STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265354	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryville Living Center	524 North Laura Maryville, MO 64468

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44395 Based on interview and record review, the facility failed to protect one resident (Resident #1), who resided on the Special Care Unit (SCU), from abuse when Certified Medication Technician (CMT) A hit Resident #1 in the face with an open hand. The facility staff then allowed the Alleged Perpetrator (AP) to stay in direct contact with Resident #1 and without supervision for over 2.5 hours. The facility census was 54. On 12/11/24, the Administrator was notified of the past noncompliance immediate jeopardy (IJ) which began on 12/11/24. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented. The IJ was corrected on 12/11/24. Review of the undated facility Abuse Prevention and Prohibition Policy showed: -The facility prohibits mistreatment, neglect or abuse of residents; -Resident abuse must be reported immediately to the Administrator; -While a facility investigation is underway, steps will be taken to prevent further abuse; -If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress, except to meet with the administrator as part of the investigation; -The facility will immediately remove any alleged perpetrator from any further contact with any resident; -When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents, through suspension, pending the outcome of the investigation, prosecution or disciplinary action against the employee; -The facility employee or agent, who becomes aware of abuse or neglect shall immediately report the matter to the facility Administrator or his/her designated representative. Review of Resident #1's Annual Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 11/27/24, showed: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Brief Interview of Mental Status (BIMS) of 99 indicating significant cognitive loss; -Physical Behaviors such as hitting and kicking 1-3 of the 7 day assessment period; -Moderate assistance of staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself) such as toileting, dressing, and personal hygiene; -Diagnoses of Dementia with Psychosis (a decline in mental abilities that affects daily life and a condition where a person with dementia experiences seeing or hearing things that are not real or false beliefs), muscle weakness, unsteadiness, cognitive communication deficit (communication difficulty caused by a cognitive impairment), restlessness, agitation (feeling of irritability, mental distress or severe restlessness), and generalized anxiety disorder (excessive and uncontrollable worry about everyday events or activities). Review of the resident's comprehensive care plan, dated 11/27/24, showed: -The resident had the potential for agitation, anxiety, and behaviors; -Explain all procedures to the resident; -Approach the resident in a calm manner; -Provide the resident a calm environment and care. Review of the facility investigation, dated 12/11/24, showed: -On 12/11/24 at 12:45 A.M., Resident #1 was found by CMT A on the floor of his/her room. Licensed Practical Nurse (LPN) A was notified and assessed the resident for injuries. Nurse Aide (NA) B and Certified Nurse Aide (CNA) C went to assist CMT A in getting Resident #1 to bed; -At 12:55 A.M., CMT A was at the resident's head, CNA C was at the resident's feet. Resident #1 was swinging his/her arms and kicking at CNA C. NA B was standing to the side observing. CMT A grabbed the resident's arm, and smacked the resident in the face, across the cheek and eye of the right side, with his/her open palm. The resident was placed in bed and NA B and CNA C left the SCU and returned to the other hall of residents; -At 2:45 A.M., the incident was reported to Charge Nurse LPN A; -At 2:49 A.M., LPN A notified the on call nurse MDS Coordinator of the incident that had occurred between 12:50 A.M. and 12:55 A.M.; -At 3:15 A.M., the Director of Nursing (DON) was notified of the incident; -At 3:30 A.M., the MDS Coordinator arrived at the facility and proceeded to the SCU where he/she found CMT A sitting in Resident #1's room. Resident #1 was in bed asleep. CMT A was then interviewed and escorted from the building; -CMT A admitted to 'bopping' the resident on the head as a knee jerk reaction. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the CMT A's undated written statement showed: -On 12/11/24 at approximately 12:45 A.M., Resident #1 was on the floor of his/her room. -CNA B and NA C were in the room to assist CMT A in getting the resident up. -CNA B was standing towards the resident's knees and NA C was off to the side observing. -The resident attempted to kick CNA B in the back. -CMT A pulled his/her hand away, tapped the top of the resident's head and told the resident to stop it. -He/She did not know why she tapped the resident and it was a knee jerk reaction During an interview on 12/16/24 at 2:50 P.M., NA B said: -He/She and CNA C had gone to assist CMT A with getting Resident #1 up off the floor on the night of 12/11/24 about 12:55 A.M. CMT A was standing above Resident#1's head. Resident #1 was lying on the floor. CNA C was standing toward the resident's legs/feet facing the side of the resident, applying the gait belt. Resident #1 was kicking and hitting at CNA C. CMT A used his/her open hand and smacked Resident #1 across the face/eye. Resident #1 went completely still. Resident #1 then growled and gritted his/her teeth at CMT A. CMT A asked did anyone see that; I hope not. CMT A and CNA C assisted Resident #1 to get into bed. CNA C and NA B left the SCU and returned to the other hall of the facility; -He/She had been at this job about 2 weeks and was very unsure what to do in the situation; -He/She and CNA C provided care and did rounds for the other residents prior to him/her going to the Charge Nurse about the incident; -He/She watched a video about abuse when he/she started at the facility, however the video did not tell him/her who to report suspected abuse to; -Resident #1 had never made a growling sound or barred his/her teeth to NA B; -He/She knew it was not right for CMT A to smack the resident. During an interview on 12/16/24 at 3:15 P.M., CNA C said: -He/She went to assist CMT A get Resident #1 off the floor on the night of 12/11/24; -NA B was standing to the side and was not physically assisting the resident; -He/She heard CMT A say you didn't see that. I hope not; -He/She did not see CMT A smack or harm Resident #1 in any way; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Every time CMT A would speak, Resident #1 would growl and chomp his/her teeth at CMT A; -He/She had never had another staff member potentially abuse someone and he/she did not know what to do; -He/She knew abuse should be reported. However, he/she was not sure who to report to. During an interview on 12/16/24 at 3:37 P.M., MDS Coordinator said: -He/She was the management nurse on call the night of 12/11/24; -LPN A notified him/her of the incident with Resident #1 and CMT A; -He/She did not tell the Charge Nurse to remove CMT A from resident care; -CMT A should have been removed from contact with residents immediately; -He/She made a mistake by not removing CMT A from resident contact. During an interview on 12/16/24 at 3:40 P.M., the DON said: -She would expect an alleged perpetrator to be removed from resident contact immediately; -CMT A might have worked for the facility a week, she was not sure; -CMT A was an agency staff member; -Agency staff do not receive education from the facility except expected care of residents. During an interview on 12/16/24 at 4:03 P.M., the Administrator said: -She was not made aware of the incident until later in the morning on the 11th; -She was not made aware the CMT was allowed to stay in resident contact until she arrived for work on the morning of the 11th; -She would expect the alleged perpetrator to be removed from resident contact. MO246431