the resident up in the common area in a recliner with his/her eyes closed. During an interview on 12/10/25 at 6:35 and 6:45 A.M., CNA E said they had ten residents to get up on night shift and it was not optional. Resident #29 was on the night shift get up list. 3. Review of Resident #14's Care Plan, dated 06/05/23, showed the resident usually awakened around 7:00 A.M. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate Cognitive Impairment;-Walker use;-Independent with roll left and right, sit to lying, sit to stand, transfers, and ambulation 150 feet. -Set up assistance from staff for dressing upper and lower and footwear. Observation on 12/10/25 at 6:15 A.M., showed the resident up in a recliner in the common area, dressed and with his/her eyes closed. Observation on 12/10/25 at 6:45 A.M. showed the resident up in the common area in a recliner with his/her eyes closed. During an interview on 12/10/25 at 6:35 and 6:45 A.M., CNA E said they had ten residents to get up on night shift and it was not optional. Resident #14 was on the get up list. 4. Review of Resident #9's Care Plan, dated 09/25/23, showed the resident preferred to awaken after 7:00 A.M. He/She goes to bed after supper between 7:00 P.M. and 9:00 P.M. but often gets up in the night to see what was going on. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe Cognitive Impairment;-Requires supervision/touching assistance from staff members for roll left and right, lying to sitting on side of bed, walk 50 feet with 2 turns, walk 150 feet; -Requires partial/moderate assistance from staff for sit to stand, chair/bed-to-chair transfer, -Requires substantial/maximal assistance from staff for upper body dressing, lower body dressing, footwear. Observation on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	1410 West Line Street Palmyra, MO 63461

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/10/25 at 6:15 A.M., showed the resident up in a recliner in the common area, dressed and with his/her eyes closed. Observation on 12/10/25 at 6:45 A.M. showed the resident up in the common area in a recliner with his/her eyes closed. The resident was making snoring sounds. During an interview on 12/10/25 at 6:35 and 6:45 A.M., CNA E said they had ten residents to get up on night shift and it was not optional. The resident was on the get up list. 5. During an interview on 12/10/25, at 6:46 A.M., Licensed Practical Nurse (LPN) EE said the night shift had a get up list for ten residents. They must get them up by the time day shift starts, or day shift will not have time to get everyone up for breakfast. During an interview on 12/15/25, at 4:43 P.M. the Director of Nursing said the following:-She had not had time to evaluate the schedule for getting residents up in the morning;-Staff should not wake a resident for their convenience, if there weas a list of early risers that would be acceptable if the residents wanted to get up early, however the resident would be able to change their mind anytime;-If a resident had a bad night and did not want to wake up or was hard to awaken, staff were expected to leave them in bed until they were ready to get up;-Staff are expected to treat residents like it was there home; if they want to sleep late, they are allowed and if a resident has a bad night leave them in bed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure independently motorized exhaust ventilation units were free from a buildup of dust/debris. The census was 59. 1. Observations on 12/10/25 from 6:30 A.M. to 2:41 P.M., during the life safety code tour of the facility, showed the following:-In the men and women bathrooms at the main entrance, the vent covers on the independently motorized ventilation units were covered with a moderate to heavy buildup of dust/debris;-In the A-Hall shower room, the vent cover on the independently motorized ventilation unit was covered with a moderate to heavy buildup of dust/debris;-In room A-02 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room A-03 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room A-04 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In the C-Hall central bath, the vent cover on the independently motorized ventilation unit was covered with a moderate to heavy buildup of dust/debris;-In room C-43 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room C-44 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room C-48 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room C-50 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate to heavy buildup of dust/debris;-In room C-53 bathroom, the vent cover on the independently motorized ventilation unit was covered with a light to moderate buildup of dust/debris;-In room D-64 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In room D-65 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-101bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-103 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-107 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate to heavy buildup of dust/debris;-In SCU-109 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-111 bathroom, the vent cover on the independently motorized ventilation unit was covered with a light to moderate buildup of dust/debris;-In SCU-113 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-114 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris;-In SCU-115 bathroom, the vent cover on the independently motorized ventilation unit was covered with a moderate buildup of dust/debris. During an interview on 12/11/25 at 4:00 P.M., the Maintenance Director said he was not aware of the dust and debris covering the vent covers to the independently motorized ventilation units. It was the maintenance departments responsibility to monitor the units at least monthly. He was not sure when each ventilations units were last inspected and cleaned.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a comprehensive assessment, including a review of the clinical rationale and approved indication for use of psychotropic medications, for three residents (Residents #14, #69, and #41) with a diagnosis of dementia, in a review of five residents selected for review of unnecessary medications, prior to utilizing anti-psychotic medications to treat the residents' behaviors. The facility failed to consistently identify and implement non-pharmacological interventions to address the residents' behaviors. The facility failed to conduct a gradual dose reduction (GDR) or provide documentation a GDR was clinically contraindicated for one resident's (Resident #14) antidepressant medication. The facility census was 59.Review of the facility's policy Psychotropic Medication, dated 10/16/24, showed the following:-Our facility will make every effort to comply with state and federal regulations related to the monitoring and use of psychopharmacological medications, this will include regular review for the continued need, appropriate dosage, side effects, risks and/or benefits;-Psychotropic medications: antipsychotics, antidepressants, antianxiety medications, hypnotics, mood stabilizers, anticonvulsants, muscle relaxants, anticholinergic medications, and antihistamines;-A nurse prior to requesting the need for this medication will do the following: a. Try to determine the underlying cause of the behavioral symptoms and take action to correct it; b. Document all interventions attempted prior to use or request of psychoactive medication. This includes but not limited to environmental changes, medical interventions such as pain medication and/ or evaluation for a change in condition. c. Evaluate/monitor the effects of the medications on the resident's behavior and keep physicians informed.-Nursing staff will develop a behavioral care plan and document behaviors:-Consulting pharmacist/physician: -Monitors psychotropic drug use in the facility to ensure that medications are not used in excessive doses or for excessive duration; -Participates in the interdisciplinary quarterly review of residents on psychoactive medications; -Notifies the physician and the Director of Nursing (DON) if whenever a psychotropic medication is past due for review. -Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than three months unless clinically contraindicated. Gradual dose reduction must be attempted for two separate quarters (at less one month between attempts). -Gradual dose reduction must be attempted annually thereafter or as a resident's clinical condition warrants, unless the physician has documented at least annually that this would not be indicated or in the resident's best interest.-After a medication is ordered each psychotropic medication must have a corresponding behavior appropriate for that classification the medication is ordered for;-These behaviors will be monitored and documented on the behavioral flow sheet every shift.-Types of medication and monitoring: -Antipsychotic medications common side effects include involuntary movements, including muscle spasms, tremors; stroke; dizziness; constipation; dry mouth; blurred vision, weight gain; sleepiness; -Antidepressants medications common side effects include dry mouth, nausea, vomiting, diarrhea, poor sleep, headache, dizziness, agitation, sleep problems, appetite issues, weight gain; -Sedatives common side effects include drowsiness, dizziness, poor concentration, confusion, impaired judgment, slowed breathing, blurred vision, impaired depth perception, slowed reaction times and reflexes. Review of the facility's undated policy, Antipsychotic Medication and Gradual Dose Reduction (GDR), showed the following:-To ensure that residents in this skilled nursing facility receive antipsychotic medications only when clinically appropriate, that gradual dose reductions are attempted when possible, and that all medication use is based on the resident's individual needs and regulatory guidance.-Antipsychotic medications shall only be used when: a. The resident has a documented diagnosis that justifies use (e.g., schizophrenia, bipolar disorder, Tourette's disorder), and b. non-pharmacological interventions have been attempted and documented;-Before Prescribing -Conduct a comprehensive assessment to (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identify the cause of behavioral symptoms; -Implement and document non-pharmacological interventions (e.g., environmental changes, structured activities, behavioral therapy);-Initiation of Antipsychotic: -Document specific diagnosis and clinical indications; -Set clear target behaviors/symptoms and measurable outcomes; -Review medication in the interdisciplinary team meeting and care plan. 1. Review of Resident #14's face sheet showed the resident had a diagnosis of Alzheimer's disease, dementia, and anxiety. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 05/22/25, showed the following:-Moderate cognitive impairment;-No behaviors, hallucinations, delusions, or rejection of care;-Independent with transfers and ambulation 150 feet;-Used a walker;-Antidepressant medication used daily. Review of the resident's Physician's Orders, dated 07/17/25, showed an order for Seroquel (an antipsychotic medication) 25 mg daily for anxiety disorder. Review of drugs.com for Seroquel showed the following:-Seroquel is an atypical antipsychotic medication used to treat schizophrenia, mania or manic disorders, and depression with bipolar disorder;-Seroquel warnings included: Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death;-Seroquel is not approved for the treatment of patients with dementia-related psychosis. Review of the resident's medical record showed no documentation to show the rationale for the new order for Seroquel, ordered July 2025. Review showed no evidence the resident had a diagnosis of schizophrenia, manic disorders or bipolar disorder. Review of the resident's Care Plan, updated 08/11/25, showed the following:-Behavior management program:-The resident requires ongoing redirection, monitoring and structured activities to alter behavior problems;-Smacks staff and peers on buttocks, hits staff on arms, and goes into linen room for washcloths numerous times;-Refuses to go to meals at times and then wants snacks and fluids;-Refuses incontinence care at times;-The resident takes handfuls of napkins out of holders and puts them in his/her pants;-The resident will respond to redirection from staff when behavior occurs thru next review;-The resident will engage in on and off unit programs to maintain current sensory awareness thru next review;-Encourage family involvement in care and visits;-Provide structured programs appropriate for the resident's cognitive status;-Social service intervention and evaluation as needed; -Prompt resident to not smack or hit staff;-Different staff to re-approach the resident when he/she refused incontinence care and meals;-Medication changes;-Gentle approaching and re-direction;-Staff will monitor him/her closely when around peers;-The resident was moved into a room by himself/herself due to resident-on-resident altercations. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Physical behavioral symptoms directed towards others one to three days in the seven-day look back period;-Diagnosis of Alzheimer's/dementia;-New antipsychotic medication daily;-Antidepressant medication daily. Review of the resident's Physician's Orders, dated September 2025, showed the following:-An order for Lexapro (an antidepressant medication) 10 milligrams (mg) daily for anxiety disorder (original order dated 09/16/24);-An order, dated 09/03/25, to increase Seroquel 25 mg daily to two times per day for a diagnosis of dementia. Review of the resident's medical record showed no documentation a gradual dose reduction (GDR) was recommended for the resident's Lexapro (originally ordered on 9/16/24) and no documentation a GDR was contraindicated. Review of the resident's Nurses Notes, dated 09/13/25, at 8:45 P.M., showed at supper the resident walked by a peer and pulled his/her hair unprovoked. Immediate staff intervention and separation of residents. The resident then re-approached peers' table and was bothering them while they were trying to eat, again requiring staff intervention. At this time, the resident swung at the nurse, attempting to hit him/her. The resident was very difficult to redirect and has been aggressive each time with staff intervention. Review of the resident's Nurses Notes, dated 09/18/25, at 10:23 P.M., showed the resident was not cooperative with staff during this shift. He/She made repeated efforts to take napkins out of the holders and hide them. He/She continued to try to put the shades down, although the other residents asked him/her not to do so. He/She yelled at (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another resident about taking the napkins when the other resident tried to stop him/her. He/She made repeated attempts to obtain beverages and would not take redirection (including trying to pour water from the pitcher on the medication cart). Review of the resident's Nurses Notes, dated 09/24/25, at 4:07 P.M., showed the resident refused breakfast or to get up to the bathroom. At lunchtime, he/she screamed at staff numerous times. Once he/she was up, he/she was obsessed with getting wash cloths and napkins which he/she put inside his/her pull up, so he/she didn't have to get up to go to the bathroom. The resident got angry at staff when he/she was redirected and hit staff. Updated physician on the resident's behaviors. Review of the resident's Nurses Notes, dated 09/26/25, at 6:02 P.M., showed the physician's response to the fax about behaviors was, I just increased Seroquel last week, gently redirect for now. Review of the resident's Nurses Notes, dated 09/28/25, at 10:35 A.M., showed the resident was becoming physically aggressive toward other residents. This resident was noted to bend another resident's left index finger back after the resident placed his/her hand over the napkin dispenser on his/her table to prevent this resident from taking it. This resident smacked another resident in the face on the left side. The resident hits staff unprovoked when he/she passes by them. The resident was unable to be redirected. Call placed to the on-call nurse practitioner to update on behavior. Requested order to possibly send to emergency room for evaluation. Order received for Haldol (haloperidol, antipsychotic medication) 5 mg intramuscular (IM; injection into the muscle) one time if resident continues to be physically aggressive toward other residents. Review of the resident's Physician's Orders, dated 09/28/25, showed an order for haloperidol lactate 5 mg/milliliter (ml), inject intramuscularly for one dose for dementia. Review of drugs.com for haloperidol showed the following:-Haloperidol is a typical antipsychotic medication used for schizophrenia, to treat motor control and speech ticks for Tourette's Syndrome (neurologic disease that presents with multiple tics);-Warnings: Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo;-Haloperidol injection is not approved for the treatment of patients with dementia-related psychosis. Review of the resident's Nurses Notes, dated 09/28/25, at 1:20 P.M., showed the resident continued to be physically aggressive toward staff and raised his/her hand to slap another resident again when the resident stopped this resident from removing napkins from his/her tray. Staff intervened and no contact made between residents. Haloperidol 5 mg given IM in right gluteal (muscle in the buttocks). Review of the resident's Nurses Notes, dated 09/28/25, at 7:17 P.M., showed the resident walked by a peer and smacked him/her on the bottom. Immediate staff intervention and separation of residents. Staff instructed the resident to keep his/her hands to himself/herself. The resident laughed and walked away. Review of the resident's Nurses Notes, dated 10/12/25, at 9:56 P.M., showed the resident was very demanding and verbal this shift, constantly asking for snacks and drinks. He/She was not taking redirection well. He/She made numerous attempts to obtain washcloths and napkins and became loud and belligerent when staff attempted to take them from him/her. Review of the resident's Nurses Notes, dated 10/17/25, at 8:19 P.M., showed the resident continued with fixation of collecting napkins and washcloths. The resident has been extremely aggressive with staff intervention. The resident smacked this nurse when caught in linen closet shoving five washcloths down his/her pants. The resident later walked by the nurse and hit him/her on his/her bottom, unprovoked. The resident picked up a fly swatter, swung it at the nurse and said, I'll smack you. Staff took the fly swatter away from the resident, and the resident retreated to his/her recliner in the common area. Review of the resident's Nurses Notes, dated 10/31/25, at 7:23 P.M., showed the resident swung at another resident, but did not make contact. Review of the resident's Nurses Notes, dated 11/01/25, at 11:23 A.M., showed the following:-The resident cursed or was verbally aggressive;-The resident scratched or hit others and was screaming. Review of the resident's Nurses Notes, dated 11/07/25, at 6:17 A.M., showed the resident rammed his/her walker into a peer's chair. Staff asked the resident to walk away, and he/she hit the nurse in the stomach. Staff educated the resident. Review of the resident's Nurses Notes, dated 11/08/25, at 8:10 P.M., showed the resident was observed in the linen closet (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mini-strokes called transient ischemic attacks (TIAs) have been reported in elderly people taking olanzapine who are confused, have memory loss, or have lost touch with reality (dementia-related psychosis). These people should not be given olanzapine;-Olanzapine is not approved for the treatment of patients with dementia-related psychosis. Review of the resident's Care Plan, dated 12/02/25, showed the following:-Psychotropic drug use with the potential for Adverse Drug Reaction (ADR);-The resident is on medication for dementia and to assist him/her to sleep at night;-Monitor for behaviors and side effects of medication including but not limited to tongue protrusion, grimacing, rapid eye blinking, lip smacking, pursing, or puckering, rapid movement of the arms or legs, or other involuntary movements of the head, face, neck and tongue muscles. Report findings to nurse;-Monitor for behaviors and side effects of psychotropic medication to include any of the following: Drowsiness, dizziness, dry mouth, blurred vision, tiredness, nausea, constipation, weight gain, trouble sleeping or muscle or nervous system problems (anxiety, agitation, jitteriness, drooling, trouble swallowing, restlessness, shaking or stiffness);-Report any behavior changes to the charge nurse: increased sleeping or restlessness.-The resident has cognitive deficits related to dementia and metabolic encephalopathy. Review of the resident's Nurses Notes, dated 12/03/25, at 9:18 P.M., showed the resident was constantly wandering around the unit, into other residents' rooms trying to eat other residents' snacks in their room, and constantly needing redirections. The resident was exit seeking, tried to find his/her car, and tried to go home. The resident was easily redirected, then forgets and continues the same behavior. The resident ended up near the back door trying to leave. Review of the resident's Nurses Notes, dated 12/04/25, at 6:48 A.M., showed the resident was confused and not orientated to place. The resident kept making different claims he/she has a ride to catch, look at the animals outside, and more. Staff found the resident on B hall, at the back entrance of the facility, and was at the entrance of other resident rooms. The resident has been redirected multiple times. The resident was unaware of his/her location, and the resident was restless. Both Certified Nurse Assistants (CNAs) have reported the resident has attempted to walk out the fire exit on A hall. The other CNA on staff said the resident was staring at the CNA and grabbed hold of his/her privates. The resident was redirected back to his/her bedroom. Review of the resident's Care Plan, updated 12/04/25, showed the following:-Behavior symptoms of wandering/risk of elopement;-The resident exhibits wandering behavior as evidenced by talking about going home frequently and is very confused (dementia) and has notable short-term memory loss;-Administer medications as ordered by the physician;-Document in the progress notes intensity, duration or frequency of behavior;-Redirect negative behaviors;-Regularly assess and evaluate risks for elopement;-Social service evaluation and follow-up. Review of the resident's Nurses Notes, dated 12/04/25, at 9:45 P.M., showed new orders received this evening for Seroquel 25 mg two times daily at 8:00 A.M. and 8:00 P.M. and Ambien (zolpidem - hypnotic medication) at bedtime. The resident has been exit seeking constantly, going into other residents' rooms, getting into other residents' and staff belongings. The resident was caught attempting to get into the medication cart, attempting to open closed doors, and arguing when staff attempt to redirect. The resident told a CNA that if he/she didn't let him/her out of here, he/she would bring hell down on everyone here. A staff member had to always be at the nurses station to keep an eye on the resident. Will administer new medications when they arrive and continue to monitor. Review of the resident's Physician's Orders, dated 12/04/25, showed the following:-Ambien 2.5 mg at bedtime;-Seroquel 25 mg twice daily. Review of the resident's Nurses Notes, dated 12/05/25, at 6:29 A.M. and 6:41 A.M., showed the resident was wandering into other resident's rooms and exit seeking from 11:46-1:20 A.M. The resident was looking for his/her spouse, and kitty. The resident was cooperative with redirection. Review of the resident's Nurses Notes, dated 12/07/25, at 9:57 P.M., showed the resident was talking to staff and messing with things on the counter. The resident was listening in on a conversation a couple CNAs were having, and the resident made the comment, All you need is one of these to take care of it while motioning using a shotgun. The resident was informed that his/her comment was inappropriate, and staff asked him/her not to say things like (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that again. Later in the evening after supper, the resident saw a CNA walking another resident into the sitting area, and the resident said to the CNA, Oh, are you training a new hooker? Staff informed the resident that what he/she said was mean and disrespectful, and the resident started laughing. The resident asked another CNA if they had a spare knife. The CNA asked what he/she wanted a knife for, and the resident made stabbing and cutting motions in his/her hand and laughed. A few moments later, the resident said, America will be nuked soon, you'll see. The resident made comments to the CNAs asking them to help him/her in the bathroom, help him/her get into bed, if they would join him/her in bed. This nurse called the physician and informed him/her of what was going on and he/she ordered to have the resident's Seroquel changed from 25 mg to 50 mg twice a day. A urinalysis was ordered for suspected urinary tract infection and a one-time order for Haldol 5 mg/ml injection, give 1 ml. The physician would like for the resident to have an appointment with geriatric psychiatrist soon for evaluation. This nurse contacted the resident's power of attorney (POA) and notified them of the changes in behavior and changes in medication. The resident's POA said the last time the resident took Seroquel; the medication did not work well with him/her and that it made his/her behaviors worse. Will make the physician aware of this to see if he/she would like resident to continue to take it. Will continue to monitor. Review of the resident's Physician's Orders dated 12/07/25, showed the following new orders: -Seroquel 25 mg two times daily for dementia was discontinued;-New order for Seroquel 50 mg two times daily; -Haloperidol lactate 5 mg/ml injection, administer now, for dementia. Review of the resident's Medication Administration Record, dated 12/07/25, showed staff administered haloperidol lactate 5 mg/ml, 1 ml (5 mg) by injection, intramuscularly. Review of the resident's Nurses Notes, dated 12/08/25, at 6:41 A.M., showed the resident awoke at 1:00 A.M. The resident was up walking in the hallway with an unsteady gate. The resident was groggy and disoriented and had an episode of bowel incontinence. The resident was not easily redirected to his/her room and was not allowing staff to clean him/her up. The resident was assisted back to bed and went to sleep. The resident was found wandering in the hallway with no pants or underwear at 4:00 A.M. The resident thought he/she was in his/her house. Redirected back to his/her room and helped back to bed. Review of the resident's Nurses Notes, dated 12/08/25, at 1:16 P.M., showed the nurse faxed the physician regarding the recent episodes with the resident. The physician said it was not the medications, it was the disease progression, dementia with agitation. The physician said he/she was called last night for orders. Ordered to do a urinalysis, discontinue Seroquel and change to risperidone 1 mg twice daily. Obtain geriatric psychology consult. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 12/08/25, showed the following:-admitted [DATE];-Severe cognitive impairment;-Mild depression symptoms;-The resident had delusions (misconceptions or beliefs that are firmly held contrary to reality);-No behaviors or rejection of care;-The resident was physically independent with ADLs but required one staff member to set up or cue resident;-Diagnosis include a urinary tract infection, dementia, chronic obstructive pulmonary disease, metabolic encephalopathy (a broad term for brain dysfunction (confusion, coma, personality changes) caused by an underlying chemical imbalance or illness affecting the body's metabolism), accidental opium poisoning;-No psychoactive medications or injections checked;-Antipsychotics were received on a routine basis only. Review of the resident's Physician's Orders, dated 12/09/25, showed a new order for risperidone 1 mg twice daily for dementia with other behavioral disturbances. Review of drugs.com for risperidone showed the following:-Risperidone is an antipsychotic medication used to treat schizophrenia, bipolar disorder, and agitation related to autism;-Risperidone carries a warning for increased risk of death in elderly patients with dementia-related psychosis;-Risperidone is not approved for use in older adults with dementia-related psychosis. Review of the resident's Nurses Notes, dated 12/10/25, at 2:47 P.M., showed the resident remains restless and irritable. The resident goes into other residents' rooms, follows staff into other residents' rooms and attempts to open exit doors. Review of the resident's Nurses Notes, dated 12/10/25, at 3:39 P.M., showed from 3:00 P.M. to 3:30 P.M., the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident has been under the dining room table. He/She put the chairs on top of the table and turned the table over. 3. Review of the Resident #41's admission MDS, dated [DATE], showed the following:-He/She admitted on [DATE];-His/Her cognition was severely impaired;-Diagnoses included non-Alzheimer's dementia, anxiety, and depression;-He/She had verbal and physical behaviors toward others;-He/She used psychotropic medication. Review the resident's Nursing Progress Note, dated 10/01/25 at 1:52 P.M., showed the resident was combative this morning. He/She did not want to be up but wanted to sleep. Review of the resident's Nursing Progress Note, dated 10/04/25 at 1:29 P.M., showed the resident's mood was very snappy, and he/she was short with the nurse. Review of the resident's Nursing Progress Notes showed no documented behaviors on 10/05/25 or 10/06/25. Review of the resident's Nursing Progress Note, dated 10/07/25 at 10:38 A.M., showed a new order was received to increase Seroquel to 100 mg at bedtime (HS). (Review showed no documented behaviors.) Review of the resident's Nursing Progress Notes, dated 10/07/25 through 10/10/25, showed no documented behaviors or agitation. Review of the resident's Physician Progress Note, dated 10/10/25, showed the following:-Nursing staff reported resident was having some issues with agitation, so Seroquel was increased to 100 mg;-The resident has been falling asleep a lot;-Diagnoses included vascular dementia with agitation;-Plan included to increase Seroquel. Review of the resident's Care Plan, last reviewed 10/10/25, showed the following:-He/She was on medication for generalized anxiety disorder;-He/She was combative with care at times and refusing medications at times;-He/She would show a decrease in episodes of physical aggression towards staff during careand will take his/her medications as ordered by next review;-Administer medications as ordered by physician;-Allow time to de-escalate and reapproach if agitated. Review of the resident's Physician's Orders, dated December 2025, showed the following:-Quetiapine (Seroquel) 100 mg tablet once daily at bedtime for diagnosis vascular dementia with agitation (original order dated 10/13/25); -Behavior charting every shift. Review of the resident's Progress Notes, dated 10/10/25 through 11/01/25, showed no documentation of any behaviors including verbal/physical aggression towards others or increased agitation. Review of the resident's Behavioral Charting, dated 11/6/25 at 6:33 P.M., showed the resident constantly requested attention or help. Review of the resident's Behavioral Charting, dated 11/14/25 at 9:27 P.M., showed the resident became agitated because no one came to his/her aid. He/She was in his/her room in bed with his/her call light on his/her chest, but he/she did not press the button. He/She yelled from his/her room. The nurse heard him/her and responded immediately. The resident said he/she was yelling for a while and was educated about using the call light rather than yelling for help. He/She said he/she needed to go to the bathroom. The nurse assisted the resident to the bathroom. Review of the resident's Behavioral Charting, dated 11/20/25 at 8:19 P.M., showed the resident constantly requested attention or help. Review of the resident's Behavioral Charting, dated 12/7/25, showed the resident was awake frequently throughout the night and kept trying to get out of bed and required redirection. Observation on 12/08/25 at 12:30 P.M. showed the resident calmly ate lunch in the dining room without any behaviors or agitation. Observation on 12/10/25 at 7:00 A.M. showed the resident lay in his/her bed with his/her eyes closed. Observation on 12/09/25 at 9:45 A.M., showed the resident slept in the recliner located in his/her room. Observation on 12/15/25 at 2:05 P.M. showed the resident calmy sat in a recliner watching television and eating a snack in sitting area in front of nurse's station. During an interview on 12/15/25 at 12:40 P.M., CNA N said the following:-The resident did not become agitated when he/she cared for him/her;-Before the resident came to t[TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure staff training needs, as identified in the facility assessment, were met for four certified nurse assistants (CNA)s, in a review of five CNAs who were employed by the facility for over one year. Review showed the staff failed to complete the required 12 hours of training per year as required to maintain their certification, including dementia management and resident abuse prevention training. The facility census was 59. Review of the facility Assessment, dated 11/20/25, showed the following education requirements:-Resident Rights on hire, annually and as needed;-Abuse, neglect, and exploitation on hire, annually and as needed;-Infection Control on hire, annually and as needed;-Changes in Condition as needed.-Staff shall complete education to maintain their certifications/licenses. 1. Review of CNA HH's employee file showed his/her hire date as 11/13/17. Review of CNA HH's training record dated 12/01/24-12/15/25, showed he/she did not complete any training during that period. The facility did not have any other training record documented for the employee. 2. Review of CNA II's employee file showed his/her hire date as 10/16/23. Review of CNA II's training record, dated 12/01/24-12/15/25, showed the following: -Abuse, Neglect and Exploitation 0.75 hours completed on 03/06/25;-Dementia Care 0.5 hours completed on 04/04/25;-Transmission Based Precautions 0.5 hours completed on 07/01/25;-Workplace emergencies and Natural Disasters -0.5 hours completed on 07/01/25;-Patient Information Privacy and security 0.15 hours completed on 07/15/25;-Resident Rights 1 hour of training completed on 08/27/25;-Dementia care 0.5 hours of training completed on 09/05/25.(The employee's training record showed four hours of education completed in the last year. The facility did not have any other training record documented for the employee.) 3. Review of CNA JJ's employee file showed his/her hire date as11/19/22. Review of CNA JJ's training record dated 12/01/24-12/15/25, showed he/she did not complete any training during that period. The facility did not have any other training record documented for the employee. 4. Review of CNA F's employee file showed his/her hire date as 08/14/23. Review of CNA F's training record dated 12/01/24-12/15/25, showed the following: -Dementia Care 0.5 hours completed on 12/27/24;-Resident Rights 1 hour of training completed on 12/27/24;-Transmission Based Precautions 0.5 hours completed on 12/27/24;-Patient Information Privacy and security 0.15 hours completed on 12/27/24;-Employee Wellness, Managing Stress 0.25 hours completed on12/22/24.(The employee's training record showed two hours and 45 minutes of education completed in the last year. The facility did not have any other training record documented for the employee.) 5. During an interview on 12/10/25, at 2:59 P.M., the Director of Nursing said the following:-The facility had a web-based training that recorded the employees' training;-She found when reviewing the records that most staff had not completed the required trainings; -She had not had the opportunity to evaluate each employees' training records;-The facility was in the process of deciding how to ensure education was completed, along with competencies and evaluations, but it was not complete at this time. During an interview on 12/09/25, at 11:00 A.M., the Administrator said the facility did not keep good education records. They were using a web-based education system, but from what he could tell, they did not ensure the employees completed required training.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed follow facility's policy/procedure to notify the physician for one resident (Resident #10), in a review of 17 sampled residents, after the resident fell on the weekend and hit his/her head. The facility also failed to timely notify Resident #10's physician after the resident presented with a change in condition. The facility census was 59.Review of the facility's policy for contacting the physician, dated 10/16/24, showed the following:-The purpose of this policy is to give guidelines to nursing staff on contacting resident physicians or the on-call physician:-Notification of physicians in non-emergent situations: -Nursing staff will fax the physician to relay reports or status change information regarding the resident. Staff will send faxes to the physician's office and ensure to include all pertinent information for the physician to be able to respond; -If no return call or fax is received from the physician's office by 4:00 P.M., the nursing staff will phone the physician's office. If he/she has left the office and a response is needed to provide care, the nurse will page the appropriate physician; -To notify the physician, call the hospital or physician answering service to have the physician paged. If no response after 30 minutes, place a second call to notify them the physician has not called back; -Never fax after hours and on weekends if a response is needed. When after hours, weekends and/or holidays, the charge nurse is to call the appropriate physician for all resident changes for orders. This includes wounds that need immediate treatment, falls with injury or change in medical condition;-Notification of Physician in emergent/life threatening situations; -If a resident is having an acute change in condition, you must call the office and not fax; -Do not use fax to communicate with physicians when the situation is emergent. Call and speak with the physician. -Remember when in doubt, call the physician or registered nurse (RN) on duty for guidance. 1. Review of Resident #10's undated face sheet showed the following:-He/She admitted to the facility on [DATE];-He/She was his/her own responsible party;-His/Her diagnoses included subarachnoid hemorrhage (bleeding in the area between your brain and the thin tissues that cover and protect it) and repeated falls. Review of the resident's progress notes, dated 11/22/25 (a Saturday) at 7:36 P.M., showed the following:-Staff documented the resident was found on the floor by the chair in his/her room;-Assessment revealed a small laceration to the resident's right front scalp;-Staff cleaned the area and applied pressure; and the bleeding stopped;-Staff sent a fax to the resident's physician. Review of the fax staff sent to the resident's physician, dated 11/22/25, showed the following:-Registered Nurse (RN) L wrote that the resident was found in front of the chair on the floor. See attached. (Review showed no attachments were sent with the fax); -RN L did not notify the resident's physician of the laceration to the right front scalp;-The physician responded on 11/28/25 (six days later) by writing noted monitor. Review of the resident's progress notes dated 11/22/25 to 11/28/25 showed no documentation staff followed up with the resident's physician with a phone call over the weekend when they did not receive a response to the fax as directed in the policy. During an interview on 12/10/25 at 12:05 P.M., RN L said he/she was present when the resident fell on [DATE]. The resident's vital signs were normal, the resident was alert and oriented, and his/her neurological assessments were within normal limits. The resident had a small abrasion to the right backside of the head with bleeding that stopped after application of pressure within five minutes. A fax was sent to the physician because neuro assessments were fine and there were no significant injuries noted. During an interview on 12/10/25 at 11:35 A.M., the Assistant Director of Nursing (ADON) said if a resident fell on a weekend and there was any injury, staff should notify the on-call physician by phone, not by fax. Staff should have called the resident's physician after the resident fell on [DATE] and had a laceration to his/her scalp. During an interview on 12/10/25 at 7:45 A.M., LPN K said the following:-On 12/01/25, he/she received report from RN M, who reported the resident had emesis, stabbing headache, some confusion, and received Tylenol; -He/She went to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's room to assess the resident at 7:40 A.M. and found the resident in bed. The resident did not respond when spoken to and/or with touch stimuli but twitched his/her foot with sternal rub. -He/She asked the Minimum Data Set (MDS) Coordinator to check on the resident as he/she (LPN K) didn't think the resident was acting right as the resident was unresponsive;-At 8:00 A.M., the MDS Coordinator said the resident was snoring and assumed the resident was sleeping;-At 9:00 A.M., he/she told the ADON he/she did not think the resident was acting right, and thought the resident needed to go to the hospital; -He/She was not familiar with the facility's physicians or where to call, so it was easier for him/her to fax the physicians; the fax machine was not working correctly on this day; -Between 9:00 A.M. and 10:00 A.M., he/she asked for RN L to assess the resident because something was not right with the resident; -RN L and RN M entered the resident's room to assess the resident. RN M came to the desk and said to send the resident to the hospital; -He/She contacted emergency medical services, and the resident was sent to the hospital. Review of the resident's nursing progress notes, dated 12/02/25, showed staff documented the resident was sent to the hospital at 11:23 A.M. Reviewed showed no documentation staff notified the resident's physician of the resident's change in condition when staff was unable to arouse the resident with physical intervention at 7:40 A.M. or upon additional assessments prior to 11:23 P.M. when the resident was sent to the hospital for evaluation. During an interview on 12/10/25 at 12:30 P.M., the Director of Nursing (DON) said the following -She expected staff to call a resident's physician when a resident fell on a weekend or after hours. A fax to the physician's office may not be seen until the next day and/or after the weekend when the physician returned to his/her office;-On 11/22/25 (Saturday), the resident fell and suffered a superficial laceration that did not require sutures;-Staff should call the physicians if there was any head injury or any bleeding noted from the head;-She expected staff to call a resident's physician immediately with any emergent situations, including finding a resident unresponsive. During an interview on 12/11/25 at 5:30 P.M., the Administrator said he expected staff to contact a resident's physician by phone if a resident fell and had any type of injuries. The facility had an on-call schedule for staff to reference to for which physician to contact after hours and/or weekends.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report injuries of unknown origin for one resident (Resident #7), who was found to have bruising and blood on his/her body, in a review of 17 sampled residents, and failed to report bruises of unknown origin for one additional resident (Resident #57). The facility census was 59. Review of the facility's policy, Abuse and Neglect, dated 2025, showed the following: -Injuries of Unknown Origin: Defined as an injury that was not observed and/or the injury could not be explained. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in areas that are not normally vulnerable to trauma), or the number of injuries observed on a resident at one time, or the reoccurrence of injuries over time (pattern identified); -All facility staff are required to immediately report suspicion/allegations of any type of abuse directly to the Administrator or designee. The Administrator will then report suspicion/allegations of abuse to the Missouri Department of Health and Senior Services immediately but no longer than two hours after the allegation was received. 1. Review of Resident #7's care plan, dated 02/08/24, showed the following: -Anticoagulant therapy/potential for bleeding. The resident was at risk for signs and symptoms of bleeding due to use of anticoagulant, warfarin; -Avoid bumping and handle gently when providing hands-on care Review of the resident's physician order sheet (POS) for September 2025 showed an order for warfarin (a blood thinner) 2.5 milligram (mg) tablet, give 1 tablet (2.5 mg) four times per week, schedule every week on Monday, Wednesday, Thursday, Friday at 07:00 P.M. to 11:00 P.M. Review of the resident's nursing progress notes, dated 09/04/25 at 1:48 A.M., showed Licensed Practical Nurse (LPN) I documented that a certified nurse assistant (CNA) notified him/her regarding a skin assessment on the resident. The resident was found to have bruises on his/her right wrist, right bottom, and bruise under right armpit. The charge nurse assessed the resident. Dried blood was found on the corner of the resident's mouth and in little specs all over his/her bed. The resident had little scratches that were bleeding on the sheets. Skin assessment was completed. Review of the resident's medical record showed no evidence the facility staff reported the bruising and bleeding as an injury of unknown origin, when it was discovered on 09/04/25 at 04:07 A.M. Review of the resident's annual Minimum Data Set (MDS), completed by facility staff, dated 11/25/25, showed the following: -Severe cognitive impairment; -Dependent for toileting and personal hygiene. During an interview on 12/29/25 at 9:10 P.M., LPN I said the following: -He/She was made aware of bruising and bleeding on the resident on 09/04/25 at 1:48 A.M. by a CNA but could not recall much about this event now; -He/She conducted a skin assessment on the resident. -He/She did not report the bruises or bleeding to administration because he/she did not think the bruises and/or bleeding were caused by abuse; -He/She could not remember if he/she had asked the CNA what happened; -He/She was not sure what had caused the bruising or bleeding, but the resident was on a blood thinner, so this might have contributed to it; -The resident was would not be able to say if he/she were abused. During an interview on 12/15/25 at 1:50 P.M., the Director of Nursing (DON) said the following: -She was not aware of the injuries of unknown origin (bruises and bleeding) found on the resident; -She would expect all staff to report any bruises or unexplained bleeding immediately to administration so an investigation could be started; -Bruising and bleeding of unknown origin could be a sign of resident abuse and should be fully investigated and reported to the state agency (SA) within two hours. During an interview on 12/15/25 at 4:00 P.M., the Administrator said the following: -Staff should assess bruising and bleeding of unknown origin on a resident right away to determine a cause, if able; -Administrative staff must be made aware of any bleeding so that an assessment and investigation could be started and a report made to the state agency (SA) within two hours. 2. Review of Resident #57's Care Plan, last updated 06/23/25, showed the following:-The resident was dependent on staff for showers, locomotion and toileting; required substantial/maximum assist from staff for dressing and personal hygiene; required partial/moderate assist for transfer and ambulation; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	1410 West Line Street Palmyra, MO 63461

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required supervision/touching assist for bed mobility;-He/She was able to make position changes on his/her own. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 11/05/25, showed the following:-Severe cognitive impairment;-Required supervision/touching assistance from staff members for roll right and left, sit to lying, lying to sitting on bed side, and sit to stand;-Required partial/moderate assistance from staff for chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer;-Required substantial/maximal assistance from staff for shower/bathe, upper body dressing, and lower body dressing.-Dependent on staff for toileting hygiene and personal hygiene. Review of the resident's Physician Orders, dated December 2025, showed the resident was on Plavix (a medication that prevents blood clots by preventing the platelets from sticking together (blood will not clot as quickly). Observation on 12/10/25 at 6:36 A.M., showed the following:-Certified Nurse Assistant (CNA) DD and CNA E transferred the resident from his/her wheelchair to the shower chair;-CNA DD undressed the resident;-The resident had a large, purple bruise on the back of his/her left upper arm;-CNA DD said, I have not seen that bruise on the resident before. The resident also has a large bruise behind his/her right leg with a knot in the center. The resident has not fallen that he/she knew of. Review of the resident's Nurses Notes, dated 12/11/25 at 6:50 A.M., (one day after the bruising was identified in the shower room) showed the CNAs reported the resident has a bruise to his/her right calve and left upper arm. Examined the resident and noted a 5 centimeter (cm) in length by 4 cm in width area of bruising to his/her right posterior lower leg/calve that was light purple in color, and a 4.5 cm in length by 5 cm in width area of bruising to posterior left upper arm that was light purple in color. Etiology of bruising unknown, both bruises are non-tender. Fax sent to the resident's physician regarding bruises. During an interview on 12/23/25 at 7:15 A.M., LPN EE said the following:-Staff reported the resident's bruises to him/her on 12/11/25; -He/She assessed the bruises and reported to the day shift staff; -He/She didn't call the DON or Administrator because he/she did not think the bruises were caused by abuse; -He/She was not sure how the resident got the bruises. During an interview on 12/15/25 at 3:15 P.M., LPN A said the following: -The CNAs reported the resident's bruising on 12/11/25 during the night shift;-He/She obtained this information through report, so he/she didn't notify the DON or the Administrator because it didn't happen on his/her shift;-He/She did not know if the bruise was investigated to rule out abuse. During an interview on 12/15/25 at 1:50 P.M. and 4:43 P.M., the DON said no one told her about the bruising found on the resident.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, for two residents (Residents #14 and #9), in a review of 17 sampled residents, within 14 days after the facility determined, or should have determined, there had been a significant change in the resident's physical or mental condition which had an impact on more than one area of the residents' health status and required interdisciplinary review and/or revision of the care plan. The facility census was 59.Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version 3.0 showed a significant change is a decline or improvement in a resident's status that:-Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting;-Impacts more than one area of the resident's health status;-Requires interdisciplinary review and/or revision to the care plan.-The manual also showed a SCSA was appropriate if there was a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of activities of daily living (ADL) decline or improvement);-Decline in two or more of the following: -Resident's decision-making ability has changed; -Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9(C)), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning; -Resident's incontinence pattern changes or there was placement of an indwelling catheter; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); -Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status; -Resident begins to use a restraint of any type when it was not used before; and/or -Emergence of a condition/disease in which a resident is judged to be unstable.- Improvement in two or more of the following: -Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, setup or clean-up assistance, or supervision or touching assistance since last assessment and does not reflect normal fluctuations in that individual's functioning; -Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; -Resident's decision making improves; -Resident's incontinence pattern improves. 1. Review of Resident #14's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 05/22/25, showed the following:-Diagnosis: Anemia, coronary artery disease, diabetes mellitus (inability to regulate blood sugar), anxiety, and malignant neoplasm of breast;-No behaviors, hallucinations, delusions, or rejection of care;-Always incontinent of bowel and bladder;-One Stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister), not present on admission. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Physical behavioral symptoms directed towards others one to three days (worsened);-Frequently incontinent of bowel and bladder (improvement);-Diagnoses of Alzheimer's and dementia checked (new);-New antipsychotic (medication for hallucinations or delusions) medication;-Pressure ulcer healed (improvement); The facility did not complete a SCSA when the resident had new diagnosis added for Alzheimer's/dementia, new antipsychotic medication; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improved incontinence, healed pressure ulcers and worsening physical behaviors. Review of the resident's weight record, showed facility staff obtained and documented the resident's weight as follows:-On 09/10/25, 180.8 lbs.;-On 10/01/25, 177.2 lbs.;-On 10/02/25, 177.6 lbs. (2% weight loss in one month, 4.5% weight loss in six months). Review of the resident's weight record showed no evidence staff weighed the resident for November 2025. Review of the resident's weight record, showed facility staff obtained and documented the resident's weight on 12/01/25 as 162 lbs. The resident had had a 15.6 lbs. since the last obtained weight on 10/2/25. Review of the resident's weight records showed the resident lost 21.8 lbs. since 06/04/25, which was an 11.86 % weight loss in six months and had lost 15.2 lbs. since 10/01/25 (no weight for November documented) which was an 8.5% weight loss in two months. Review of the resident's Nurses Notes, dated 12/04/25 at 1:33 P.M., showed the resident had two new wounds to the coccyx (bony part of lower back/buttocks) area measuring 1.5 centimeters (cm) x 1 cm and the other as 1cm x 1cm. Barrier cream applied to both wounds and buttocks. Primary physician was faxed this information, waiting for new orders at this time. The facility did not complete a SCSA when the resident had new weight loss, new pressure ulcers, and the changes from the 08/22/25 MDS assessment. 2. Review of Resident #9's annual Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 01/07/25, showed the following:-Severe cognitive impairment;-Diagnosis: Alzheimer's;-No behaviors or rejection of care;-Walker;-Set up or clean up assistance from staff for eating, and walking;-Requires supervision/touching assistance from staff members for roll left and right, sitting to lying, lying to sitting on side of bed, sit to stand, char/bed-to-chair transfer, toilet transfer, and tub/shower transfer, -Requires partial/moderate assistance from staff for upper and lower body dressing, -Dependent on staff for oral hygiene, toileting hygiene, shower/bathe, and putting on/taking off footwear;-One no injury fall, and one fall with injury;-Antianxiety medication. Review of the resident's quarterly MDS, dated [DATE], showed there were no significant changes. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Independent with walking up to 150 feet (improvement);-Set up or clean up assistance from staff for chair/bed-to-[NAME] (improvement), toilet transfer (improvement);-Requires partial/moderate assistance from staff for shower/bathe (improvement), tub/shower transfer (worsening), -No antianxiety medication (improvement). The facility did not complete a SCSA when the resident had improvements in the areas of walking and anxiety and worsening of assistance needed from staff for showering/bathing. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Requires supervision/touching assistance from staff members for walking 50 feet with two turns (worsening), and walking 150 feet (worsening); -Requires partial/moderate assistance from staff for shower/bathe (improvement), sit to stand (worsening), chair/bed-to-chair (worsening), and toilet transfer (worsening); -Dependent on staff for eating (worsening); -Scheduled pain medications (new); -New mechanically altered diet. The facility did not complete a SCSA when the resident had several declines in ADLs and one improvement, newly scheduled pain medications and a new mechanically altered diet. 3. During an interview on 12/23/25, at 3:00 P.M. the MDS coordinator said the following:-The facility had a clinical meeting daily to discuss declines in ADLs. If the change goes and comes back and doesn't return to baseline then staff know a significant change should be completed;-When doing resident's quarterly assessments, she compared the information to the last quarterly assessment;-If there was a gradual change within the year, it may not be as significant, usually within the quarter;-She was required to follow the RAI manual;-She had never heard of comparing the resident to the last comprehensive assessment.-She had not completed any official training, just what she had been able to find for guidance. During an interview on 12/15/25 at 2:30 P.M. the Director of Nursing said she did not know much about the MDS process but would expect staff to follow the RAI manual for completion of the MDS and Care plans.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct and document a thorough nursing assessment of one resident (Resident #41), in a review of 17 sampled residents, when staff found the resident with a change in condition and was unresponsive. Staff failed to follow facility policy to immediately contact 911 when the resident had an emergent situation and was found unresponsive. The facility census was 59.Review of the facility's policy for contacting the physician, dated [DATE], showed the following:-The purpose of this policy is to give guidelines to nursing staff on contacting resident physicians or the on-call physician:-Notification of Physician in emergent/life threatening situations; -If a resident is having an acute change in condition, you must call the office and not fax. -Residents that are full code and have an emergent situation, the staff will call 911 and then notify the appropriate physician on duty, the family and the registered nurse (RN) on duty. -If a resident is a do not resuscitate (DNR), no hospitalization, or receiving palliative care, you will need to notify the resident's power of attorney (POA) to be sure their wishes are followed. If they wish for the resident to go to the hospital, then call 911, the physician on call, and the RN on duty. Some examples of emergent situations include a decline in the resident's normal consciousness;-Do not use fax to communicate with physicians when the situation is emergent. Call and speak with the physician. Do you delay resident transport; -Remember when in doubt, call the physician or Registered Nurse (RN) on duty for guidance. 1. Review of Resident #10's healthcare directive, dated [DATE], showed the following:-He/She did not want lifesaving code (cardiopulmonary resuscitation (CPR), an emergency lifesaving procedure performed when the heart stops beating); -He/She wanted to go to the hospital. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by facility staff, dated [DATE], showed his/her cognition was moderately impaired. During an interview on [DATE] at 1:23 P.M., Registered Nurse (RN) M said on [DATE], the certified nurse aides (CNA) reported the resident complained of a headache and had some emesis. He/She administered Tylenol and assisted the resident to the bathroom at approximately 5:30 A.M. At 6:40 A.M., the resident said he/she still had a headache. The resident's blood pressure was a little high. He/She reported the resident's complaint of headache, emesis, and the administration of Tylenol to Licensed Practical Nurse (LPN) K at approximately 7:00 -7:15 A.M. Review of resident's blood pressure record, dated [DATE] at 6:47 A.M., showed the resident's blood pressure was 183/95 (normal blood pressure is 120/80). Review of the resident's nursing progress notes, dated [DATE], showed no documentation of an assessment or the resident's condition, including the resident's headache and emesis and administration of Tylenol. Review of resident's Medication Administration Record (MAR), dated [DATE], showed Licensed Practical Nurse (LPN) K documented medications were not administered on [DATE] during the 7:00 A.M. to 11:00 A.M. medication pass due to condition. Review of the resident's progress notes, dated [DATE], showed no documentation related to the resident's condition that prevented staff from administering the resident's medications during the 7:00 A.M. to 11:00 A.M. medication pass. During an interview on [DATE] at 7:45 A.M., LPN K said the following:-On [DATE], he/she received report from RN M, the resident had emesis, stabbing headache, some confusion, and received Tylenol; -He/She went to the resident's room to assess the resident at 7:40 A.M. and found the resident in bed. The resident did not respond when spoken to and/or with touch stimuli but twitched his/her foot with sternal rub; -He/She ran out into the hall and asked the MDS Coordinator to check on the resident because he/she didn't think the resident was acting right as the resident would not wake up and/or respond to stimuli; -At 8:00 A.M., the MDS Coordinator said the resident was snoring and assumed the resident was sleeping; -At 9:00 A.M., he/she told the Assistant Director of Nursing (ADON) he/she did not think the resident was acting right and thought the resident needed to go to the hospital. The ADON did not help him/her and walked away; -He/She recently attended an in-service at the facility and was told residents could not be sent (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the hospital without a physician's order; -He/She was not familiar with the facility's physicians and where to call. It was easier for him/her to fax the physicians, but the fax machine was not working correctly on [DATE]; -Between 9:00 A.M. and 10:00 A.M., he/she asked for RN L to assess the resident because something was not right with the resident; -RN L and RN M entered the resident's room to assess the resident. RN M came to the desk and said to send the resident to the hospital; -He/She contacted emergency medical services, and the resident was transported to the hospital; -He/She knew the resident needed to be sent to the hospital. If he/she had been at any other facility, he/she would have sent the resident and then notified the physician, but that was not what he/she was instructed to do; -He/She still did not have clarification for when to send a resident to the hospital. He/she did not document in the resident's progress notes because he/she did not have time. He/she should have documented the resident's status and events that occurred. Review of the resident's vital signs record, dated [DATE] at 10:32 A.M., showed the resident's blood pressure was 185/92. Review of the resident's nursing progress notes, dated [DATE], showed the following:-At 12:45 P.M., the Director of Nursing (DON) documented she was called to the resident's room for the resident not responding to verbal stimuli. Upon entering the resident's room, she found the resident in bed unresponsive to verbal and touch stimuli, pupils were fixed and dilated, face was flushed, and resident was incontinent of urine. The resident's blood pressure was 200/84 and his/her pulse was 106 (normal pulse is 60-100). Staff called EMS. EMS arrived and resident transferred to the hospital. Review of the resident's nursing progress notes, dated [DATE], showed staff documented the resident was sent to the hospital at 11:23 A.M. (Reviewed showed no documentation staff notified the resident's physician of the resident's change in condition when staff was unable to arouse the resident with physical intervention at 7:40 A.M. or upon additional assessments prior to 11:23 P.M. when the resident was sent to the hospital for evaluation. Review showed no documentation of the resident's condition between [DATE] at 3:11 P.M. and [DATE] at 11:23 A.M.) During an interview on [DATE] at 11:30 A.M., the MDS Coordinator said on [DATE] at approximately 8:00 A.M., LPN K gestured for her to step into the resident's room, because LPN K could not get the resident awake. The resident lay in bed fully clothed and was snoring. There was nothing that appeared altered about the resident. The resident just appeared as he/she was sleeping well. She did not sense any urgency from the staff or the resident at that time. She touched the resident's arm which altered the resident's snoring with movement. During an interview on [DATE] at 11:35 A.M., the ADON said the following:-On [DATE], RN M reported that the resident had complained of a headache, diarrhea, and received Tylenol at 5:30 A.M. She did not recall going over to the resident's hall and LPN K asking for her to assess the resident; -There had been a recent meeting the facility's medical director who said staff needed to call him and/or the resident's physician before sending a resident to the hospital. She was not sure if that meant staff were to call the physician prior to sending the resident to the hospital when it was an emergent situation. She felt staff should send residents out in an emergent situation, including when a resident was unresponsive. During an interview on [DATE] at 1:23 P.M., RN M said on [DATE] between 10:30 A.M. and 11:00 A.M., LPN K said the resident would not wake up. Upon assessment, the resident was unresponsive to sternal rub and was snoring. He/She instructed LPN K to call EMS. LPN K said he/she needed a physician's order. He/She instructed LPN K that this situation was emergent, and he/she needed to call EMS. He/She thought this was due to a misinterpretation of the medical director wanting staff to notify the physicians before sending residents to the hospital, but residents in an emergent situation needed to be sent and this needed better clarification. During an interview on [DATE] at 12:05 P.M., RN L said he/she was on the resident's unit the morning of [DATE] awaiting to speak to the ADON when LPN K came to him/her and asked him/her to evaluate the resident. The resident was unresponsive to verbal and touch stimuli including sternal rub, pupils were fixed and non-reactive, and the resident was incontinent. Report received was that the resident had a headache and was throwing up earlier that morning. Staff administered Tylenol, assisted the resident to the restroom, and was last noted well at 6:30 A.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He/She instructed staff to contact EMS. The facility's Medical Director wanted physician's orders to send all residents to the hospital. Staff should have brought in a supervisor to assess the resident and send out to the hospital if the resident was unresponsive. During an interview on [DATE] at 10:00 A.M., the DON said the following: -She expected staff to call a resident's physician immediately with any emergent situations, including finding a resident unresponsive;-Prior to survey, staff were in-serviced during an all staff meeting regarding when to contact and send a resident to the hospital; -With emergent situations (such as unresponsiveness), staff were to contact 911, then the resident's physician, family, etc. In urgent situations (different from emergency situations), staff were to contact the physician for orders first;-Each emergent situation was different related to transfers to hospital with DNR residents. For example, if resident was on comfort measures and/or palliative care, staff would contact the physician and/or family prior to sending to the hospital; -Staff should have contacted 911 for emergent care for Resident #10, when he/she was found unresponsive at 7:40 A.M.;-She expected the MDS Coordinator to have completed an assessment, including obtaining vital signs if he/she was asked to look over the resident when staff reported the resident had changes in his/her status. During an interview on [DATE] at 10:00 A.M., the Administrator said the following: -He expected staff to send a resident to the hospital and not delay treatment in an emergent situation, including finding a resident unresponsive;-He was unaware of the situation with Resident #10 and the delay in resident's transfer was unacceptable;-He expected staff to contact 911 with residents who experienced an emergent event;-Resident #10 was not on palliative and/or comfort care, but still had DNR status;-Staff should have called 911 when they found Resident #10 unresponsive. During an interview on [DATE] at 12:45 P.M., the facility's Medical Director said he expected staff to send a resident to the hospital in an emergent situation based on the resident's wishes in their medical directive. If a resident was a do not resuscitate (DNR), do not intubate, and do not send to the hospital, staff should contact the physician first before sending the resident to the hospital. If the resident wanted to be sent to the hospital and the situation was emergent, staff should send the resident to the hospital and then contact the physician.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure one nurse aide (NA) completed a state-approved training program within four months of hire. The facility census was 59. 1. Review of NA D's employee file showed a hire date of 02/18/25. Review of NA D's payroll showed the employee worked 205 hours as a NA from 11/12/25 to 12/15/25. Review of the facility's schedule for 12/11/25, showed NA D was scheduled for 11:00 P.M.-7:30 A.M. as a NA. During an interview on 12/16/25, at 4:00 P.M., NA D said he/she worked at the facility as an NA for since February 2025. He/She completed a training program but had not passed his/her test. During an interview on 12/09/25, at 11:30 A.M., the Administrator said NA D took the training course but failed the test twice. NA D was scheduled to test again. During an interview on 12/10/25 at 2:59 P.M., the Director of Nursing (DON) said NA D was not certified. NA D has worked as an NA since February 2025. NA D passed his/her class but failed the test. She did not know NA D could not work past four months if he/she was not certified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265237	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Nursing Home	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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to maintain an infection prevention and control program (IPCP) that included a functional antibiotic stewardship program that monitored antibiotic use for two residents (Resident #2 and #32), in a review of 17 sampled residents. The facility had not had a designated Infection Preventionist or an active antibiotic stewardship program with tracking of infections or antibiotic use since November 2025. The facility census was 59. Review of the facility's policy, Antibiotic Stewardship, dated 10/15/24, showed the following: -Purpose: To ensure proper use of antimicrobials including appropriate treatment, duration of treatment and indication as well as ensuring that antibiotics are not used when contraindicated;-Policy: Nursing staff will not request antibiotics from attending physicians; -Culture shall be obtained when possible prior to antibiotics on all residents. Nursing will request cultures (for example, for urine or sputum) if a physician orders antibiotics without them; -When culture reports return to the facility, nursing will assess the results to assure that the antibiotic currently being used is sensitive and if resistant then request from the attending physician that the antibiotic be discontinued and /or changed; -A list of residents with infections and antibiotic use will be sent to the medical director on a monthly basis. This will include resident name, date, type of infection diagnosed, diagnostic testing, attending physician, medication dose and duration, whether the medication was discontinued if culture was negative and whether it was sensitive to the medication used; -The medical director will talk to and/or write letters to the attending physician if antibiotics are used inappropriately, including lack of diagnostic testing, wrong diagnosis, wrong antibiotic, wrong dose, or wrong duration. He/She will be in charge of educating the physicians and will also inform nursing administration when improvements could have been made in staff carrying out this policy. 1. Review of Resident #2's undated physician order sheet (POS), showed the following: -Macrobid (an antibiotic) 100 milligrams (mg) by oral route three times per week for chronic urinary tract infection (UTI), every week on Monday, Wednesday, Friday at 07:00 P.M. to 11:00 P.M.; -Original order date: 09/24/24; -Renewed on 11/20/25; -Open ended (no stop date). Review of the resident's Medication Administration Record (MAR), dated 09/01/25 through 09/30/25, showed the resident received Macrobid 100 mg by mouth daily on Monday, Wednesday, and Friday. Review of the resident's MAR, dated 10/01/25 through 10/31/25, showed the resident received Macrobid 100 mg by mouth daily on Monday, Wednesday, and Friday. Review of the resident's MAR, dated 12/01/25 through 12/15/25, showed the resident received Macrobid 100 mg by mouth daily on Monday, Wednesday, and Friday. During an interview on 12/11/25 at 10:15 A.M., Licensed Practical Nurse (LPN) CC said the following: -The facility did not have an infection preventionist (IP) or antibiotic stewardship program at this time; -Resident #2 was on an antibiotic, Macrobid 100mg three times a week for the prevention of a urinary tract infection; -The resident did not have any current signs or symptoms of a urinary tract infection, such as urgency, discomfort, or pain; -The resident had not had any recent urinary tract infections that he/she was aware of. 2. Review of Resident #32's urine culture and sensitivity (a test that identifies the bacteria or fungi in a urine sample causing the UTI and determines how to treat the infection), dated 11/21/25, showed the following:-Presence of Escherichia Coli (E. coli, bacteria that can be caused by not wiping properly after going to the bathroom which can cause E. coli from feces to get into the urinary tract, causing a UTI);-The resident was started on Macrobid (antibiotic) 600 milligrams (mg) twice daily;-Physician ordered Rocephin (antibiotic) 1 gram to be administered intramuscularly (IM) for three days. 3. During an interview on 12/15/25, at 3:10 P.M., the Assistant Director of Nursing said she will be the primary Infection Preventionist, but the Director of Nursing (DON) was also going to do the training and maybe another back up person. During an interview on 12/15/25 at 03:15 P.M., the DON said the following: -The facility previously had an IP who tracked antibiotic usage, but he/she left abruptly in November 2025, and the DON could not find the previous documentation or antibiotic tracking records; -The facility currently did not have a designated IP; -The facility was not tracking (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic usage of residents at this time. During an interview on 12/09/25, at 10:00 A.M., the Administrator said the following: -The Infection Preventionist (IP) quit two weeks ago and did not leave a lot of the paperwork and files that he/she was responsible for;-He did not know what documentation the facility had for antibiotic stewardship;-The Assistant Director of Nursing (ADON) was now the IP, and the Director of Nursing (DON) and another backup staff person would be trained so there were people who could fill in as needed; -The infection control monitoring was not up to date.