STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265643	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center Inc	810 East Edwards Street 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 one resident's right to be free from mental and physical abuse when during care, as three staff were providing cares, RN A forcefully pushed the residents wheelchair forward and pulled it back and told the resident something to the effect of Ride'em cowgirl, verbally threatened to shame/humiliate the resident publicly for his/her behavior of taking off his/her clothes in public, when the resident resisted cares and made a biting motion, RN A told the resident babies bite. The resident was reported to be visibly upset and crying and when an aide offered to stay with the resident so the resident could calm down, RN A said no and that the resident needed to go to the dining room so others could see how he/she was acting and they would know what RN A has to deal with. The facility census was 28. On 3/23/26, the Administrator was notified of the past noncompliance which began on 3/3/26. On 3/3/26, facility administration was notified of the incident, an investigation immediately began and corrective actions were implemented to include; assessment of the resident, suspension of RN A, interviews with other residents for indications of abuse, implementation of daily auditing of staff interactions with residents, QAPI (Quality Assurance and Performance Improvement) tracking initiated, and mandatory in-service training for all staff on abuse prevention, treating residents with dignity and respect and safe handling of residents. The noncompliance was corrected on 3/19/26. Review of facility policy, Facility Policy and Procedure: Abuse, dated 7/18/23, showed:- Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual caretake of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being;- All personnel must promptly report any incident of resident abuse, including injuries of an unknown source; - Mandatory reporting of adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse;- Mental Abuse includes humiliation, harassment, threats of punishment, or deprivation;- Any person witnessing or suspecting abuse or neglect of a resident shall immediately remove the resident from a harmful environment and report the suspected abuse to the charge nurse;- Employees of the facility that have been accused of resident abuse will be placed on suspension pending investigation. Review of Resident #1's Face Sheet showed:- Resident is cognitively impaired;- Diagnoses: chronic kidney disease, anemia, diabetes, dementia, and anxiety disorder.Review of facility investigation, dated 3/3/26, included: - On March 3,2026 at around 1:15P.M. the facility received an allegation that RN A used demeaning language toward the resident while the resident was agitated and attempting to remove clothing and that RN A forcefully handled the resident and jerked the wheelchair while the resident was seated. The allegation involved potential verbal abuse, mental abuse, and inappropriate physical handling. - Upon notification, the facility ensured resident safety, completed full head-to-toe assessment, interviewed resident (as cognitively able), removed accused staff member from direct resident care pending investigation, initiated internal abuse investigation per facility policy, implemented increased monitoring of resident. -No visible bruising, redness, new swelling, or injury (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	noted on assessment. Vital signs stable. - Witnesses reported resident was agitated and resistant during transfer. - Statements indicate RN A used a firm and elevated tone directing resident to sit down, Resident reportedly stated, You're hurting my foot., RN A reportedly responded, Pick up your feet then. Witnesses' statements describe the RN's tone as raised and firm. - While assisting resident onto the commode resident was crying and repeatedly attempting to remove her shirt. Resident verbally resisted assistance, yelling No, No, No. Witness reported RN A stated, Do you want me to call your spouse and tell him/her you're trying to be naked in front of everyone. RN A reportedly grabbed resident's forearm while instructing her to Stop and Knock it off. Witness described RN's tone as harsher and louder than usual. - A witness reported RN A stated she wanted to take resident to dining room so they could see how she acted. The witness expressed discomfort transporting resident publicly while she was attempting to disrobe. During hallway transport, the resident again attempted to remove clothing. Witness reported RN A jerked the wheelchair forward and backward several times. RN A reportedly stated, Hold on, it's a bucking bronc. - Resident assessed immediately following the incident with no bruising, swelling, redness, or injury identified, no complaints of pain at time of assessment, vital signs stable. The resident was upset during the event but later returned to baseline affect. Due to cognitive impairment (dementia), resident was unable to provide a reliable detailed account. No ongoing fear expressed following the incident. - RN A provided a written statement via text message regarding the incident. In his/her statement, RN A indicated he/she did not agree with the characterization of events. RN A reported that while attempting to transport the resident through the doorway, one leg of the wheelchair became caught on the door frame. He/she stated that she moved the wheelchair forward and backward in an effort to free it from the doorway.RN A reported that CNA A and CMT A were present, both speaking to the resident during the interaction. RN A stated that she was attempting to maneuver the wheelchair and gain space to open the door. He/She acknowledged making a statement similar to [NAME]-[NAME], ride'em cowgirl, which he/she described as an attempt to redirect the situation and communicate her difficulty maneuvering the wheelchair. -RN A denied intent to harm the resident and indicated he/she was attempting to manage a challenging behavioral situation involving disrobing. - During follow-up interview with the Administrator and DON, RN A clarified that RN A did not call the resident a baby. He/She stated that while the resident was biting her during the interaction, he/she said, Don't bite, babies bite. RN A denied directly labeling the resident as a baby. She stated the comment was made in response to being bitten and was intended as redirection.- Determination: multiple consistent witness statements, staff acknowledgement of raised voice, demeaning and threatening statements, grabbing of resident's forearm, and jerking of wheelchair while resident was seated. Although no physical injury occurred, the conduct included demeaning and humiliating language, unnecessary public exposure risk, physical handling inconsistent with safe and respectful standards, and created emotional distress.- The facility implemented removal of staff member from direct resident care, disciplinary action per HR policy, mandatory abuse prevention and re-education for nursing staff, facility wide in-service training on abuse, dignity, respectful communication, and safe resident handling. - The facility substantiated verbal abuse and inappropriate physical handling and terminated RN A. Review of facility after action documentation, showed:- 3/3/26 random sample of 12 residents interviewed regarding any abuse witnessed or experienced by the resident at the facility. There were no concerns reported.- 3/9/26 through 3/19/26 Daily Auditing tool used for monitoring of staff interactions regarding, communication, behavioral responses, physical interactions, dignity, and privacy with residents. There were no concerns reported. - QAPI Tracking initiated on 3/6/26 covering: Abuse Prevention, Resident Rights, and Staff Performance. - Mandatory Staff in-service, dated 3/3/26 for Abuse Prevention, Dignity, and Safe Resident Handling. 27 staff members attended.- Staff Abuse Training, dated 3/3/26, 27 staff members attended.Review of the Resident's Care Plan, updated 3/17/26, showed:- Resident had behavioral symptoms which required staff to approach resident slowly, calmly and with clear instructions. - Staff are directed, that if the resident shows signs of being (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	overwhelmed or upset to give the resident space, perform cares later, use gentle reassurance, reduce noise and distractions and keep his/her routine consistent.- Resident has chronic back pain that can come and go, pain is not always spoken, watch for behaviors. Resident's pain may increase with movement or certain positions.- Resident has dementia and has been recently hospitalized for altered mental status. Resident had increased confusion which required staff to keep environment quiet and not overwhelming for resident. Staff are to monitor for acute changes from baseline dementia behaviors. During an interview on 3/23/26 at 12:10 P.M., RN A said: - Around 11:30 A.M. the resident started to try and disrobe and would not take his/her medicine. RN B and RN A were able to put the resident in his/her wheelchair and CNA A and CMT A took the resident to his/her room. - RN A, CNA A and CMT A were all present when the resident was placed into the bathroom for toileting. The resident's brief was changed, and fresh clothes were placed on the resident. It was hard to get the resident dressed since he/she was yelling. - CMT A was making threats to the resident that he/she was going to call his/her spouse about his/her behavior. Once the staff got the resident back into his/her wheelchair, RN A started brushing the resident's hair. - When RN (A) tried to wheel the resident out of the room in his/her wheelchair the foot pedal got caught on the wall. While this was going, he/she did say Ride em cowgirl! while he/she was trying to get the wheelchair unstuck. Both CNA A and CMT A were present at this time. - When they left the room with the resident, the resident tried to disrobe and tried to bite his/her and at that point he/she told the resident, Biting is what babies do, don't bite me. -Due to low staffing, it wasn't feasible for CMT A to just sit with the resident and try to calm the resident down during lunch time.- Once they were in the dining room, food and drink was brought to the resident, the resident would only drink and would not take his/her medications. The DON came to help but still the resident was resistive. - Later in the breakroom he/she was approached by the Administrator and DON and asked about abuse allegations regarding the way he/she provided care to Resident #1. - He/she told the DON and administrator the only reason his/her voice was raised in the bathroom was because it was a small space and hard to hear each other. - He/she told the administrator he/she never touched the resident other than to dress the resident. - He/she was terminated over the incident. During an interview on 3/23/26 at 9:50 A.M., Certified Medical Technician CMT A said:- On 3/3/26 around 12:30 P.M., he/she witnessed the resident in the facility living room trying to disrobe. Registered Nurse RN A and RN B we're trying to get the resident into his/her wheelchair to transport the resident back to his/her room. Once the resident was in the wheelchair, RN A and Certified Nursing Assistant CNA A took the resident to his/her room.- CMT A arrived shortly thereafter and stood in the doorway and, due to the cramped space did not provide care but did observe the two staff members with the resident. - RN A and CNA A assisted the resident to stand and transfer to the toilet. - CMT A observed RN A being rude to the resident calling the resident a baby because the resident was crying. - RN A threatened the resident that RN A would tell his/her spouse that he/she was trying to disrobe in front of other residents. - RN A made the statement in a loud and harsh voice and the resident cried even more. - The resident continued to cry after he/she got off the toilet and continued trying to disrobe. -CMT A offered to stay with the resident and attempt to calm him/her down while the other staff members attended to other duties. -He/she did not feel that the resident was mentally ready to be in the dining room because he/she was still crying. - RN A declined CMT A's offer to stay with the resident and said the resident needed to go to the dining room so management could see what bad behaviors he/she had to deal with. - RN A, with the resident in a wheelchair, started to shake the wheelchair back and forth and said the resident was a bucking bronco. - He/she felt RN A s actions were intentional to torment the resident. - RN A and CMT A transported the resident to the dining room while the resident was still crying. - The resident continued to be upset while in the dining room and continued to try and disrobe. - RN A tried to keep the resident's hands away from his/her clothes so to prevent him/her from disrobing. - CMT A went to the kitchen to get food and drink for the resident. When CMT A came back with the resident's meal, the Director of Nursing (DON) had arrived to help administer the resident's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	medication. - Since RN A and the DON were there CMT A went directly to the Administrator to report what had occurred. CMT A felt RN As actions were abuse. During an interview on 3/23/26 at 10:25 A.M., CNA A said:- CMT A was present as well. - He/she did not stay long in the room and doesn't know exactly when the alleged abuse occurred. If he/she would have seen anything he/she would have reported it immediately administration.- The facility recently had abuse and neglect training for the staff earlier this month. During an interview on 3/23/26 at 2:15 P.M. the Administrator and DON said: - RN A should have backed off a bit from the resident as he/she was being overly verbally aggressive towards the resident.- The facility has sufficient staffing, and it would have been appropriate for CMT A to stay with the resident to help calm him/her rather than bringing him/her to the dining room while visibly upset. - Their investigation substantiated verbal abuse and inappropriate physical handling of the resident and RN A was terminated.