STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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 - Immediate jeopardy to resident health or safety 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** 35615 Based on observation, interview and record review, the facility failed to ensure two residents (Resident #1 and #2) of seven sampled residents were free from verbal abuse when Certified Nurse Aide (CNA) C cursed and yelled at the residents. Staff witnessed CNA C curse and yell directly at Resident #1 and Resident #2 while providing the residents assistance with Activities of Daily Living (ADLs). The facility census was 65. The administrator was notified on 3/18/22 at 4:30 P.M. of the Immediate Jeopardy (IJ) which began on 3/1/22. The IJ was removed on 3/18/22, as confirmed by surveyor onsite verification. Review of the facility policy undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy showed the following in part: -An administrator, licensed nurse, employee or volunteer should not physically, mentally or emotionally abuse a residents. -Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish. Abuse included verbal, sexual, physical, and mental abuse and including abuse facilitated or enabled through the use of technology. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to resident or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse included but were not limited to threats of harm, saying things to frighten a resident such as telling a resident they would never be able to see family again. 1. Review of the facility investigation summary, dated 3/7/22, showed the Director of Nurses (DON) documented Registered Nurse (RN) B reported on 3/2/22 complaints of alleged verbal abuse by CNA C towards two residents (Resident #1 and Resident #2). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility acquired written statement from CNA D, dated 3/4/22, showed on 3/2/22 around 1:00 A. M., CNA C was in Resident #1's room with CNA D. Resident #1 sat on the edge of his/her bed and was trying to stand up. CNA C said, what the hell are you doing, it is time for bed, not time to get up! You need to lay the fuck down, I'm not dealing with your shit tonight. CNA C proceeded to lay Resident #1 down, cover him/her up, and CNA C sat in the chair to make sure Resident #1 fell asleep. Review of the facility acquired written statement from RN B, dated 3/2/22, showed the following: -Last night (3/1/22) at the beginning of the shift, CNA C told Resident #2 Just shut up. Go to your room and I will be down there in a minute when Resident #2 asked to go to the bathroom. Resident #2 went down the wrong hall and CNA C yelled from behind the nurses' station, damn it, go to your damn room; -From the beginning of the shift until almost 12:00 A.M., CNA C was rude and talked down to the residents; -At approximately 1:20 A.M. CNA C said Resident #1 was on the floor. RN B went to the resident's room and found the resident on the floor asking what happened. CNA C said to Resident #1, you did not keep your ass in bed and you fell and landed on your ass. RN B brought Resident #1 in a wheelchair to the common area near the nurses' station and transferred the resident to a recliner. CNA C asked why the hell did you bring the resident up here, he/she was just going to scream all night and CNA C was not listening to his/her (the resident's) ass. RN B informed CNA C his/her language was enough, the resident just fell and needed brought up front where RN B could keep an eye on the resident; -CNA C yelled at other residents during the shift if they put their call light on. Review of the facility acquired written statement from Licensed Practical Nurse (LPN) A, dated 3/2/22, showed when LPN A arrived to work, CNA C was at the East side nurses station with Resident #1. CNA C said Resident #1 needed his/her ass back in the locked dementia care unit while pointing at Resident #1. LPN A told CNA C watch your mouth that was inappropriate. 2. Record review of Resident #1's Care Plan, dated 2/10/22, showed the following: -Diagnosis of Alzheimer's disease, dementia, depression, and fractured hip; -The resident had a decline in ADLs and mobility and required staff assistance with ADLs. Staff should monitor and assist as needed; -The resident took medication for depression. Staff should encourage socialization, and encourage to attend activities of choice. If behaviors were present always attempt to rule out medical or environmental stimuli as a causative factor. Record review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/16/22, showed the following: -Severely impaired cognition; (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Had little interest or pleasure in doing things, felt down, depressed or hopeless. The resident felt tired and had little energy, felt bad about his/herself, or felt he/she was a failure or had let his/herself or family down for 12 to 14 days of the previous two weeks; -Moderately depressed; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing, and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. Observation on 3/15/22 at 1:15 P.M., showed the resident seated in a wheelchair near the nurses' desk. A bedside table sat in front of the resident with items for the resident's use and activity. Staff said the resident was anxious today and needed continuous observation. During interview on 3/18/22 at 1:50 P.M., Resident #1's family member said he/she was the resident's responsible party. The resident would not have liked to be spoken to in that manner. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Short and long term memory problems; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing, and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. Review of the resident's Care Plan, updated 1/5/22, showed the following: -Diagnosis of stroke, dementia with behavioral disturbance, lung cancer, abnormal gait and mobility, chronic pain, retinopathy, history of brain cancer; -The resident had impaired mobility and activity of daily living (ADLs) performance and required extensive staff assistance with ADLs; -The resident had altered vision and impaired hearing. Staff should keep distractions to a minimum, give the resident time to respond, tell the resident what staff were doing and why, reduce the noise level before talking with the resident, maintain eye contact with speaking, stand close when speaking with the resident and provide adequate lighting; -The resident had depression and alteration in thought processes. Staff should encourage participation in activities, allow the resident to make choices whenever possible, and allow time for him/her to process thoughts and respond. Staff should offer simple instructions, be flexible and patient and encourage involvement in daily life to make the resident feel safe, physically comfortable, and experience a sense of control. Observation and interview of the resident on 3/15/22 at 3:15 P.M., showed the resident sat in a wheelchair, was visually impaired, and made loud noises at the end of a sentence. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 3/29/22 at 2:02 P.M., Resident #2's family member said he/she was the resident's responsible party. The resident in his/her normal mental state would not tolerate verbal abuse. 4. During interview on 3/18/22 at 10:10 P.M., CNA D said the following: -He/She heard CNA C say to Resident #2, it was fucking late and Resident #2 needed to get in the fucking bed; -Resident #2 heard CNA C; -The resident was seated near the nurses' desk in a wheelchair at the time; -The resident started down the hall in his/her wheelchair, he/she did not say anything; -He/She heard CNA C say to Resident #1 what the hell are you doing, it was time for bed, not time to get up, you need to lay the fuck down, I am not dealing with your shit tonight; -CNA C was verbally abusive to both residents; -CNA D told RN B about the verbal abuse. During interview on 3/18/22 at 9:55 P.M., RN B said the following: -He/She was the night shift charge nurse on 3/1/22 from 11:00 P.M. to 7:00 A.M.; -CNA C was verbally abusive to Resident #1 and Resident #2 that night; -RN B heard CNA C tell Resident #2 just shut up, go to your room and I will be down there in a minute followed by damn it go to your damn room; -RN B heard CNA C tell Resident #1 you did not keep your ass in bed and you fell and landed on your ass. During interview on 3/18/22 at 10:00 A.M., LPN A said on 3/2/22 he/she arrived at the facility at 6:45 A.M. Resident #1 sat at the nurses' desk in a wheelchair. CNA C stood directly behind the resident with his/her hands on the resident's wheelchair and said you need to take his/her ass back to the locked dementia unit. The resident was able to hear what CNA C said. The resident did not respond. LPN A told CNA C that was not appropriate language. Cussing at residents was verbal and emotional abuse. During interviews on 3/15/22 at 2:30 P.M. and 3/18/22 at 2:00 P.M., the Director of Nursing (DON) said the following: -She learned of the verbal abuse from RN B the morning of 3/2/22 at approximately 8:30 A.M.; -Cussing at residents was verbal abuse. During interviews the administrator said the following: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/15/22 at 4:10 P.M. she was not notified CNA C had verbally abused Resident #1 and Resident #2 during the night shift on 3/1/22 through 3/2/22. -On 3/18/22 at 1:30 P.M., she said cussing at or towards a resident was abuse. CNA C was verbally abusive towards both residents when he/she cussed and yelled at the residents. Cussing or yelling at Resident #1 could be agitating to the resident, the resident got anxious easily. MO #00197890 NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on interview and record review, the facility failed to report verbal abuse allegations to the state survey agency immediately, but not later than two hours after the allegation was made, when staff witnessed CNA C verbally abuse two residents (Resident #1 and #2) at the start of the night shift (11:00 P.M.) on 3/1/22. The facility census was 65. 1. Review of the facility policy undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy showed the following in part: -It was the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property; -An administrator, licensed nurse, employee or volunteer should not physically, mentally or emotionally abuse a residents. Any facility employee or volunteer who became aware of abuse should immediately report to the administrator; -The administrator of designee would report abuse to the state agency per State and Federal requirements; -Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish. Abuse included verbal, sexual, physical, and mental abuse and including abuse facilitated or enabled through the use of technology. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Verbal abuse was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to resident or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse included but were not limited to threats of harm, saying things to frighten a resident such as telling a resident they would never be able to see family again; -Reporting and response section included abuse allegations were reported per Federal and State Law. The facility would ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator and to other officials including the State Survey Agency in accordance with State law through established procedures; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Internal reporting included employees must always report any abuse or suspicion of abuse immediately to the administrator. Failure to report could make the employee just as responsible for the abuse in accordance with State Law. The administrator would involve key leadership personnel as necessary to assist with reporting, investigating and follow up. 2. Review of the facility investigation summary, dated 3/7/22, showed the DON documented Registered Nurse (RN) B reported on 3/2/22 complaints of alleged verbal abuse by CNA C towards two residents Resident #1 and Resident #2. Review showed no documentation of notifying the state agency regarding the abuse. Review of the facility acquired written statement from CNA D, dated 3/4/22, showed on 3/2/22 around 1:00 A. M. CNA C was in Resident #1's room with CNA D. Resident #1 sat on the edge of his/her bed and was trying to stand up. CNA C said what the hell are you doing, it is time for bed, not time to get up! You need to lay the fuck down, I'm not dealing with your shit tonight. During interview on 3/18/22 at 10:10 P.M., CNA D said the following: -He/She heard CNA C say to Resident #2, it was fucking late (approximately 11:00 P.M.) and Resident #2 needed to get in the fucking bed. Resident #2 heard CNA C, the resident sat near the nurses' desk in a wheelchair at the time. The resident started down the hall in his/her wheelchair; -He/She heard CNA C tell Resident #1 what the hell are you doing, it was time for bed, not time to get up, you need to lay the fuck down, I am not dealing with your shit tonight; -CNA C was verbally abusive to both residents; -CNA D told RN B about the verbal abuse. Review of the facility acquired written statement from Licensed Practical Nurse (LPN) A dated 3/2/22 showed when LPN A arrived to work, CNA C was at the East side nurses station with Resident #1. CNA C said Resident #1 needed his/her ass back in the locked dementia care unit while pointing at Resident #1. LPN A told CNA C watch your mouth that was inappropriate. CNA C went down the hall towards the dining room. During interview on 3/18/22 at 10:00 A.M. LPN A said on 3/2/22 he/she arrived at the facility at 6:45 A.M. Resident #1 sat at the nurses' desk in a wheelchair. CNA C stood directly behind the resident with his/her hands on the resident's wheelchair and said you need to take his/her ass back to the locked dementia unit. The resident was able to hear what CNA C said. CNA C left at the end of the night shift, at 7:15 A.M. Cussing at residents was verbal and emotional abuse. Review of the facility acquired written statement from RN B, dated 3/2/22, showed the following: -Last night (3/1/22) at the beginning of the shift (approximately 11:00 P.M.) CNA C told Resident #2 just shut up. Go to your room and I will be down there in a minute, when Resident #2 asked to go to the bathroom. Resident #2 went down the wrong hall and CNA C yelled from behind the nurses' station, damn it, go to your damn room; (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At approximately 1:20 A.M. CNA C said Resident #1 was on the floor. RN B went to the resident's room where Resident #1 sat on the floor and Resident #1 asked what happened. CNA C replied (to the resident), you did not keep your ass in bed and you fell and landed on your ass. RN B brought Resident #1 in a wheelchair to the common area near the nurses' station and transferred the resident to a recliner. CNA C asked why the hell did you bring the resident up here, he/she was just going to scream all night and CNA C was not listening to his/her ass. 3. Review of Resident #1's Care Plan dated 2/10/22 showed the following: -Diagnosis of Alzheimer's disease, dementia, depression, and fractured hip; -The resident ha a decline in Activities of Daily Living (ADLs) and mobility and required staff assistance with ADLs. Staff should monitor and assist as needed; -The resident took medication for depression. Staff should encourage socialization, and encourage to attend activities of choice. If behaviors were present always attempt to rule out medical or environmental stimuli as a causative factor. Review of the resident's admission Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 2/16/22, showed the following: -Severely impaired cognition; -Had little interest or pleasure in doing thing, felt down, depressed or hopeless, felt tired and had little energy, felt bad about his/herself, or was a failure or had let his/herself or family down for 12 to 14 days of the previous two weeks; -Moderately depressed; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. 4. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Short and long term memory problems; -Physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing) occurred one to three days in the previous seven days; -Verbal behavioral symptoms directed toward other (threatening others, screaming at others, cursing at others) occurred one to three days in the previous seven days; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Care Plan, updated 1/5/22, showed the following: -Diagnosis of stroke, dementia with behavioral disturbance, lung cancer, abnormal gait and mobility, chronic pain, retinopathy, history of brain cancer; -The resident had impaired mobility and activity of daily living (ADLs) performance and required extensive staff assistance with ADLs; -The resident had altered vision and impaired hearing. Staff should keep distractions to a minimum, give the resident time to respond, tell the resident what staff were doing and why, reduce the noise level before talking with the resident, maintain eye contact with speaking, stand close when speaking with the resident and provide adequate lighting; -The resident had depression and alteration in thought processes. Staff should encourage participation in activities, allow the resident to make choices whenever possible, and allow time for him/her to process thoughts and respond. Staff should offer simple instructions, be flexible and patient and encourage involvement in daily life to make the resident feel safe, physically comfortable and experience a sense of control. 5. During interview on 3/18/22 at 9:55 P.M., RN B said the following: -He/She was the night shift charge nurse on 3/1/22 from 11:00 P.M. to 7:00 A.M.; -CNA C was verbally abusive to Resident #1 and Resident #2 that night; -RN B heard CNA C tell Resident #2 just shut up, go to your room and I will be down there in a minute followed by damn it go to your damn room; -RN B heard CNA C tell Resident #1 you did not keep your ass in bed and you fell and landed on your ass; -RN B informed the DON on 3/2/22 at about 8:30 A.M. He/She did not inform and call the DON or administrator during the night. He/She forgot about the two hour reporting requirement to the State Agency. He/She was aware, but did not report the abuse at the time of the occurrence. He/She should have called the DON or administrator at the time the abuse and removed CNA C from caring for residents immediately. During interview on 3/15/22 at 2:30 P.M., the DON said she learned of the verbal abuse from RN B the morning of 3/2/22 at approximately 8:30 A.M. She did not know why staff did not call her when the abuse first occurred. No staff called her during the night and inform her CNA C was verbally abusive to residents. She expected staff to notify her immediately of any abuse. The facility should report the allegation of abuse to the State Agency within two hours. During interviews on 3/15/22 at 4:10 P.M. and 3/18/22 at 1:30 P.M., the administrator said the following: -She was not notified CNA C had verbally abused Resident #1 and Resident #2 during the night shift on 3/1/22 through 3/2/22. She was unaware of the abuse until the morning of 3/2/22; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cussing at or towards a resident was abuse. RN B did not call the administrator at the time of the verbal abuse. Staff should have reported the verbal abuse to the State Agency within two hours of occurrence.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on interview and record review, the facility failed to ensure residents were protected from further abuse after staff members witnessed CNA C verbally abuse two residents (Resident #1 and resident #2). CNA C continued to work throughout the night shift and provided care to residents on the assigned hall and was reassigned at the end of the shift to the locked dementia unit to assist with resident cares. The facility also failed to report the allegations of verbal abuse to the residents responsible party as specified in the facility policy. The facility census was 65. 1. Review of the facility policy undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy showed the following in part: -Prevention section included to prevent abuse staff should be supervised to identify inappropriate behaviors while caring for or in attendance with residents; -Investigation section included reports of abuse were promptly and thoroughly investigated. The investigation was the process used to try to determine what happened. Staff would begin the investigation immediately. When an incident or suspected incident of abuse was reported the administrator or designee would investigate the incident with the assistance of appropriate personnel. All staff must cooperate during the investigation to ensure the resident was fully protected. The administrator would keep the resident or his/her representative informed of the progress of the investigation. The administrator or designee would inform the resident and/or his/her representative of the findings of the investigation and corrective action taken; -The administrator or designee would inform the resident and/or responsible party the results of the investigation. -Protection section included the resident would be protected from the alleged offender. Immediately upon receiving a report of alleged abuse the administrator and or designee would coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable individual were of the utmost priority. Safety, security and support of the resident, their roommate, if applicable, and other resident s with the potential to be affected would be provided. Procedures must be in place to provide the resident with a safe, protected environment during the investigation; -The alleged perpetrator would immediately be removed and residents protected. Employees accused of alleged abuse would be immediately removed from the facility and would remain removed pending the results of the thorough investigation; -Examine, assess and interview the resident and other residents potentially affected immediately to determine any injury and identify any immediate clinical interventions necessary; -Social Services or designee should keep in frequent contact with the resident and/or resident representative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility investigation summary, dated 3/7/22, showed the DON documented Registered Nurse (RN) B reported on 3/2/22 complaints of alleged verbal abuse by CNA C towards two residents (Resident #1 and Resident #2). CNA C was suspended pending further investigation and would be terminated. Review showed no documentation of notifying the resident's responsible party regarding the abuse. Review of the facility acquired written statement from CNA D, dated 3/4/22, showed on 3/2/22 around 1:00 A. M. CNA C was in Resident #1's room with CNA D. Resident #1 sat on the edge of his/her bed and was trying to stand up. CNA C said what the hell are you doing, it is time for bed, not time to get up! You need to lay the fuck down, I'm not dealing with your shit tonight. CNA C proceeded to lay resident #1 down, cover her up and CNA C sat in the chair to make sure Resident #1 fell asleep. During interview on 3/18/22 at 10:10 P.M. CNA D said the following: -He/She heard CNA C say to Resident #2, it was fucking late and Resident #2 needed to get in the fucking bed. Resident #2 heard CNA C, the resident sat near the nurses' desk in a wheelchair at the time. The resident started down the hall in his/her wheelchair; -He/She heard CNA C tell Resident #1 what the hell are you doing, it was time for bed, not time to get up, you need to lay the fuck down, I am not dealing with your shit tonight; -CNA C was verbally abusive to both residents; -CNA D told RN B about the verbal abuse. Review of the facility acquired written statement from RN B, dated 3/2/22, showed the following: -Last night (3/1/22) at the beginning of the shift CNA C told Resident #2 just shut up. Go to your room and I will be down there in a minute when Resident #2 asked to go to the bathroom. Resident #2 went down the wrong hall and CNA C yelled from behind the nurses' station, damn it, go to your damn room; -RN B and CNA D went down the hall and assisted Resident #2 to bed. When they arrived back at the nurses station CNA C asked where Resident #2 was and RN B told CNA C the resident was in bed. CNA C said well fuck, he/she was hoping the resident would stay up later, CNA C did not want to deal with the resident's fucking ass that night; -From the beginning of the shift until almost 12:00 A.M., CNA C was rude and talked down to the residents; -At approximately 1:20 A.M. CNA C said Resident #1 was on the floor. RN B went to the resident's room where Resident #1 sat on the floor and Resident #1 asked what happened. CNA C said to Resident #1, you did not keep your ass in bed and you fell and landed on your ass. RN B brought Resident #1 in a wheelchair to the common area near the nurses' station and transferred the resident to a recliner. CNA C asked why the hell did you bring the resident up here, he/she was just going to scream all night and CNA C was not listening to his/her ass. RN B informed CNA C his/her language was enough, the resident just fell and needed brought up front where RN B could keep an eye on the resident; (continued on next page)

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Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C yelled at other residents during the shift if they put their call light on; -At 5:40 A.M. CNA C was floated back to the locked dementia care unit and came back to the east side at approximately 6:30 A.M. During interview on 3/18/22 at 9:55 P.M. RN B said the following: -He/She was the night shift charge nurse on 3/1/22 from 11:00 P.M. to 7:00 A.M.; -CNA C was verbally abusive to Resident #1 and Resident #2 that night; -RN B heard CNA C tell Resident #2 just shut up, go to your room and I will be down there in a minute followed by damn it go to your damn room; -RN B heard CNA C tell Resident #1 you did not keep your ass in bed and you fell and landed on your ass; -RN B was aware where CNA C was the remainder of the night shift. At 5:40 A.M. CNA C went to the locked dementia care unit for about an hour to assist residents and staff. The dementia care unit was short staffed that night; -RN B informed the DON on 3/2/22 at about 8:30 A.M. He/She did not inform and call the DON or administrator during the night. He/She should have called the DON or administrator at the time the abuse and removed CNA C from caring for residents immediately. Review of the facility acquired written statement from Licensed Practical Nurse (LPN) A dated 3/2/22 showed when LPN A arrived to work, CNA C was at the East side nurses station with Resident #1. CNA C said Resident #1 needed his/her ass back in the locked dementia care unit while pointing at Resident #1. 3. Review of Resident #1's Care Plan, dated 2/10/22, showed the following: -Diagnosis of Alzheimer's disease, dementia, depression, and fractured hip; -The resident had a decline in Activities of Daily Living (ADLs) and mobility and required staff assistance with ADLs. Staff should monitor and assist as needed; -The resident took medication for depression. Staff should encourage socialization, and encourage to attend activities of choice. If behaviors were present always attempt to rule out medical or environmental stimuli as a causative factor. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/16/22, showed the following: -Severely impaired cognition; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had little interest or pleasure in doing thing, felt down, depressed or hopeless, felt tired and had little energy, felt bad about his/herself, or was a failure or had let his/herself or family down for 12 to 14 days of the previous two weeks; -Moderately depressed; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. During interview on 3/18/22 at 1:50 P.M. Resident #1's family member said he/she was the resident's responsible party and was not notified by the facility of any verbal abuse allegations by staff that occurred 3/2/22. 4. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Short and long term memory problems; -Required extensive assistance of one staff member with bed mobility, locomotion on the unit, dressing and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting. Review of the resident's Care Plan, updated 1/5/22, showed the following: -Diagnosis of stroke, dementia with behavioral disturbance, lung cancer, abnormal gait and mobility, chronic pain, retinopathy, history of brain cancer; -The resident had impaired mobility and activity of daily living (ADLs) performance and required extensive staff assistance with ADLs; -The resident had altered vision and impaired hearing. Staff should keep distractions to a minimum, give the resident time to respond, tell the resident what staff were doing and why, reduce the noise level before talking with the resident, maintain eye contact with speaking, stand close when speaking with the resident and provide adequate lighting; -The resident had depression and alteration in thought processes. Staff should encourage participation in activities, allow the resident to make choices whenever possible, and allow time for him/her to process thoughts and respond. Staff should offer simple instructions, be flexible and patient and encourage involvement in daily life to make the resident feel safe, physically comfortable and experience a sense of control. During interview on 3/29/22 at 2:02 P.M., Resident #2's family member said he/she was the resident's responsible party and was not notified by the facility of any verbal abuse allegations by staff that occurred 3/2/22. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During interview on 3/18/22 at 10:00 A.M., LPN A said on 3/2/22 he/she arrived at the facility at 6:45 A.M. Resident #1 sat at the nurses' desk in a wheelchair. CNA C stood directly behind the resident with his/her hands on the resident's wheelchair and said you need to take her ass back to the locked dementia unit. The resident was able to hear what CNA C said. CNA C left at the end of the night shift, at 7:15 A.M. Staff should have sent CNA C home immediately when the verbal abuse occurred. Cussing at residents was verbal and emotional abuse. During interview on 3/21/22 at 8:50 A.M., CNA C said the following: -He/She worked on 3/1/22 the night shift from 7:00 P.M. to 7:00 A.M. on the East Hall (Resident #1 and #2's hall). He/She was suspended after the shift for a resident complaint of him/her cussing at residents. -At 5:30 A.M. during the shift he/she was sent to the locked dementia unit to assist with resident cares and the morning routine. He/She returned to the East Hall at 6:30 A.M., checked on East Hall residents and left at 7:15 A.M.; -He/She was allowed to stay and work the entire night and go over to the locked dementia unit for an hour to assist those residents. No staff or charge nurse monitored him/her and no continuous supervision was implemented during the shift. During interviews on 3/15/22 at 2:30 P.M. and 3/18/22 at 2:00 P.M., the DON said she learned of the verbal abuse from RN B the morning of 3/2/22 at approximately 8:30 A.M. She expected staff to notify her and the administrator of any allegation of abuse immediately. Staff should call her and report the allegation at the time it occurred so an investigation could begin immediately. CNA C should not have continued to work the remainder of the shift and should have left the facility immediately. She did not notify Resident #1 or Resident #2's family or next of kin of the verbal abuse. It was her responsibility to inform the resident's family of abuse and she had not talked with either family about the verbal abuse. During interviews on 3/14/22 at 4:10 P.M. and 3/1/8/22 at 1:30 P.M., the administrator said the following: -She was not notified CNA C had verbally abused Resident #1 and Resident #2 during the night shift on 3/1/22 through 3/2/22. She was unaware of the abuse until the morning of 3/2/22; -Cussing at or towards a resident was abuse. RN B said he/she did not send CNA C home because he/she was worried about not having enough staff. If RN B did not remove CNA C from the situation and protect the residents, then RN B should have called the administrator for an immediate plan to protect the residents from additional abuse. All staff should follow the facility abuse policy. At the very least, staff should have separated CNA C from all residents at the time of the abuse. Neither resident's families were notified of the abuse. She should have notified both resident's families of the verbal abuse immediately. The facility policy included notification of family or responsible party of abuse immediately. She was concerned about getting the abuse investigation completed and did not notify Resident #1 or Resident#2's families.