

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Maryville Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview and record review the facility staff failed to follow the facility staffing policy of two staff members during the daytime hours for the Memory Care Unity (MCU) when Licensed Practical Nurse (LPN) A left the MCU, leaving Certified Nurse's Aide (CNA) A as the only staff member on the MCU when Resident #1 put his/her hand over Resident #2's mouth and hit Resident #3's arms with his/her hand. This deficient practice affected three of three sampled residents. The facility census was 44. On 07/30/26, the Administrator was notified of the past noncompliance which began on 07/22/26. Upon discovery, the facility administration immediately conducted an investigation, and corrective actions were implemented to include staff training regarding dementia care, staffing on the memory care unit, and abuse and neglect. The noncompliance was corrected on 07/23/26. Review of the facilities Investigation Report, dated 07/22/26, showed:-Resident's #1, #2, and #3 were sitting in the dining room on the memory care unit with CNA A;-Resident #1 and Resident #2 were verbally arguing and Resident #1 covered Resident #2's mouth with his/her hand;-CNA A separated the resident's;-Resident #1 then threw his/her walker at CNA A and a pair of pants that were on Resident #1's walker fell onto the floor;-Resident #3 reached down to pick up Resident #1's pants;-Resident #1 became irritated with Resident #3 picking up his/her pants and swung at Resident #3 and Resident #3 swung back at Resident #1, both resident's then began swatting at each other;-The resident's were immediately separated by CNA A;-LPN A was notified as he/she was walking up the hallway;-Resident #1 was placed on one on one observation;-All resident's were assessed for injuries and no resident had any injuries;-A urine sample was obtained from Resident #1 that showed he/she had a urinary tract infection;-The family of all resident's involved were notified;-A police report was filed with the local police department;-Education was provided for all nursing staff regarding abuse and neglect, dementia and behaviors, and ensuring two staff were on the memory care unit at all times from 6:00 A.M to 10:00 P.M. and to call for help when needed;-Corrective action was given to LPN A to not leave the MCU with only one staff member. Review of the facility staffing guidelines, not dated, showed:-Two staff need to be on the MCU from 6:00 A.M. until 10:00 P.M. at all times;-If a staff member is assigned to the MCU and needs to leave, that staff member needs to ensure that another staff member replaces them until they return. 1.Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 06/30/26, showed:-The resident was not cognitively intact;-The resident had not exhibited physical or verbal behavioral symptoms;-Diagnoses of dementia (a decline in mental ability severe enough to interfere with daily life), major depressive disorder, and history of urinary tract infections. Review of the resident's progress note, dated 07/23/26, showed: New medication order received for Bactrim DS (an antibiotic) twice a day for seven days due to a urinary tract infection. 2.Review of Resident #2's Quarterly MDS, (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE], showed: -The resident had severe cognitive impairment;-The resident had not exhibited physical or verbal behavioral symptoms;-Diagnoses of dementia, Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple tasks), and depression. During an Interview on 07/30/26 at 12:12 P.M. Resident #2's representative said:-The facility notified him/her of the altercation with Resident #1;-He/She did not have any concerns regarding Resident #2's safety at the facility. 3.Review of Resident #3's Quarterly MDS, dated [DATE], showed: -The resident was not cognitively intact;-The resident had not exhibited physical or verbal behavioral symptoms;-Diagnoses of dementia, anxiety, and major depressive disorder. During an Interview on 07/30/26 at 11:53 A.M. Resident #3's representative said:-The facility notified him/her of the altercation with Resident #1;-Resident #3 did not appear fearful after the altercation with Resident #1 and he/she did not have any concerns for Resident #3's safety at the facility. During an Interview on 07/30/26 at 1:13 P.M. Certified Medication Technician (CMT) A said: He/She had received training after the altercation with Resident's #1, #2, and #3 regarding abuse and neglect, dementia, and always having at least two staff members on the memory care unit at all times. During an Interview on 07/30/26 at 1:32 P.M. LPN A said:-Resident #1 had been a little agitated so he/she was sitting with the resident's in the dining room to keep an eye on them;-He/She had to take some paperwork to another staff member that was not on the MCU asked CNA A to watch the residents in the dining room while he/she was gone;-He/She was not gone very long, he/she had dropped of some paperwork then went right back to the MCU;-He/She had left the MCU with just one staff member since he/she was not going to be gone very long;-He/She had training regarding abuse and neglect, dementia, and always having two staff members on the MCU at all times since the altercation between Resident's #1, #2, and #3 occurred. During an Interview on 07/30/26 at 1:43 P.M. CNA A said:-LPN A had said that he/she needed to go do something off of the MCU and asked CNA A to sit with the residents in the dining room while LPN A was gone; -Right after LPN A had left the MCU, Resident #1 put his/her hand over Resident #2's mouth since Resident #2 was yelling at resident #1;-CNA A separated Resident #1 and Resident #2, Resident #1 then hit CNA A with his/her walker causing a pair of pants that were hanging on the resident's walker to fall onto the floor;-Resident #3 reached down to pick up the pants that had fallen off of Resident #1's walker;-Resident #1 then swung at Resident #3 with a closed fist and Resident #3 swung back at resident #1 with a closed fist, both hitting each other in the arms. During an Interview on 07/30/26 at 2:53 P.M. the Administrator said:-She expected LPN A to call, text, or use a walkie talkie to get another staff member to be on the MCU before he/she left; -Facility staff were provided training regarding abuse and neglect, dementia care, and ensuring two staff members were on the MCU at all times between the hours of 6:00 A.M. through 10:00 P.M. Intake 3108318		