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	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryville Rehabilitation & Health Care Center	524 North Laura Maryville, MO 64468

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and interview the facility failed to provide a dignified existence for one resident, who resided on the Special Care Unit, (Resident #1), when Certified Nurse Aide (CNA) A took a picture of Resident #1, without resident or family/guardian consent and shared it with a coworker. The facility census was 48Review of the facility provided Resident Rights Policy dated 12/2024 showed:-Each resident residing in this community has the right and will be afforded the right to a dignified existence;-It is the responsibility of all who work in this community including employees, to protect the rights of each resident;-Resident Rights include privacy and confidentiality.Review of Resident #1's Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) showed:-He/She had significant cognitive loss; -He/She was dependent on staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself); -Diagnosis of dementia and hearing loss. Review of Resident #1's Comprehensive Care Plan date 03/25/2026 showed:-He/She was unable to voice previous routines and preferences, please refer to the Durable Power of Attorney (DPOA) for routines and preferences, date initiated 03/25/2025; -He/She had impaired cognitive function and thought process due to dementia and resides on the SCU;-The resident's dignity and autonomy will be maintained at the highest level.Review of the facility provided investigation dated 06/03/2026 showed:-On 06/03/2026 at approximately 2:45 P.M. Certified Nurse Aide A, took a photo, with a mustache filter, of Resident #1 fully dressed walking into the kitchen of the SCU in the facility, and a caption of are you working tonight to Certified Medication Technician A;-When CMT A reported for work at 6:00 P.M on 06/03/2026 he/she reported the picture to Licensed Practical Nurse (LPN) B ; -CNA A was suspended; -Other residents were questioned, felt safe and were unaware of any pictures being taken; -The Administrator started Abuse and Neglect education with all staff. During an interview on 06/09/2026 at 11:20 A.M. Family Representative A for Resident #1 said:-He/She was unsure how Resident #1 would have felt about taking a picture; -Resident #1 probably would have been okay with the picture if it was between the two of them but not being shared with others; -Resident #1 took pictures with Family Representative A previously, but he/she was unsure how the resident would feel about those being shared as he/she never shared them with anyone.During an interview on 06/09/2026 at 2:32 P.M. LPN B said: -He/She was notified by CMT A had received a picture of Resident #1 from CNA A; -Resident #1 would not understand that a picture was even taken; -He/She cared for Resident #1 previously and the resident may have thought the picture was funny, but he/she did not know for sure; -Taking pictures of residents was not okay and he/she reported to the Administrator immediately; -He/She had education on abuse and neglect after the picture was taken. During an interview on 06/09/2026 at 3:39 P.M. CMT A said:-On 06/03/2026 at approximately 2:45 P.M. he/she received a picture of Resident #1 from CNA A; -The picture showed Resident #1, with a mustache, fully clothed, walking with his/her walker, and a caption that asked are you working tonight; -He/She reported to LPN A when he/she arrived for his/her shift;-He/She had education on abuse and neglect after the incident.During an interview on 06/09/2026 at 4:07 P.M. CNA A said:-He/She did take a picture of Resident #1 with a mustache filter and sent it to his/her friend who worked at the facility; -He/She did not ask the resident permission to take the picture as the (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident would not understand what he/she was doing;-He/She did not save the picture, put the picture on line or anywhere but to CMT B; -He/She did not remember if he/she had any education on taking photos, dignity or privacy, but had education not to take photos and post them online; -He/She thought if he/she didn't post the picture on line it was not a big deal and would not cause any harm; -He/She did not mean to cause any harm to the resident.During an interview on 06/12/2026 at 2:27 P.M. the Administrator said:-He/She would expect staff not to take any pictures of residents; -CNA A was suspended and had been terminated;-Education on Abuse and Neglect was provided to staff; -Residents were questioned about pictures and safety and no concerns were brought up; -Resident Rights training is done at time of hire and annually. Intake 3033227

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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 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 interview and record review, the facility failed to protect one resident (Resident #1) right to be free from misappropriation of property, when an employee did not follow policy for accurate narcotic (highly addictive prescription medication) count, did not visualize liquid narcotic medication during count procedures and the resident was missing 40 milligrams (mg) of morphine sulfate (liquid narcotic medication that is highly addictive) medication on 06/29/26 and no documented use. The facility census was 45.Review of the facility Controlled Substance Policy dated 12/2024 showed:-Controlled substances are subject to special record keeping requirements;-The authorized person receiving and checking in a drug is to prepare a controlled substance proof of use record form;-Thereafter a physical inventory of that medication will be made at the change of each nursing shift;-All controlled substances are to be counted every shift; -The on-coming nurse or Certified Medication Technician (CMT) will be responsible for looking at the medication to verify the amount of the medication present at the time of count; -Any discrepancy in the inventory of a controlled substance is to be reported to the Director of Nursing immediately. Review of the facility Abuse Prevention and Prohibition Policy dated 11/2025 showed:-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; -The person made aware of allegations of abuse or neglect OR the Administrator will report the allegations of abuse and neglect to law enforcement.Review of Resident #1's Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 04/22/26 showed:-Significant cognitive impairment; -Diagnoses included: Alzheimer's Disease, cognitive communication deficit, dementia, anxiety, and heart failure; -He/She received Hospice services.Review of the resident's Comprehensive Care Plan dated 04/25/26 showed the resident had a terminal prognosis (illness that will lead to death typically within six months), and received Hospice care. Review of the facility Investigation Report dated 06/29/26 showed:-During shift change on 06/29/26 at 6:00 A.M. Licensed Practical Nurse (LPN) A found that the resident's bottle of liquid Morphine sulfate had a total of 28ml of a 30ml bottle and no documentation of administration; -Conclusion was unable to determine missing narcotic medication; -Interviews with staff showed CMT A reported he/she and LPN C counted narcotics on 06/27/26 and 06/28/26 and did not remove the bottle from the box or look at the bottle of medication. Review of the resident's physician orders for July 2026 showed:-Morphine sulfate (a potent opioid pain medication) oral solution 20milligrams (mg)/milliliter (ml); give 0.25 ml by mouth every hour as needed for minimal pain/air hunger of 1-3. Give 0.5ml every hour as needed for moderate pain/hair hunger. Give 0.75ml every hour as needed for severe pain/air hunger and 1 ml by mouth every hour as needed for excruciating pain/air hunger of, ordered 05/12/26. Review of the resident's July Medication Administration Record (MAR) showed the facility staff did not document administration of Morphine Sulfate.Review of the resident's Controlled drug receipt/record/disposition form showed:-No signature of the nurse the received the medication; -No quantity received recorded; -Date dispensed 04/29/26; -Name and Strength: Morphine Sulfate 100mg/5ml; -Quantity Dispensed: 30mls; -On 06/29/26 0ml administered, 28ml remained. During an interview on 07/07/26 at 4:05 P.M., the local Police Officer A said he/she had not been notified of missing narcotics. The facility staff did not make a police report of missing narcotics.During an interview on 07/07/26 at 4:16 P.M., the Medical Director said she had not been notified the resident had missing narcotics. She would expect to be notified when narcotics are missing. During an interview on 07/07/26 at 5:03 P.M., the Administrator said:-She was awaiting lab results of staff involved in missing narcotics; -The police had not been notified, but she would call them; -Education on correct narcotic count procedures was done with staff. During an interview on 07/08/26 at 8:58 A.M., LPN A said:-On 06/29/26 was the first shift he/she had worked at the facility; -He/She counted narcotics with CMT A on 06/29/26 around 6:00 A.M.; -He/She saw that the bottle of morphine for the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had been opened and there were not 30 ml of fluid in the bottle; -He/She notified LPN B immediately; -LPN B took the bottle of morphine and the count sheet.During an interview on 07/20/26 at 9:05 A.M., LPN B said; -He/She was notified of missing narcotics on 06/29/26 during count because he/she went to the Special Care Unit to check on staff; -LPN A showed him/her a discrepancy where the resident's morphine had 28ml in the bottle instead of 30ml and 2 ml were unaccounted for; -He/She took the morphine bottle and the count sheet and locked them in the medication room to await the Director of Nursing's (DON) arrival;-The DON was notified of the discrepancy between 7:30 A.M. and 8:00 A.M. when she arrived. During an interview on 07/20/26 at 2:10 P.M., LPN C said:-He/She counted narcotics over the weekend of 06/27/26 and 06/28/26 with CMT A; -He/She was not working 06/29/26 when the discrepancy was found;-He/She saw the resident's bottle of Morphine Sulfate, but did not look closely enough to see there was medication missing; -He/She should have checked the bottle more closely for discrepancy; -The DON should be notified immediately of any missing narcotics.During an interview on 07/20/26 at 2:30 P.M., the Director of Nursing said:-She was notified of the discrepancy in narcotic count for the resident when she arrived to work on 06/29/26; -LPN B placed the medication and count sheet in the medication room prior to her arrival; -The nurse who was working on the special care unit was the one who recognized the discrepancy; -She counted the medication with LPN B to determine there were only 28 ml in the bottle; -There was medication residue in the syringe used to administer the medication; -She researched the discrepancy by asking staff if they had administered the medication; -She was unable to find a staff member who had administered the medication so Department of Health was notified; -She would expect staff to notify her of missing narcotics; -Staff probably should have texted or called her immediately when the discrepancy was found. Intake 3063583

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have sufficient staff to prevent one resident (Resident #2) who resided on the Special Care Unit, from exiting the facility unattended, sustaining a fall in the courtyard, obtaining a 6 inch abrasion to his/her arm and caused extreme pain, while unaccompanied by staff. The facility census was 48.Review of the facility provided Skilled Fall Policy dated 05/2025 showed:-The fall program promotes safety, prevention and education of both staff and residents; -Each resident will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents.Review of the facility provided Elopement Policy dated 09/2025 showed:-It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible; -When a door alarm sounds staff shall immediately respond to and determine the cause of the alarm; Review of the Facility assessment dated [DATE] showed:-A census of 42 residents;-34 Residents needed 1-2 staff for assistance; -8 residents were dependent on staff ; -No staffing ratios noted. The facility did not provide a policy on staffing.Review of Resident #2's Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 04/09/2026 showed:-Significant cognitive loss; -Moderate to maximum assistance of staff with Activities of Daily Living (ADLs: tasks completed in a day to care for oneself)-Walks with supervision or one assistance of staff.Review of Resident #2's Fall Risk Assessment completed on 05/16/2026 showed:-score of 35 indicated high risk for falls. Review of Resident #2's Comprehensive Care Plan dated 06/06/2025 showed: -He/She was at risk for falls and had a history of falls, confusion, balance problems and he/she was unaware of safety needs date initiated 06/12/2025; -Maintenance was to check courtyard for safety concerns, date initiated 08/25/2025-Do not leave the resident in the courtyard without staff presence, date initiated 06/08/2026; -The resident had a behavior problem at times, wanted to leave the facility, went into other residents rooms, and resided on the dementia unit, date initiated 06/18/2025; -The resident had exit seeking behaviors at times, redirect as needed, date initiated 06/18/2025 -Staff were to anticipate and meet the resident's needs, date initiated 06/18/2025.Review of the resident's Nurse Progress Notes showed:-On 06/07/2026 at 7:45 P.M. Certified Nurse Aide (CNA) B reported Resident #2 was found outside on his/her backside; the resident complained of extreme pain in his/her upper left femur (long bone of the upper leg) and elbow; a 6 inch abrasion was noted to his/her left outer forearm; unable to perform Range of Motion (ROM the normal movement of a joint) because of pain and position, family notified and said to send the resident to the emergency room if needed, the ambulance was notified and the resident was sent to the emergency room. Observations on the Special Care Unit on 06/09/2026 at 2:10 PM showed:-No staff visible in hallway; -Doors to multiple resident rooms were closed;-No sounds of staff, such as voices, equipment etc, in resident rooms,-Resident #3 was walking in nurses station area; walked down the hall to the dining area, and attempted to push open the locked courtyard exit door; -At 2:30 P.M. CNA B came out of one resident room; -At 2:45 P.M. the Certified Medication Technician entered the SCU through the front doors. During an interview on 06/09/2026 at 2:00 P.M. Licensed Practical Nurse (LPN) A said:-All fall events should be charted in Progress Notes and Risk Management completed;-The courtyard door on the SCU is unlocked all the time and there is an alarm; -The alarm is loud so it can be heard throughout the unit; -Resident #2 was only outside for 10 minutes; -There was a CNA on the SCU at the time of Resident #2's fall and the CMT was passing medication on the front hall. During an interview on 06/09/2026 at 3:39 P.M. Certified Medication Technician (CMT) A said:-He/She worked a 12 hour shift on 06/09/2026; -He/She was usually assigned to the SCU; -He/She got report at 6:00 P.M. when he/she arrived on the SCU then immediately went to the front (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hall to pass medications; -Assigned CNA staff were on the SCU alone while the CMT was passing medications for an hour and a half to two hours; -He/She did not inform Certified Nurse Aide A, that he/she was going off the hall; -The door to the courtyard is supposed to be locked unless staff are taking residents outside; -Most staff know that CMTs go up front to pass medications and they are alone on the SCU at that time.During an interview on 06/09/2026 at 2:40 P.M. CNA B said:- The exit door to the courtyard was supposed to be locked at all times; -A CMT was scheduled on the SCU on 06/07/2026 with him/her; -The CMT assigned to the SCU left the unit to pass medications up front;-It was normal for the CMT to leave the assigned SCU and pass medications up front;-On the evening of 06/07/2026 he/she was assisting a resident into bed; he/she heard the door alarm sound; completed covering the resident and went to investigate the alarm; he/she saw that Resident #2 was sitting in the courtyard and yelled for assistance; no one responded; he/she left the SCU and went in search of assistance; -He/She knew he/she should not leave Resident #2 outside on the ground but needed to find help and he/she was alone on the unit; -Only one staff was on the unit when the second staff was passing medications, taking residents out to smoke or on break; -He/She was not sure how long Resident #2 was outside or what time the resident was seen last; -The nurse responded to his/her request for help and the resident was sent to the hospital;-Resident #2 was moaning and crying in pain;-When only one staff was on the unit they make the residents wait for assistance, so the one staff on the unit is not in a room and can monitor residents.Intake 3037653