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	05/07/2025

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect two residents who resided on the Memory Care Unit (Resident #1 and #5) from physical abuse by Resident #2, when Resident #2 pulled Resident #1's hair and hit Resident #5 with a water pitcher full of water, causing redness and mental distress for Resident #5. The facility census was 49. Review of the facility policy Abuse, Prevention, Prohibition Policy dated 3/2025 showed: -Each resident has right to be free from abuse; -Residents must not be subjected to abuse by anyone, including other residents; -The facility prohibits mistreatment or abuse of residents; - Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. On 5/7/25, the Administrator was notified of the past noncompliance situation which occurred on 4/27/25. On 4/27/25, facility administration was notified of the incident, an investigation immediately began and corrective actions were implemented when the staff immediately seperated Residents #1 and #2 after the first event and seperated Resident #2 and #5 after the second incident. Staff placed Resident #2 on 15 minute check monitoring until he/she was sent to a behavioral health hospital for evaluation and treatment on 5/1/25. The Administrator provided abuse training for the staff after the events. The facility moved Resident #5 on a different hall from Resident #2. Resident #2's Primary Care Physician ordered Lorazepam (a medication to treat anxiety) 0.5 milligram (mg) table by mouth every 6 hours as needed. The noncompliance was corrected on 5/1/25. 1. Review of Resident #5's Quarterly Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 2/25/25 showed: -Extensive cognitive loss; -No behaviors; (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 - Actual harm Residents Affected - Few	-Diagnoses of Dementia with psychotic disturbance (when individuals with dementia experience symptoms such as seeing or hearing things that are not there and believing things that are not real), anxiety, depression, Parkinson's Disease and cognitive communication deficit (communication difficulty from cognitive loss). Review of the resident's Comprehensive Care Plan dated 3/4/25 showed: -He/She received antipsychotic medication for dementia, with psychotic disturbance: Behaviors of restlessness, agitation and aggression. Monitor the resident's behaviors; -He/She had physical behaviors directed towards others during episodes of personal care and toward his/her spouse; he/she will not cause harm to self or others; redirect from other residents when he/she becomes aggressive, intervene as needed; -The resident and his/her spouse have had physical altercations; the residents will be redirected without harm; monitor for signs of agitation or frustration towards/between spouse. If either showed symptoms they should be seperated. Review of Resident #5's medical record showed: -4/29/25 at 6:28 P.M. the resident's spouse hit him/her in the head with a full water pitcher. Staff stopped the spouse and removed the resident immediately. The resident reached his/her hand out and said help. I don't know why he/she did that but he/she is very mad at me. The right side of the resident's face was red with a small abrasion. Review of the facility investigation dated 4/29/25 showed: - 4/29/25 Licensed Practical Nurse (LPN) A heard whimpering coming from Resident #5's room; - LPN A observed Resident #5 in a reclining chair and his/her right upper extremity was raised in a protective position; - Resident #2 leaned over Resident #5 and hit him/her with a full water pitcher in the head, making contact twice before LPN A could intervene; - The residents were seperated; - Resident #5 received abrasions to both hands, neck and right cheek; - 4/29/25 Resident #2 was sent to a local Emergency Department (ED), and returned to the facility later the same day; - 4/29/25 AN order for Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety was obtained; - 4/29/25 Resident #5 was moved from the Memory Care Unit (MCU) to separate him/her from Resident #2; - 4/29/25 Abuse education was provided to the staff; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 5/1/25 Resident #2 was sent to a behavioral Health hospital for evaluation and treatment. During an interview on 5/7/25 at 2:25 P.M. Certifed Nurses Aide (CNA) B said: -Resident #2 had been agitated more over the past two weeks, screaming at staff and at Resident #5; -On 4/29/25 he/she had gone in to Resident #5's room to clean the resident up after an incontinent episode; -He/She explained what he/she was doing; -Resident #2 sat in a recliner in Resident #5's room; -He/She left the room with Resident #5 sitting on the resident's bed and Resident #2 sitting in the recliner chair; -He/She took the dirty linen and trash out, upon returning approximately 2 minutes later, he/she heard whimpering, and found Resident #2 and #5 in Resident #5's room with Licensed Practical Nurse (LPN) A; -LPN A was attempting to get Resident #2 to leave the room, Resident #5's clothing was wet, the floor was wet, and Resident #5 had his/her hand to the side of his/her head; -LPN A took Resident #2 to his/her room and CNA B took Resident #5 outside for fresh air; -Resident #2 was on 15 minute checks until he/she went to the hospital. During an interview on 5/7/25 at 4:03 P.M. LPN A said : -On 4/27/25 he/she entered the Memory Care Unit, CNA B said he/she was taking out linen and trash, and left the unit; -He/She heard a whimpering and scuffling sound, she entered Resident #5's room and found Resident #5 crouched down beside his/her bed with his/her hands up in a defensive position; -Resident #2 was standing over Resident #5 swinging a full water pitcher at Resident #5's head; -Resident #2 made contact with the side of Resident #5's head twice before he/she could stop Resident #2; -Resident #2 stopped when he/she heard LPN A say his/her name; -CNA B returned to Resident #5's room; -Resident #2 went with LPN A willingly, but was grabbing and trying to throw peri wash as he/she left Resident #5's room, Resident #2 was taken to his/her room, and LPN A went to get help to clean up the water; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Less than 2 minutes later, LPN A returned to Resident #5's room, Resident #2 was again in Resident #5's room; -LPN B removed Resident #2 from Resident #5's room, telling him/her, he/she could not be in there, Resident #2 said he/she remembered what happened and it meant he/she still got it; -Resident #5 reported he/she wanted to cry; -The incident was abuse; -Resident #5 had been happy and pleasant since Resident #2 was gone. Observation on 5/7/25 at 12:45 P.M. showed Resident #5: -Left hand had multiple small scratched, pinpoint open areas to back of his/her hand. 2. Review of Resident #1's Annual MDS dated [DATE] showed: -Extensive cognitive loss; -No behaviors; -Diagnoses of dementia, anxiety, and high blood pressure. Review of the residents Comprehensive Care Plan dated 3/24/25 showed: The resident had behavior problem of being friendly toward male residents; such as touching their face, playing with their hair, hugging them and being close to their faces. Initiated 4/27/25. Review of the Resident's medical record showed: -On 4/27/25 at 9:14 A.M. the resident was walking out of the A.M. meal, cupped his/her hands around a Resident #5's face. Resident #2 yanked Resident #1's hair and pulled him/her down. Resident #2 said to keep his/her hands off Resident #5. Resident #1 said he/she was sorry. The residents were seperated and Resident #1 was taken to his/her room, where an assessment showed no redness, injury or tenderness. Doctor, family and Administrator notified. During an interview on 5/7/25 at 2:00 P.M. CNA A said: -Resident #1 was walking out of the dining room on 4/27/25; -Residents #2 and #5 were at their table; -Resident #1 stopped at Resident #5 and began twirling his/her hair; -Resident #2 grabbed Resident #1's hair, pulling Resident #1 until he/she bent over; -The Charge Nurse seperated the residents and Resident #2 was placed on 15 minute checks; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #2 had been more agitated, more easily upset between mid April and when he/she left for the hospital. 3. Review of Resident #2's Quarterly MDS dated [DATE] showed: -Moderate cognitive loss; -Verbal behaviors directed at others such as cursing and yelling out 1-3 days of the week; -No physical behaviors; -Diagnoses of vascular dementia (a type of dementia caused by loss of blood flow to part of the brain, leading to memory, thinking and behavior problems), depression, and anxiety. Review of the residents Comprehensive Care Plan dated 4/26/25 showed: -He/She would become overwhelmed and anxious about his/her spouse's condition and attempted to help at times. He/She had requested not to share a room. He/She will be comfortable about his/her spouse and not cause harm to either from attempting to help. Initiated 3/4/25; -The resident had a behavior problem, physical behaviors directed toward others; behaviors will be redirected and he/she will not harm others; redirect from others he/she had previous altercations with; Intervene as necessary to protect the rights and safety of others; Divert his/her attention and remove from the situation. Initiated 4/27/25. Review of Resident #2 Progress Notes showed: -4/8/25 a Certified Medication Technician (CMT) reported the resident punched him/her in the arm and had increased behavior of yelling at staff; -4/11/25 the resident's primary care physician (PCP) ordered lab work to be obtained; -4/12/25 the resident's PCP declined a gradual dose reduction (GDR) of psychotropic medications (medicine that effect a persons mind, emotions and behavior) due to the resident's increased behaviors; -4/16/25 the resident became angry and threw his/her spouse's walker. He/She was seen by the psychiatric doctor for increased agitation and behaviors: The physician recommended daily music and crosswords to slow the resident's mental decline, discontinue the medication Buspar (an antianxiety medication) and start Ativan (an antianxiety medication); -4/27/25 the resident pulled Resident #1's hair. The resident's physician and family were notified of the incident. The resident was very confused, wandered in and out of rooms, and thought others were following him/her in the hallway. He/She was upset he/she and the spouse were not in the same room; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-4/29/25 Resident #2's family was notified the resident hit Resident #5 with a water pitcher. The Psychiatric physician ordered Ativan to be given every six hours as needed for anxiety. The resident was sent to an area emergency room for evaluation and returned to the facility. The resident was pacing, wanted to go home, and was taking clothes in and out of the closet. As needed antianxiety medication given. Referrals were sent from the facility for psychiatric inpatient stay, with no open beds available; -5/1/25 The resident was transferred for inpatient psychiatric stay. During an interview on 5/7/25 at 4:47 P.M. the Administrator said: -Resident #2 meant to hit Resident #5; -This incident was abuse; -The resident's are a married couple and deserve to have private visits; -There was no indication that Resident #2 was going to hit Resident #5; -He/She was unsure how the incidents with Resident #1, Resident #2 and Resident #5 could have been prevented. -All staff education on Abuse and Neglect was completed on 4/28/25. MO253456 MO253487