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	03/11/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interviews and record review, the facility failed to protect one resident (Resident #1) from misappropriation, when $600 of the resident's money went missing from the Social Services Designee's (SSD) office. The facility did not reimburse the resident for the missing money until 03/10/26. The facility census 43.Review of the facility's Abuse Prevention, and Prohibition Policy, dated November 2025, showed:-This facility prohibits mistreatment, neglect, or abuse or residents; -The facility prohibits misappropriation of resident property;-Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent;-Social Services or designee will assist the resident/family to identify and mark personal possessions upon admission;- An inventory will be completed and maintained in the resident's clinical record;-Social Services or designee will educate the resident/family of the need to report any items of significance being brought in or removed so that this can be noted on the inventory in the clinical record;-Social Services or designee will educate the resident on how to report suspected occurrences, explaining the need to report, how to report, the investigation process, and the facility's response to the allegation; -Social Services Designee, overseen by the Administrator, will investigate all reports or complaints of missing resident property following the policy and procedure;-The Administrator will make the appropriate notifications and initiate an investigation of the allegation of misappropriation of resident property;-Should a specific employee be suspected of or have allegations made of misappropriation, the facility will follow the investigation protocol set forth in this policy;-The facility will educate the resident/family on how to deal with valuable items: i.e. taking items home, proper storage;-The facility will educate staff on the policy and procedure for prevention of misappropriation of resident property and of investigation, reporting, and staff responsibility. 1. Review of Resident #1's undated face sheet showed:-The resident's diagnoses included: Atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), vertigo (a sensation of spinning or swaying, often caused by inner ear issues, that leads to severe dizziness and balance loss). Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff) dated 02/24/26, showed he/she scored an 8 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents) indicating moderate cognitive decline. No behaviors were exhibited during the assessment period. Review of the resident's comprehensive care plan, dated 03/04/26, showed interventions related to locking up personal belongings to keep them safe. Review of the resident's progress notes showed the SSD documented on 2/19/26 at 4:53 P.M.:-The resident informed the SSD there was some cash in his/her purse; -The SSD and charge nurse counted $2137.00, along with a check book and three bank cards;- The resident kept $20;- The SSD put $2117, the check book and bank cards in the box in the SSD desk;-The SSD then called and notified the resident's family of the money and requested it to be picked up. Review of the facility investigation, dated 02/20/26, showed:-On 02/19/26, the resident was admitted to the facility at approximately 3:00 P.M.-At approximately 5:00 P.M., the resident informed the SSD that he/she had a cash in his/her purse;-He/She allowed the SSD to go through the purse and secure the cash;-The SSD counted the cash with the charge nurse on duty;-It was noted that the resident had $2137.00 in (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cash, along with a check book and three bank cards;-The resident elected to keep $20 in cash on his/her person;-The SSD took the remainder of the cash, $2117.00, the check book, and bank cards, and placed them in the safe box in the desk in the SSD office;-The SSD placed a call to the resident's family, requesting they come and pick up these items;-The SSD then left the facility for the day, locking the door to the SSD office; -On 02/20/26 at approximately 1:30 P.M., the SSD went to retrieve the cash, check book and bank cards to give them to the resident's family;-It was noted the cash was not in the same position as it had been placed in the safe box the evening prior;-The cash was counted and it was discovered $600.00 was missing, leaving $1517.00;-The check book and bank cards were still in the safe box;-It was noted that the safe box and desk drawer in the SSD office do not lock;-The Director of Nursing (DON) and Administrator were notified of the missing money;-The DON notified local law enforcement and family of the missing money; -The Administrator initiated an investigation;-All staff working between 02/19/26 at 5:00 P.M. to 02/20/26 at 2:00 P.M. were interviewed;-No staff had any knowledge regarding the missing money;-The set of keys the charge nurses carry does not have a key to the SSD office;-There was a box kept in the medication room with emergency keys to all rooms in the facility;-This key box was found to be unlocked and the zip lock around the lock box was missing;-The SSD key was present in the lock box;-The SSD was suspended pending the results of the investigation;-He/She returned to work on 02/25/26;-All staff were educated on how to handle resident money and property, and how to report missing resident money or property;-The safe box was removed from the SSD office;-A new lock box was ordered for the Administrator's office;-All resident money will now be given to the Business Office Manager (BOM) or the Administrator;-The facility will reimburse the resident for the missing money. Review of the police report dated 02/20/26 showed:-Law enforcement was contacted on 02/20/26 at 2:45 P.M. and arrived to the facility at 2:53 P.M.:-Officers met with the Administrator and SSD and were given the details of how the money was acquired, stored and noted to be missing;-SSD reported there had been $617.00 in miscellaneous bills and $1500.00 in $100 bills;-SSD stated that he/she documented the money in a progress note in the resident's electronic medical record; -SSD also stated that he/she did not inform other staff members of the money and only staff who had access to progress notes are the nurses;money and denied accessing the SSD office. During an interview on 03/11/26 at 11:22 A.M., the BOM said:-A grievance was filed on behalf of the resident on 02/20/26, indicating he/she had $600.00 go missing while being held in the SSD office; -The Administrator instructed the BOM to submit a request for the refund for the resident from the corporate office on 03/10/26;-He/She was waiting for a response from the corporate office to release the funds to the resident's family. During an interview on 03/11/26 at 3:25 P.M., the SSD said:-The resident had $2137 in cash in his/her possession;-The SSD counted the money with the charge nurse;- The resident kept $20 and $2117 in cash, the checkbook and bank cards were put in the box in the drawer in the SSD's desk; -He/She contacted the resident's family on the afternoon of 02/19/26 to pick up the cash, check book and bank cards from the SSD office;-He/She has not had money or property go missing from the SSD office before this event; -He/She was in the office on 02/20/26, from 8:00 A.M. to 1:30 P.M. with the exception of attending a meeting 9:00 A.M. to 9:30 A.M.;-When he/she went to retrieve the money from the box in the drawer at approximately 1:30 P.M. he/she saw it had been moved and some was missing;-SSD confirmed he/she locked the office when leaving for the day on 02/19/26 and the office was locked when he/she returned to work on 02/20/26;-The Administrator and DON had a key to the Social Services Office, and a key is kept in the emergency box in the medication room;-The nurses and certified medication technicians have a key to the medication room. During an interview on 03/11/26 at 2:45 P.M., the Administrator said:-The request for the funds to reimburse the resident of the missing money was delayed due to waiting for approval from the corporate office to submit a request;-The SSD was suspended on 02/20/26 after law enforcement arrived at the facility and interviewed him/her;-The SSD was allowed to return to work on 02/25/26 after the facility investigation was complete and the investigation showed it was undetermined who had taken the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	money from the SSD office; -The facility has received no additional reports of missing money or property from residents and/or their families.-A new lock box has been ordered for the Administrator's office;-All resident money and valuables will now be kept in the BOM office or Administrator office while awaiting pick up by the resident's family. Intake 2784530

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F 0684 Level of Harm - 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 observation, interview and record review the facility failed to provide follow up care in a timely manner after one resident, Resident #2, sustained a fall, had reported signs of pain, did not receive treatment for four days and subsequently had a fractured hip. The facility census was 43.Review of the facility policy titled, Skilled Fall, Policy dated 05/2025 showed each resident of this community who experiences a fall will be treated and assessed to adequately treat any current injuries. Review of the facility policy titled, Significant Condition Change and Notification, dated 12/2024, showed:-To ensure the resident's medical practitioner was notified of resident changes such as: an accident or incident with or without injury that has the potential for needed medical intervention;-Mobility changes;-Abnormal, unusual or new complaints of pain;-Need to significantly alter treatment. Review of the facility policy titled, Pain Management, dated 02/2025 showed:-It is the policy of this facility to respect and support the residents right to optimal pain assessment and management; -Acute pain is usually sudden in onset, and is often caused by injury, trauma or medical treatments; -Strategies for pain management include but are not limited to: Addressing/treating underlying causes of pain to the extent possible; -Expressions of pain may be verbal or non-verbal and are subjective to the resident (i.e. groaning, crying, whimpering, screaming). Review of Resident #2's admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff), dated 01/02/26, showed:-Brief Interview of Mental Status (BIMS) of 99 indicated significant cognitive deficit; -Able to understand and make self understood; -Dependent on staff for toileting and bathing; -No falls or history of falls; -Diagnoses included: Stroke with right side weakness, need for assistance with personal care, Chronic Obstructive Pulmonary Disease (COPD a disease where the lungs do not take in and use oxygen appropriately), and Transient Ischemic Attack (TIA :a temporary blockage of blood flow in the brain causing stroke like symptoms and does not cause permanent damage). Review of the resident's Fall Risk Assessment, dated 01/03/26, showed he/she was a low risk for falls. Review of the resident's Comprehensive Care Plan, dated 01/10/26, showed: -He/She was at risk for falls, and had walking and balance problems;-He/She was not to be left alone in the wheelchair (w/c) in his/her room;-He/She was not to be left alone in the bathroom;-He/She should have call light within reach when in his/her room;-The resident's fall on 02/10/26 was not addressed on the care plan;-The resident's pain was not addressed on the care plan. Review of the resident's nurse progress note, dated 1/21/26 at 12:51 P.M., showed:-Therapy reported the resident remained on services for a stroke;-Some days the resident required minimum assistance of staff for transfers, he/she had adequate strength and cognition varied. Review of the resident's nurse progress note, dated 02/10/26 at 7:15 P.M., Licensed Practical Nurse (LPN) A documented:-The nurse was called to the resident's room where the resident was found on the floor near his/her bed;-The resident said he/she was trying to get into bed;-Staff used a mechanical lift to get the resident into bed. Review of the resident's progress notes, for February 2026, showed the facility staff did not document an assessment after the resident's fall on 2/10/26. Review of the resident's nurse progress note, dated 2/11/26 at 10:59 P.M., showed the resident's gait (walking), grasp (hand holding) and upper and lower extremity movement was not assessed. Review of the resident's nurse progress note, dated 2/12/26 at 4:23 P.M, the Administrator documented:-The resident's family reported the resident complained of pain in his/her right leg/hip area especially with therapy;-Order received for mobile x-ray to be completed of right hip;-Mobile x-ray was unable to obtain the x-ray on 2/12/26 and would obtain the x-ray on 2/13/26. Review of the resident's nurse progress note, dated 2/12/26 9:00 P.M., showed the resident's gait, upper and lower extremity movement was not assessed. Review of the resident's nurse progress note, dated 2/13/26 at 10:17 A.M., LPN B documented he/she did not assess the resident's lower extremity movement. Review of the resident's nurse progress note, dated 2/13/26 at 3:39 P.M., the Director of Nursing (DON) documented:-The resident's family was concerned with the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	resident's complaints of pain;-The family was educated on awaiting x-ray;-The family asked if the resident could be given Tylenol for pain. Review of the resident's February Physician Orders Sheet (POS) showed an order, dated 02/13/26 at 4:12 P.M., for acetaminophen tablet 325milligram (mg), give two tablets by mouth every 4 hours as needed for general discomfort and no other pain medication ordered. Review of the resident's radiology report, dated 2/13/26, showed the impression of an acute right hip fracture. Review of the resident's nurse progress note, dated 2/14/26 at 4:45 A.M., showed:-The resident's x-ray report was called to the facility nurse;-The resident's family was notified and permission was granted to send him/her to an area hospital for evaluation;-The resident went to the hospital by ambulance. Review of the resident's Medication Administration Record (MAR), dated February 2026, showed-No acetaminophen was administered in the month of February; -Pain assessments were completed on February 11th, 12th and 13th and recorded as 0 on a 0-10 scale on all shifts. During an interview on 03/06/26 at 2: 30 P.M., Physical Therapist (PT) A said: -The resident had not had any complaints of pain until after the fall on 2/10/26; -He/She attempted to provide therapy on 02/11/26 and the resident would grimace and his/her face would turn red; -He/She knew something was wrong and notified LPN B the resident was having pain;-Nothing was done to address the resident's pain; the resident was not sent to the hospital for a few days. During an interview on 03/06/26 at 2:56 P.M., the Administrator said:-The resident's family reported he/she had pain on the 12th and 13th; -She did not know why the resident was not sent to the hospital the night the x-ray was ordered, since the mobile x-ray company could not get to the facility; -She would base the need to be sent to the hospital if the resident was in distress or having acute pain; -She tried to avoid sending the resident to the hospital due to the acute illness the resident may come in contact with at the hospital, and increased confusion for confused residents;-She spoke with the resident's family on 02/12/26 and offered to get a mobile x-ray. During an interview on 03/06/26 at 3:05 P.M., LPN B said:-He/She did not recall if staff reported to him/her the resident was in pain; -The resident's family reported he/she was in pain one day but was unsure what day it was; -He/She did not feel like the resident's pain was urgent or that it was an emergency to send him/her to the hospital; -If a mobile x-ray was going to take an excessive amount of time to obtain, he/she would send the resident to the hospital. During an interview on 03/11/26 at 1:50 P.M., Certified Nurse Aide (CNA) A said:-He/She was present when the resident fell on [DATE]; -The resident was grunting and groaning with movement;-The resident's leg looked swollen;-A licensed nurse checked the resident so, CNA A did not report any swelling to anyone else. During an interview on 03/11/26 at 2:10 P.M. LPN C said :-The resident did not complain of pain that he/she was aware of; -The resident was non-verbal and would mostly nod yes or no when asked; -After a fall an assessment should be completed for 72 hours;-At the time of the resident's fall the resident did not see any swelling of the resident's thighs. During an interview on 03/11/26 at 3:15 P.M., the DON said:-The resident should have been sent to the hospital when mobile x-ray was not available when ordered; -During her investigation multiple CNA's staff reported the resident had complaints of pain after the fall and before being sent to the hospital; -She spoke with the resident's family about his/her pain and asked the charge nurse to administer pain medication;-She is unsure why the medication was not given;-It was unacceptable that a resident laid in pain for several days prior to treatment; -She expected staff to provide immediate intervention and assess a resident for 72 hours after a fall to include range of motion for upper and lower extremities;-She expected pain assessments to be completed for 72 hours after a fall. Intake 2743923Intake 2748212Intake 2785301