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	05/02/2023

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to notify one resident's representative (Resident #67) in a review of 22 sampled residents, when the resident had falls. The facility census was 76. Review of the facility policy Change in a Resident's Condition or Status revised February 2021 showed the facility promptly notifies the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. Review of Resident #67's care plan dated 11/23/22 showed the resident is at risk for falls. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/5/23 showed the following: -Severely impaired cognition; -No falls since prior assessment. Review of the resident's progress notes dated 4/11/23 at 8:58 A.M. showed the following: -Late entry: -Resident was found sitting on the floor in his/her room, denied hitting head or in pain; -Staff did notice a skin tear to the left forearm, dressing applied; -No evidence facility staff notified the resident's responsible party of the resident's fall on 4/11/23. Review of the resident's significant change MDS dated [DATE] showed the following: -Severely impaired cognition; -Two or more non-injury falls since last assessment. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes dated 4/15/23 at 5:42 A.M. showed the following: -This nurse alerted to resident room per staff; -This nurse observed resident on the floor of own room directly in front of own wheelchair; -Proper notifications complete (no specification as to who was notified by staff). Review of the resident's fall incident report dated 4/15/23 showed staff notified the resident's responsible party (Family Member 1) of the resident's fall at 5:30 A.M. During an interview on 4/25/23 at 9:12 A.M. the resident's responsible party (Family Member 1) said the following: -He/She is the resident's first emergency contact; -He/She was not notified of the resident's falls on 4/11/23 and 4/15/23. During an interview on 5/2/23 at 7:00 P.M. Licensed Practical Nurse (LPN) M said the following: -He/She was the nurse on 4/15/23; -He/She probably left a message for the resident's responsible party; -He/She probably asked the day shift nurse to try to get hold of the resident's responsible party, but he/she did not document that. During an interview on 5/2/23 at 7:05 P.M. the Assistant Director of Nursing (ADON) said the charge nurse is responsible for notifying the resident's responsible party of falls.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44610 Based on observation, interview, and record review, the facility failed to provide a clean, comfortable, and homelike environment by failing to ensure walls and floors were in good repair. The facility census was 76. Review of the facility policy Homelike Environment revised February 2021 showed the following: -Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Review of the facility policy Maintenance Service revised December 2009 showed the following: -Maintenance service shall be provided to all areas of the building, grounds, and equipment; -The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; -Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines; b. Maintaining the building in good repair and free from hazards; f. Establishing priorities in providing repair service; i. Providing routinely scheduled maintenance service to all areas; j. Others that may become necessary or appropriate. 1. Observation on 4/24/23 at 1:23 P.M., showed the following: -At the end of the hallway for rooms 3 through 6, the vinyl cove base was separated from the wall under the Heating, Ventilation, and Air Conditioning (HVAC) unit; -In the central bath located on the hallway for occupied rooms 3 through 6, there was a 3 inch by 5 foot long area of flooring between tub and shower floor tile that was separating from the concrete slab. Sealant on the shower wall, under the control handle, was separating from the wall, and a ceiling tile above the tub was water stained; -In occupied room [ROOM NUMBER], there were ten small holes approximately 1/4 inch in diameter in the wall next to the bed; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the central bath located on the hallway for occupied rooms 7 through 12, there was an approximately 6 foot by 9 foot area of flooring missing with concrete slab visible underneath; -In the occupied memory unit common area under the kitchenette counter top, there was an approximate 1 foot by 2 foot area of flooring missing with concrete slab visible underneath. 2. Observation on 5/1/23 at 6:30 P.M., showed the air return vent, located in the ceiling in the basement near the elevator, was covered in dust. 3. Observation on 4/26/23 at 1:35 P.M. in the East Wing Shower Room showed the following: -Rust discoloration on the floor under the heat register and under the window; -Missing tile on the wall on the toilet side of the room exposing wood underneath with black and white discoloration; -Missing floor tiles in the shower stall; -Black discoloration around the perimeter of the shower stall; -The ventilation fans were covered with rust. During an interview on 4/26/23 at 1:35 P.M. Certified Nurse Aide (CNA) D said the East Wing Shower Room had been in the current condition for a while. East Wing resident showers were currently given in this shower room. During an interview on 4/26/23 at 1:40 P.M. Resident #2 said the East Wing Shower Room is where he/she takes a shower. The shower room doesn't look very nice. 4. Observation on 4/26/23 at 1:40 P.M. in occupied resident room [ROOM NUMBER] showed multiple marred areas in the paint and dry wall on the wall next to the resident's bed. 5. Observation on 4/26/23 at 9:06 A.M. in occupied resident room [ROOM NUMBER] showed multiple black paint scrapes along the bathroom door frame and room door frame. 6. Observation on 4/26/23 at 2:43 P.M. on the end of the South Wing Hallway (Rooms 20-29) showed a piece of silver duct tape held down the floor trim under the fire doors. The floor trim curled up at the ends near the door frame. 7. Observation on 4/27/23 at 10:03 A.M. in the bathroom in occupied resident room [ROOM NUMBER] showed multiple black marks on the walls. 8. Observation on 5/1/23 at 1:13 P.M. in the hallway outside occupied resident room [ROOM NUMBER] showed a large brown circular stain on the ceiling tile directly outside the resident's room. The ceiling tile was bulging downward. During an interview on 5/2/23 at 2:03 P.M., the Maintenance Director said the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He has been the maintenance director with the corporation less than a year, and oversees nine facilities; -He has two full time maintenance staff at this facility to assist him with identifying and making repairs; -The facility was behind in maintenance and repair when he accepted the position, and he prioritizes projects as they are identified; -Staff submit work orders and verbally notify the maintenance department when facility environmental/equipment issues are identified; -Wall and flooring issues are an ongoing process for the maintenance department; -He was not aware of the vinyl base board separating from the wall, holes in room [ROOM NUMBER], or 1 foot by 2 foot area of linoleum flooring missing in the memory unit kitchenette; -He was aware of the 3 inch by 5 foot, and 6 foot by 9 foot linoleum areas in both central baths, and planned on having the areas repaired in one/two months; -He was aware the air return vent/filter in basement hallway was covered with dust. During an interview on 5/2/23 at 8:15 P.M., the Administrator said the following: -The facility was behind in maintenance and repairs prior to the maintenance director beginning his duties, approximately one year ago; -She expected there to be daily monitoring of maintenance/repairs, and issues to be prioritized and repaired when identified.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 38016 Based on interview and record review, the facility failed to protect residents on the facility special care unit, including four residents (Resident #54, #59, #500 and #501), in a review of thirteen sampled residents, from verbal and sexual abuse by one resident (Resident #68). Resident #68 had a history of verbal and physical sexually inappropriate behavior. The resident exhibited inappropriate sexual behavior towards other residents on the unit which included touching or attempts to touch their bodies with his/her hands or mouth in a sexual manner and made sexual comments toward them. Resident #501, a cognitively intact resident, experienced psychosocial distress due to interactions with Resident #68 when the resident made him/her feel sexually harassed and mentally abused. Resident #501 demanded to be moved from the special care unit where he she resided with Resident #68, to another part of the facility as a result. The facility census was 73. On 07/13/23 at 5:30 P.M., the facility's administrator was notified of the immediate jeopardy which began on 12/7/22. The IJ was removed on 7/18/23 as confirmed by surveyor onsite verification. Review of the facility policy, Identifying Types of Abuse, revised September 2022 showed the following: -As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents; -Abuse of any kind against residents is strictly prohibited; -Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology; -Abuse toward a resident can occur as resident-to-resident abuse; -Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation; -Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability; -Examples of mental and verbal abuse include, but are not limited to harassing a resident, derogatory statements directed to the resident; -Sexual abuse is non-consensual sexual conduct of any type with a resident. Sexual abuse includes, but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area; -Generally, sexual contact is nonconsensual if the resident appears to want the contact to occur, but lacks the cognitive ability to consent or the resident does not want the contact to occur; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Some situations of abuse do not result in an observable physical injury or the psychosocial effects of abuse may not be immediately apparent. In addition, the alleged victim may not report abuse due to shame, fear, or retaliation. Other residents may not be able to speak due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred; -Abuse may result in psychological, behavioral, or psychosocial outcomes; -The following situations are recognized as those that are likely to cause psychosocial harm which may take months or years to manifest, and have long-term effects on the resident and his/her relationship with others and include sexual assault, unwanted sexual touching and sexual harassment. 1. Review of Resident #68's facility face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's undated facility diagnosis page showed the resident with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, dementia and sexual dysfunction. Review of the resident's facility progress notes showed staff documented the following: -On 11/10/22 at 7:14 P.M., the resident was sexually inappropriate towards staff and was educated on expectations of behavior. Will continue to monitor; -On 11/12/22 at 7:20 P.M., during the resident's shower he/she was noted to be sexually inappropriate with the CNA, making comments about the aide rubbing his/her genitalia. Resident was informed that this behavior was inappropriate. Resident was also noted to be asking this nurse and his/her CNA if we were having sex with our boyfriends/girlfriends; -On 11/14/22 at 6:58 P.M., the resident has been hard to redirect this shift; had to be redirected multiple times for sexual statements, will continue to monitor; -On 11/18/22 at 4:53 P.M., the resident was sexually inappropriate at times. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/22/22, showed the resident had a Brief Interview for Mental Status (BIMS) (screening tool to assess cognition) of 10, indicating the resident had mild cognitive impairment. The resident had verbal behaviors on two days (in a seven day look back period), transferred, walked and moved in the bed independently. Review of the resident's facility progress notes showed staff documented the following: -On 12/07/22 at 6:23 P.M., Resident currently sits at the dining room table talking to other residents and trying to kiss multiple (residents of the opposite sex). Resident was redirected multiple times. Resident was educated that his/her behavior was inappropriate and upsetting other residents; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 12/8/22 at 6:39 P.M., the resident has continued to have multiple episodes of inappropriate behaviors. Noted to be sitting at the breakfast table and said (people of the opposite sex), are like whiskey, they are all good but some are better than others in bed. He/She also asked the CNA multiple times, Do you wanna take a shower with me? You can wash me and then gestured towards his/her genitals. Resident was redirected multiple times and educated that his/her behavior was inappropriate and upsetting other residents, he/she said I will try to work on it. Review of the resident's care plan dated 12/8/22 showed no evidence the resident presented with behaviors or direction for staff to address the resident's sexually inappropriate behaviors. Review of the resident's facility progress notes showed staff documented the following: -On 12/13/22 at 6:50 P.M., the resident has had five episodes of being inappropriate this shift; -On 12/16/22 at 6:03 P.M., the resident had two episodes of sexual inappropriate behavior this shift; -On 12/17/22 at 4:50 P.M., the resident had multiple episodes of sexual inappropriate behavior this shift as well as being verbal hateful, belligerent and verbally abusive to staff and residents; -On 12/18/22 5:39 P.M., the resident has been verbally sexually inappropriate and belligerent today; -On 12/30/22 at 7:11 P.M., has been verbally inappropriate this shift; -On 01/01/23 at 7:20 P.M., has been hateful, belligerent and verbally sexually inappropriate this shift. He/She looked at the table where residents of the opposite sex sat and said, Do you guys wanna get lucky tonight? Do you know what (named specific medication for sexual performance)? I use it so I get lucky; -On 01/02/23 at 6:54 P.M., the resident has been belligerent and sexually inappropriate this shift. He/She would walk around to residents of the opposite sex and try kissing them on the mouth. This nurse had to redirect him/her. Resident screamed, Damn, you just can't let me have no damn fun!; -On 01/15/23 at 7:12 P.M., was sexually inappropriate this shift with another resident. The residents were found in this resident's room on his/her bed, kissing on one another and inappropriately touching one another. The residents were separated and individually educated this was not an appropriate setting for these behaviors; -On 01/26/23 at 2:16 P.M., this resident noted to be sitting very close with another resident of the opposite sex, holding hands with each other and rubbing arms. This nurse attempted to relocate the resident, but this was unsuccessful due to this resident not wanting to move; -On 01/29/23 at 6:20 P.M., the resident grabbed hold of one of the dietary staff of the opposite sex and put his/her arms around him/her and squeezed, saying those are nice. This nurse told the resident that he/she could not be handling or vocalizing like that and it was inappropriate. The resident screamed, It is not inappropriate, he/she let me do it!; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 01/30/23 at 6:48 P.M., orders received, resident not to be alone with staff or residents of the opposite sex. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 14 (cognitively intact), the resident had verbal behaviors one to three days of the seven day look back period, and was independent with walking, transfers and bed mobility. Review of the resident's facility progress notes showed staff documented the following: -On 02/21/23 at 9:35 A.M., the social worker documented in the last seven days, the resident had one incident of sexually inappropriate behavior. Earlier in February the resident had three incidents of sexually inappropriate behavior, in January-19 incidents, and in December-15 incidents of sexually inappropriate behavior; -On 02/22/23 at 6:22 P.M., the resident walked up to another resident of the opposite sex and asked the other resident to give him/her a kiss; -On 03/06/23 at 2:57 P.M., the resident went up to another resident and kissed that resident on the forehead; and was noted to do this twice during this shift; -On 03/08/23 at 8:20 A.M., noted to go up to another resident of the opposite sex while he/she was eating his/her breakfast and grab the collar of this resident's shirt and ask if he/she could see what was under there; -On 03/08/22 at 11:28 A.M., when another resident of the opposite sex was returning to his/her seat from the bathroom, this resident asked this resident, Can I rub them (breasts)? The other resident replied that no, Resident #68 could not rub his/her breasts. After this incident the resident was redirected; -On 03/10/23 at 1:20 P.M., the resident asked a resident of the opposite sex if they liked to have sex. Staff redirected the resident. The resident then went to another resident and asked him/her the same question. When attempting to redirect, he/she asked if staff was married and had sex; -On 03/11/23 at 10:58 A.M., the resident asked a resident of the opposite sex if he/she has had sex since he/she has been at the facility; -On 03/12/23 at 4:27 P.M., resident noted to rub another resident of the opposite sex's back and he/she asked him/her if he/she had ever had sex. This resident told the resident of the opposite sex, If you come to (resident's room), I'll rub on your breast and I'll rub down there so you will know what it feels like; -On 03/15/23 at 1:41 P.M., resident has had sexual behaviors towards other residents this shift. The resident told another resident He/She would like to have some good clean sex with (opposite sex) residents, while (opposite sex) residents sat at the table eating lunch. One of the residents told him/her he/she was a dirty old (person) and that he/she didn't appreciate the way he/she was talking to him/her, and not to speak to him/her anymore. This resident said okay and that he/she really looked good in his/her shirt. Staff informed this resident that he/she could not talk to other residents in that manner because it made them feel uncomfortable; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 03/21/23 at 2:03 P.M., the resident has had some inappropriate remarks towards staff and other residents. This resident asked a resident of the opposite sex if he/she had sex recently while being in this nursing home and if he/she wanted to do so, then come to (resident's room) and they could have some. Resident of the opposite sex told him NO they can't do that in here; -On 03/25/23 at 3:04 P.M., this nurse witnessed this resident kiss another resident on the forehead; -On 03/26/23 at 3:07 P.M., this nurse overheard this resident tell a resident of the opposite sex that he/she could sit on his/her lap. Review of the resident's care plan, revised 03/28/23, showed the resident presented with sexual behaviors and now took estrogen (hormone) therapy related to sexual behaviors. The care plan did not identify any other action, other than monitoring for medication side effects, to address the resident's behaviors. Review of the resident's facility progress notes showed staff documented the following: -On 04/03/23 at 6:58 P.M., resident noted to make multiple sexual comments towards staff and other residents; -On 04/13/23 at 6:37 P.M., the resident made multiple sexual comments during this shift to residents and staff. Unable to redirect. During morning meal, this resident was noted to be rubbing a resident of the opposite sex's breast while the other resident attempted to push the resident's hand away. Resident #68 said, Doesn't that feel good?; -On 04/17/23 at 6:28 P.M., continues with inappropriate sexual comments to residents and staff multiple times; -On 04/23/23 at 11:35 A.M., resident exhibiting inappropriate behaviors today. Resident observed in a resident of the opposite sex's room, standing over him/her and touching him/her. This resident was redirected by CNA staff and was given education on why this was not appropriate; -On 04/23/23 at 11:42 A.M., regarding previous nurse's note - CNA defined touching as the resident had his/her hand on the other resident's lap, was rubbing his/her back, and their faces were touching; -On 04/25/23 at 6:34 P.M., resident noted to be asking multiple different residents of the opposite gender to give me a kiss. Resident redirected and reminded of possible germs & infection. Resident acknowledged understanding, but has been noncompliant; -On 04/26/23 at 7:24 P.M., resident noted to be very inappropriate sexually with other residents this shift. Resident grabbed a resident of the opposite gender's breast and told him/her he/she had very nice boobies; -On 04/27/23 at 6:30 P.M., resident has had a couple of inappropriate sexual behaviors this shift; trying to kiss other residents, and asked staff if they had been sexually active before coming to work today; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 05/11/23 at 3:04 P.M., noted during after morning meal to have his/her hands under another resident's shirt. Review of the resident's quarterly MDS, dated [DATE], showed the following: -BIMS of 10, the resident had mild cognitive impairment; -Verbal behaviors occurred on four to six days during the seven day look back period; -Independent with bed mobility, transfers and walking. Review of the resident's facility progress notes showed staff documented the following: -On 05/19/23 at 7:13 A.M., the social worker documented in the last seven days he/she had five incidents of sexually inappropriateness. Earlier in May he/she had one incident of grabbing and nine incidents of sexually inappropriateness. In April he/she had 15 incidents of sexually inappropriateness and in March, 26 incidents of sexually inappropriateness; -On 05/29/23 at 7:37 P.M., the resident stood up at the table and unzipped his/her pants and asked to feel this. Told the resident this was inappropriate to do that and asked him/her to zip his/her pants back up; -On 05/31/23 at 11:09 A.M., resident noted to have inappropriate sexual behavior toward other residents this shift; -On 06/09/23 at 5:14 P.M., staff reported that this resident and a resident of the opposite sex were in this resident's room participating in inappropriate sexual behaviors; -On 06/10/23 at 6:23 P.M., resident made frequent sexual remarks to residents of the opposite sex, and asked them if they would give him/her a kiss on the cheek; -On 06/27/23 at 5:37 P.M., resident was kissing another resident; -On 07/01/23 at 6:36 P.M., resident walked up behind a resident of the opposite sex and put his/her hands around his/her shoulders for a hug; the other resident became upset and yelled at this resident to get off of him/her; -On 07/08/23 at 6:53 P.M., resident was noted to compliment the residents and the workers frequently and requested another resident give him/her a kiss. 2. Review of Resident #501's undated face sheet showed the resident had diagnoses including mild cognitive impairment and unspecified dementia. Review of the resident's facility progress notes showed staff documented the following: -On 12/04/2022 at 6:01 P.M., this resident came to this nurse this evening and said he/she did not like another resident (of the opposite sex) and the next time the other resident came near him/her, he/she was going to hit him/her in the stomach; (continued on next page)

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	265108	A. Building B. Wing	05/02/2023

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 01/04/23 at 11:44 A.M., the resident walked up to the desk while this nurse was having a conversation with another resident. He/She snapped at the other resident saying, Shut up you rude old (person of the opposite sex). This nurse told this resident, This is not a situation that involves you so let's please leave him/her alone and I will come talk to you in just a moment. This resident screamed at this nurse and CNA saying, This does involve me, I live here, he/she makes my life a living hell, I am so fed up with all of you. Review of the resident's census sheet showed he/she moved from the dementia unit (where Resident #68 resided) on 01/04/23 to a room in another part of the facility. Review of the resident's annual MDS dated [DATE] showed the following: -BIMS of 15, cognitively intact; -Adequate hearing; -No behaviors; -Has clear comprehension of others. Review of the resident's care plan, revised 05/26/23, showed the following: -He/She wanted to feel that he/she was in control of his/her life; -He/She has alteration in his/her thought process related to dementia; he/she would like to feel safe. During an interview on 7/13/23, at 2:36 P.M., Resident #501 said the following: -He/She resided on the locked unit for about a year; -He/She demanded to move off of the unit because of Resident #68; -Resident #68 would not leave him/her alone, he/she would follow Resident #501 around constantly; -Resident #68 drove me nuts; -Resident #68 would say sexual things all the time, he/she still shivers at the thought of it; -Resident #68's hands were always on somebody; -Resident #68 tried to touch Resident #501 several times; -The more Resident #501 turned Resident #68 away the more he/she tried; -If Resident #68 wasn't bugging Resident #501 he/she was staring at Resident #501; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-He/She was mad at the staff because they wouldn't make Resident #68 stop, the staff would say, He/She is not hurting anyone, but the resident said, He/She was hurting me; -He/She was being sexually harassed by Resident #68, you don't have to touch someone to be sexually abused; -It is not right; -Resident #68 would try to come in his/her room; -He/She can't understand why the staff didn't make him/her leave the resident alone; -It got to the point Resident #501 was scared he/she was going to hurt Resident #68; -Even now, when Resident #68 comes out for events in the main area of the facility he/she will stare at Resident #501 from across the room; -Resident #68 hurts you in a mental way that destroys you and it turns Resident #68 on; -I wanted to pick up a chair and smash it over his/her head, like I was losing myself, I do not have those kind of thoughts; -Resident #68 knew he/she was conquering me, killing me emotionally, and following me around so much I couldn't breathe, like a prisoner; -That is why he/she demanded to move off of the unit. 3. Review of Resident #54's facility diagnosis page showed the resident had a diagnosis of dementia. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 13, (a BIMS of 15 indicates intact cognition). Review of the resident's progress notes showed staff documented on 01/15/23 at 7:14 P.M., the resident was sexually inappropriate this shift with another resident (Resident #68). They were found in the other resident's room on his/her bed, kissing on one another and inappropriately touching one another. Residents were separated and individually educated on this not being an appropriate setting for this behavior. Review of the resident's annual MDS, dated [DATE], showed the resident had a BIMS of 12; the resident had mild cognitive impairment. Review of the resident's progress notes showed the facility Social Worker documented on 02/13/23 at 8:02 A. M. that the resident's BIMS score was 13 and he/she had had one incident of being sexually inappropriate in January (2023). Review of the resident's care plan, dated 03/28/23, showed the resident has alteration in thought process related to dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's progress notes showed staff documented on 05/11/23 at 3:06 P.M., the resident was noted to have inappropriate behaviors with another resident (Resident #68). Review of the resident's quarterly MDS, dated [DATE], showed the following: -BIMS of 3 indicating severe cognitive impairment; -Had the ability to clearly comprehend; -Made self understood. Review of the resident's progress notes showed staff documented the following: -On 05/12/23 at 1:00 P.M., the Social Worker documented that the resident's BIMS score was three and he/she had two incidents of sexually inappropriate behavior in the last seven days. Earlier in May, he/she had two incidents of sexually inappropriate behavior. In April, he/she had ten incidents of sexually inappropriate behavior and in March, three incidents. -On 06/09/23 at 5:30 P.M., staff reported this resident and another resident of the opposite sex (Resident #68) were in the other resident's room participating in inappropriate sexual behavior. This resident appeared to have his/her shirt up and the other resident had his/her mouth on this resident's breast. 4. Review of Resident #500's facility face sheet showed he/she has diagnoses that include age related cognitive decline. Review of the resident's care plan, dated 06/01/21, showed the resident has alteration in thought process related to dementia, the resident will feel safe. Review of the resident's annual MDS, dated [DATE], showed the following: -BIMS of 9; the resident was cognitively impaired; -Had clear comprehension of others; -Able to make self understood. During an interview on 07/13/23 at 4:22 P.M., the resident said the following: -He/She knew who Resident #68 was; -Resident #68 had tried some hanky panky stuff with him/her before, but he/she always told him/her to get lost; he/she didn't do that kind of stuff; -Resident #68 would try and grab at his/her chest, and kiss or touch him/her. 5. Review of Resident #59's facility diagnoses page showed he/she has diagnoses that include Alzheimer's disease and other symptoms and signs involving cognitive functions and awareness. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's significant change MDS, dated [DATE], showed the resident had a BIMS of 4; the resident was cognitively impaired. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 99 (resident unable to complete the interview); the resident was severely cognitively impaired. During an interview on 07/13/23 at 9:45 A.M., Licensed Practical Nurse (LPN) A said the following: -The documentation in Resident #54's progress notes on 01/15/23 documented an incident between Resident #54 and Resident #68 that occurred in Resident #68's room; -He/She was sure Resident #54's progress note of 05/11/23 also documented an incident with Resident #68 that was also of a sexual nature; -The documentation in Resident #54's progress notes on 06/09/23 was again in regards to Resident #68. This was the second time the residents had been found together in Resident #68's room engaging in inappropriate behavior; -He/She had made the documentation in Resident #68's progress notes for 03/08/23 and could recall that the resident of the opposite sex was Resident #59 with that incident; -He/She had also documented in Resident #68's progress notes the incident on 03/08/23; that incident was with Resident #500; -Resident #68 flirted with several of the residents of the opposite sex as well as staff. Resident #500 Never took any stuff from Resident #68 and it always seemed to be Resident #54 that Resident #68 was more attracted to; -He/She had documented the entry in Resident #68's progress notes on 07/01/23 at 6:36 P.M., but could not recall if the other resident was Resident #54 or Resident #500. During an interview on 07/14/23 at 4:14 P.M., Registered Nurse (RN) E said he/she had made the entries in Resident #68's progress notes on 04/23/23 at 11:35 A.M. and 11:42 A.M. He/She could not recall who the resident of the opposite sex was. He/She could only recall making the documentation and that an aide had reported it to him/her. He/She would not consider this abuse. He/She did not recall checking on either resident after the reported incident. Residents in the dementia unit would not be able to give any type of consent, that is why staff needed to redirect when possible. During an interview on 07/13/23 at 10:28 A.M., LPN D said the following: -He/She made the entry in Resident #68's progress notes on 03/11/23 at 10:58 A.M. The resident she was referring to was Resident #54. Resident #68 and #54 had been found together in inappropriate acts a couple of different times. He/She was not sure if he/she would consider Resident #68's behavior abuse or not. The residents had dementia so he/she was not sure if that made a difference or not; -He/She made the entry in Resident #68's progress notes on 03/12/23 at 4:27 P.M., this incident also documented the concern between Resident #68 and #54. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/13/23 at 11:15 A.M., LPN B said the following: -He/She made the entry in Resident #68's progress notes on 03/15/23 at 1:41 P.M. He/She could not recall who the other resident was that was involved. He/She did document that Resident #68's behavior made other residents uncomfortable and that it was of a sexual nature, but he/she was not sure if it was abuse. He/She could not tell if Resident #68's behaviors affected other residents because they had diagnoses of dementia, he/she just knew he/she would not like to be treated that way; -He/She made the entry for 03/21/23 at 2:03 P.M. He/She could not recall the opposite sex resident who was invited back to Resident #68's room. Resident #68 was always making comments to staff in the presence of other residents who probably would feel uncomfortable if they understood what Resident #68 was saying or asking, whether it be to staff or other residents; -On 06/09/23 at 5:14 P.M., he/she made the entry in Resident #68's progress notes. The incident documented was between Resident #54 and Resident #68, Resident #54 was in Resident #68's room. Resident #54 had his/her shirt pulled up and under garment pulled down and Resident #68 had his/her mouth on Resident #54's breast. During an interview on 07/13/23 at 11:52 A.M., LPN F said the following: -He/She made the progress note entries in Resident #68's chart on 04/25/23 and 04/26/23; -On 04/26/23, the resident of the opposite sex involved was Resident #54. During an interview on 07/14/23 at 3:05 P.M., the Social Service Director said the following: -She had heard that Resident #68 had made sexually inappropriate comments and had behaviors. She heard this from staff who reported it to her, but she had been told Resident #68 was re-directable so she had no further concerns and had not reported to anyone; -She does recaps quarterly and documents in the resident progress notes. She had read the documentation that staff completed that showed the resident had sexually inappropriate behaviors; -She was aware of the incident between Resident #54 and Resident #68 that occurred on 06/09/23 when Resident #68 had his/her mouth on Resident #54's breast, but did not recall the incident when Resident #68 and #54 were found in Resident #68's bed touching and kissing; -She was not sure if these incidents were considered abuse; -She had tried to call Resident #54's power of attorney (POA) to see if it was alright for Resident #54 to engage in such behaviors if he/she wanted to; -She knew Resident #54 had a BIMS of 3; a score of three means the resident was cognitively impaired and could not make decisions for him/herself. During an interview on 07/11/23 at 5:30 P.M. and 07/12/23 at 12:22 P.M., the administrator said the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-She was aware of Resident #68's behaviors that were both verbally and physically sexual in nature; -She had instructed staff to redirect the resident and the resident had been started on medications to help curb sexual tendencies; -She was aware Resident #54 and Resident #68 were found in bed together in January and also aware of an incident in June when Resident #68 has his/her mouth on Resident #54's breast; -She had received complaints about Resident #68 from Resident #501, and knew this resident did not like Resident #68; -She did not know there had been an incident between Resident #68 and Resident #59; -She was aware Resident #68 made advances toward Resident #500 but nothing was acted on; Resident #68 just tried to touch him/her; -She was aware there had been an order to ensure Resident #68 was not alone with staff and residents of the opposite sex. Staff ensure this with room checks every 15 minutes; -She did not consider Resident #68's behavior to be abuse; -She thought Resident #54 had sexual inappropriate behaviors towards Resident #68; specifically when he/she exposed him/herself to Resident #68 and came out of his/her room either with no clothes on or when he/she opened up his/her robe; -She did not know who the aggressor was in these incidents; -A resident with a BIMS of three and with an active power of attorney would not be able to make a determination or consent; -Sexual abuse can be both verbal and physical; -If the behavior happens over and over, it would be considered abuse. She felt like staff redirected Resident #68 and his/her behaviors were not considered abuse; -Dementia residents can be re-directed to get the unwanted behavior to stop; -She did not feel that any harm had been done so these incidents were not considered abuse; -She was not sure how the reasonable person would feel if they were exposed to Resident #68's behaviors. During an interview on 07/14/23 at 3:15 P.M., the Nurse Practitioner said the following: -Resident #68 and #54 were both residents he has seen and cared for at the facility; -He was aware of Resident #68's sexual behaviors, with both verbal and physical contacts; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Neither resident was able to give consent as they have diagnosis of dementia, are cognitively impaired and unable to make such decisions. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level K. 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 E 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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38016 Based on interview and record review, the facility failed to report allegations of abuse to the state agency for four residents (Resident #54, #59, #500 and #501), in a review of 13 sampled residents, when one resident (Resident #68), who had a history of sexually inappropriate behaviors, abused residents sexually by touching or attempting to touch their bodies with his/her hands or mouth in a sexual manner and making sexual comments toward them. The facility census was 73. Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating (Revised September 2022), showed the following: -All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation: -If resident abuse is suspected, the suspicion must be reported immediately to the administrator, Director of Nurses (DON), Assistant Director of Nurses (ADON), or to the state Department of Health and Senior services; -The administrator DON, ADON or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, law enforcement officials, the resident's attending physician, and the facility medical director; -Immediately is defined as within 30 minutes of an allegation involving abuse or result in serious bodily injury; or verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone; -Notices include, as appropriate the resident's name, room number, type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.), date and time the alleged incident occurred, name(s) of all persons involved in the alleged incident, and what immediate action was taken by the facility. 1. Review of Resident #68's facility face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's undated facility diagnosis page showed the resident with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, dementia and sexual dysfunction. Review of the resident's facility progress notes showed staff documented the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/14/22 at 6:58 P.M., the resident has been hard to redirect this shift; had to be redirected multiple times for sexual statements, will continue to monitor; -On 11/18/22 at 4:53 P.M., the resident was sexually inappropriate at times. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/22/22, showed the resident had a Brief Interview for Mental Status (BIMS) (screening tool to assess cognition) of 10, indicating the resident had mild cognitive impairment. The resident had verbal behaviors on two days (in a seven day look back period), transferred, walked and moved in the bed independently. Review of the resident's facility progress notes showed staff documented the following: -On 12/07/22 at 6:23 P.M., the resident has had multiple episodes of inappropriate behaviors. Resident currently sits at the dining room table talking to other residents and trying to kiss multiple residents of the opposite sex. Resident was redirected multiple times. Resident was educated that his/her behavior was inappropriate and upsetting other residents; -On 12/8/22 at 6:39 P.M., the resident has continued to have multiple episodes of inappropriate behaviors. Noted to be sitting at the breakfast table and said (people of the opposite sex), are like whiskey, they are all good but some are better than others in bed. Resident was redirected multiple times and educated that his/her behavior was inappropriate and upsetting other residents, he/she said I will try to work on it. Review of the resident's facility progress notes showed staff documented the following: -On 12/13/22 at 6:50 P.M., the resident has had five episodes of being inappropriate this shift; -On 12/16/22 at 6:03 P.M., the resident had two episodes of sexual inappropriate behavior this shift; -On 12/17/22 at 4:50 P.M., the resident had multiple episodes of sexual inappropriate behavior this shift as well as being verbally hateful, belligerent and verbally abusive to residents; -On 12/18/22 5:39 P.M., the resident has been verbally sexually inappropriate and belligerent today; -On 01/01/23 at 7:20 P.M., has been hateful, belligerent and verbally sexually inappropriate this shift. He/She looked at the table where residents of the opposite sex sat and said, Do you guys wanna get lucky tonight? Do you know what (named specific medication for sexual performance)? I use it so I get lucky; -On 01/02/23 at 6:54 P.M., the resident has been belligerent and sexually inappropriate this shift. He/She would walk around to residents of the opposite sex and try kissing them on the mouth. This nurse had to redirect him/her. Resident screamed, Damn, you just can't let me have no damn fun!; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 01/15/23 at 7:12 P.M., was sexually inappropriate this shift with another resident. The residents were found in this resident's room on his/her bed, kissing on one another and inappropriately touching one another. The residents were separated and individually educated this was not an appropriate setting for these behaviors; -On 01/26/23 at 2:16 P.M., this resident noted to be sitting very close with another resident of the opposite sex, holding hands with each other and rubbing arms. This nurse attempted to relocate the resident, but this was unsuccessful due to this resident not wanting to move; -On 01/30/23 at 6:48 P.M., orders received, resident not to be alone with residents of the opposite sex. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 14 (cognitively intact), the resident had verbal behaviors one to three days of the seven day look back period, and was independent with walking, transfers and bed mobility. Review of the resident's facility progress notes showed staff documented the following: -On 02/21/23 at 9:35 A.M., the social worker documented in the last seven days, the resident had one incident of sexually inappropriate behavior. Earlier in February the resident had three incidents of sexually inappropriate behavior, in January-19 incidents, and in December-15 incidents of sexually inappropriate behavior; -On 02/22/23 at 6:22 P.M., the resident walked up to another resident of the opposite sex and asked the other resident to give him/her a kiss; -On 03/06/23 at 2:57 P.M., the resident went up to another resident and kissed that resident on the forehead; and was noted to do this twice during this shift; -On 03/08/23 at 8:20 A.M., noted to go up to another resident of the opposite sex while he/she was eating his/her breakfast and grab the collar of this resident's shirt and ask if he/she could see what was under there; -On 03/08/22 at 11:28 A.M., when another resident of the opposite sex was returning to his/her seat from the bathroom, this resident asked this resident, Can I rub them (breasts)? The other resident replied that no, Resident #68 could not rub his/her breasts. After this incident the resident was redirected; -On 03/10/23 at 1:20 P.M., the resident asked a resident of the opposite sex if they liked to have sex. Staff redirected the resident. The resident then went to another resident and asked him/her the same question; -On 03/11/23 at 10:58 A.M., the resident asked a resident of the opposite sex if he/she has had sex since he/she has been at the facility; (continued on next page)

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	265108	A. Building B. Wing	05/02/2023

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/12/23 at 4:27 P.M., resident noted to rub another resident of the opposite sex's back and he/she asked him/her if he/she had ever had sex. This resident told the resident of the opposite sex, If you come to room [ROOM NUMBER], I'll rub on your breasts and I'll rub down there so you will know what it feels like; -On 03/15/23 at 1:41 P.M., resident has had sexual behaviors towards other residents this shift. The resident told another resident He/She would like to have some good clean sex with (opposite sex) residents, while (opposite sex) residents sat at the table eating lunch. One of the residents told him/her he/she was a dirty old (person) and that he/she didn't appreciate the way he/she was talking to him/her, and not to speak to him/her anymore. This resident said okay and that he/she really looked good in his/her shirt. Staff informed this resident that he/she could not talk to other residents in that manner because it made them feel uncomfortable; -On 03/21/23 at 2:03 P.M., the resident has had some inappropriate remarks towards other residents. This resident asked a resident of the opposite sex if he/she had sex recently while being in this nursing home and if he/she wanted to do so, then come to room [ROOM NUMBER] and they could have some. Resident of the opposite sex told him NO they can't do that in here; -On 03/25/23 at 3:04 P.M., this nurse witnessed this resident kiss another resident on the forehead; -On 03/26/23 at 3:07 P.M., this nurse overheard this resident tell a resident of the opposite sex that he/she could sit on his/her lap. Review of the resident's facility progress notes showed staff documented the following: -On 04/03/23 at 6:58 P.M., resident noted to make multiple sexual comments towards other residents; -On 04/13/23 at 6:37 P.M., the resident made multiple sexual comments during this shift to residents. Unable to redirect. During morning meal, this resident was noted to be rubbing a resident of the opposite sex's breast while the other resident attempted to push the resident's hand away. Resident #68 said, Doesn't that feel good?; -On 04/17/23 at 6:28 P.M., continues with inappropriate sexual comments to residents multiple times; -On 04/23/23 at 11:35 A.M., resident exhibiting inappropriate behaviors today. Resident observed in a resident of the opposite sex's room, standing over him/her and touching him/her. This resident was redirected by CNA staff and was given education on why this was not appropriate; -On 04/23/23 at 11:42 A.M., regarding previous nurse's note - CNA defined touching as the resident had his/her hand on the other resident's lap, was rubbing his/her back, and their faces were touching; -On 04/25/23 at 6:34 P.M., resident noted to be asking multiple different residents of the opposite gender to give me a kiss. Resident redirected and reminded of possible germs & infection. Resident acknowledged understanding, but has been noncompliant; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/26/23 at 7:24 P.M., resident noted to be very inappropriate sexually with other residents this shift. Resident grabbed a resident of the opposite gender's breast and told him/her he/she had very nice boobies; -On 04/27/23 at 6:30 P.M., resident has had a couple of inappropriate sexual behaviors this shift; trying to kiss other residents; -On 05/11/23 at 3:04 P.M., noted during after morning meal to have his/her hands under another resident's shirt. Review of the resident's facility progress notes showed staff documented the following: -On 05/19/23 at 7:13 A.M., the social worker documented in the last seven days he/she had five incidents of sexually inappropriate behaviors. Earlier in May he/she had one incident of grabbing and nine incidents of sexually inappropriate behaviors. In April he/she had 15 incidents of sexually inappropriateness and in March, 26 incidents of sexually inappropriate behaviors; -On 05/29/23 at 7:37 P.M., the resident stood up at the table and unzipped his/her pants and asked to feel this. Told the resident this was inappropriate to do that and asked him/her to zip his/her pants back up; -On 05/31/23 at 11:09 A.M., resident noted to have inappropriate sexual behavior toward other residents this shift; -On 06/09/23 at 5:14 P.M., staff reported that this resident and a cognitively impaired resident of the opposite sex (Resident #54) were in this resident's room participating in inappropriate sexual behaviors; -On 06/10/23 at 6:23 P.M., resident made frequent sexual remarks to residents of the opposite sex, and asked them if they would give him/her a kiss on the cheek; -On 06/27/23 at 5:37 P.M., resident was kissing another resident; -On 07/01/23 at 6:36 P.M., resident walked up behind a resident of the opposite sex and put his/her hands around his/her shoulders for a hug; the other resident became upset and yelled at this resident to get off of him/her; -On 07/08/23 at 6:53 P.M., resident was noted to compliment the residents frequently and requested another resident give him/her a kiss. 2. Review of Resident #501's undated face sheet showed the resident had diagnoses including mild cognitive impairment and unspecified dementia. Review of the resident's facility progress notes showed staff documented the following: -On 12/04/2022 at 6:01 P.M., this resident came to this nurse this evening and said he/she did not like another resident (of the opposite sex) and the next time the other resident came near him/her, he/she was going to hit him/her in the stomach; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 01/04/23 at 11:44 A.M., the resident walked up to the desk while this nurse was having a conversation with another resident. He/She snapped at the other resident saying, Shut up you rude old (person of the opposite sex). This nurse told this resident, This is not a situation that involves you so let's please leave him/her alone and I will come talk to you in just a moment. This resident screamed at this nurse and CNA saying, This does involve me, I live here, he/she makes my life a living hell, I am so fed up with all of you. Review of the resident's census sheet showed he/she moved from the dementia unit (where Resident #68 resided) on 01/04/23 to a room in another part of the facility. Review of the resident's annual MDS dated [DATE] showed the following: -BIMS of 15, cognitively intact; -Adequate hearing; -No behaviors; -Has clear comprehension of others. Review of the resident's care plan, revised 05/26/23, showed the following: -He/She wanted to feel that he/she was in control of his/her life; -He/She has alteration in his/her thought process related to dementia; he/she would like to feel safe. During an interview on 7/13/23, at 2:36 P.M., Resident #501 said the following: -He/She resided on the locked unit for about a year; -He/She demanded to move off of the unit because of Resident #68; -Resident #68 would not leave him/her alone, he/she would follow Resident #501 around constantly; -Resident #68 drove me nuts; -Resident #68 would say sexual things all the time, he/she still shivers at the thought of it; -Resident #68's hands were always on somebody; -Resident #68 tried to touch Resident #501 several times; -The more Resident #501 turned Resident #68 away the more he/she tried; -If Resident #68 wasn't bugging Resident #501 he/she was staring at Resident #501; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-BIMS of 3 indicating severe cognitive impairment; -Had the ability to clearly comprehend; -Made self understood. Review of the resident's progress notes showed staff documented the following: -On 05/12/23 at 1:00 P.M., the Social Worker documented that the resident's BIMS score was three and he/she had two incidents of sexually inappropriate behavior in the last seven days. Earlier in May, he/she had two incidents of sexually inappropriate behavior. In April, he/she had ten incidents of sexually inappropriate behavior and in March, three incidents. -On 06/09/23 at 5:30 P.M., staff reported this resident and another resident of the opposite sex were in the other resident's room participating in inappropriate sexual behavior. This resident appeared to have his/her shirt up and the other resident had his/her mouth on this resident's breast. 4. Review of Resident #500's facility face sheet showed he/she has diagnoses that include age related cognitive decline. Review of the resident's annual MDS, dated [DATE], showed the following: -BIMS of 9; the resident was cognitively impaired; -Had clear comprehension of others; -Able to make self understood. During an interview on 07/13/23 at 4:22 P.M., the resident said the following: -He/She knew who Resident #68 was; -Resident #68 had tried some hanky panky stuff with him/her before, but he/she always told him/her to get lost; he/she didn't do that kind of stuff; -Resident #68 would try and grab at his/her chest, and kiss or touch him/her. 5. Review of Resident #59's facility diagnoses page showed he/she has diagnoses that include Alzheimer's disease and other symptoms and signs involving cognitive functions and awareness. Review of the resident's significant change MDS, dated [DATE], showed the resident had a BIMS of 4; the resident was cognitively impaired. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 99; the resident was severely cognitively impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 07/14/23 at 4:14 P.M., Registered Nurse (RN) E said he/she had made the entries in Resident #68's progress notes on 04/23/23 at 11:35 A.M. and 11:42 A.M. He/She could not recall who the resident of the opposite sex was. He/She could only recall making the documentation and that an aide had reported it to him/her. He/She would not consider this abuse after he/she got the clarification he/she documented. He/She did not recall checking on either resident after the reporting. Residents in the dementia unit would not be able to give any type of consent; that is why staff needed to redirect when possible. He/She had not reported this to anyone because he/she did not think it was abuse. During an interview on 07/13/23 at 9:45 A.M., Licensed Practical Nurse (LPN) A said the following: -The documentation in Resident #54's progress notes on 01/15/23 documented an incident between Resident #54 and Resident #68 that occurred in Resident #68's room; -He/She was sure Resident #54's progress note of 05/11/23 also documented an incident with Resident #68 that was also of a sexual nature; -The documentation in Resident #54's progress notes on 06/09/23 was again with Resident #68; this was the second time the residents had been found together in Resident #68's room engaging in inappropriate behavior; -He/She had made the documentation in Resident #68's progress notes for 03/08/23 and could recall that the resident of the opposite sex was Resident #59; -He/She had also documented in Resident #68's progress notes the incident on 03/08/23; that incident was with Resident #500; -He/She had shared these behaviors with the social worker, the Director of Nursing and administration but not reported them as abuse. During an interview on 07/13/23 at 10:28 A.M., LPN D said the following: -He/She had made the entry in Resident #68's progress notes on 03/11/23 at 10:58 A.M.; the resident she was referring to was Resident #54; Resident #68 and #54 he/she thought had been found together in inappropriate acts a couple of different times; he/she was not sure if he/she would consider Resident #68's behavior abuse or not; he/she was familiar with what verbal and sexual abuse were; the residents had dementia so he/she was not sure if that made a difference or not; -He/She had also made the entry in Resident #68's progress notes on 03/12/23 at 4:27 P.M., this incident also documented the concern between Resident #68 and #54. During an interview on 07/13/23 at 11:15 A.M., LPN B said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had made the entry in Resident #68's progress notes on 03/15/23 at 1:41 P.M. He/She could not recall who the other resident was that he/she documented about. He/She did document that his/her behavior made other residents uncomfortable and that it was of a sexual nature, but he/she was not sure if it classified as abuse; he/she could not tell if Resident #68's behaviors really affected other residents because they had diagnoses of dementia, he/she just knew he/she would not like to be treated that way; -He/She had also made the entry for 03/21/23 at 2:03 P.M.; he/she could not recall the opposite sex resident who was invited back to Resident #68's room; -On 06/09/23 at 5:14 P.M., he/she made the entry in Resident #68's progress notes; the incident documented was between Resident #54 and Resident #68; Resident #54 was in Resident #68's room; Resident #54 had his/her shirt pulled up and under garment pulled down and Resident #68 had his/her mouth on Resident #54's breast. During an interview on 07/14/23 at 3:05 P.M., the Social Services Director said the following: -She had heard that Resident #68 had made sexually inappropriate comments and had behaviors; she had heard this from staff who reported it to her, but she had been told Resident #68 was re-directable, so she had no further concerns and had not reported these things to anyone; -She does recaps quarterly and documents in the resident progress notes; she had read the documentation that staff completed that showed the resident had sexually inappropriate behaviors; -She was aware of the incident between Resident #54 and Resident #68 that occurred on 06/09/23 when Resident #68 had his/her mouth on Resident #54's breast but did not recall the incident when Resident #68 and #54 were found in Resident #68's bed touching and kissing; -She was not sure if these incidents were considered abuse; -She had not made any report to the state agency regarding any of these incidents. During an interview on 07/11/23 at 5:30 P.M. and 07/12/23 at 12:22 P.M., the administrator said the following: -She was aware of Resident #68's behaviors, both verbal and physical in a sexual nature; -She had not reported these things to the state agency; -She was aware Resident #54 and Resident #68 were found in bed together in January and also aware of an incident in June when Resident #68 has his/her mouth on Resident #54's breast; -She had received complaints about Resident #68 from Resident #501; -She did not know there had been an incident between Resident #68 and Resident #59; -She was aware Resident #68 made advances toward Resident #500, but nothing was acted on; Resident #68 just tried to touch him/her; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She did not consider Resident #68's behavior to be considered abuse; -She thought Resident #54 had sexual inappropriate behaviors towards Resident #68; specifically when he/she exposed him/herself to Resident #68 and came out of his/her room either with no clothes on or when he/she opened up his/her robe; -She did not know who the aggressor was in these incidents; -Someone with a BIMS of 3 and had an active POA would not be able to make a determination or consent; -Sexual abuse can be both verbal and physical; -If the behavior happens over and over, it would be considered abuse; - She felt like staff re-directed Resident #68 and his/her behaviors were not considered abuse; -Any suspected abuse should be reported to at least the Director of Nursing and then the administrator; -She did not feel that any harm had been done so these incidents were not considered abuse and were not reported to the state agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on interview and record review the facility failed to thoroughly investigate allegations of sexual abuse reported by one resident (Resident #501) and documented by facility staff for three residents (Resident #54, #59 and #500) in a review of 13 sampled residents. The facility census was 73. Review of the facility policy identifying Types of Abuse (revised September 2022), showed the following: -As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents; -Abuse prevention includes recognizing and understanding the definitions and types of abuse that can occur. -Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse; ; -Abuse toward a resident can occur as resident-to-resident abuse. Review of the Facility policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating (Revised September 2022), showed the following: -All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -All allegations are thoroughly investigated. The administrator initiates investigations; -Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations; -The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation; -Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction; -The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility; -Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The individual conducting the investigation reviews the documentation and evidence; reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, including his or her interactions with staff and other residents, interviews the person(s) reporting the incident, interviews any witnesses to the incident, interviews the resident (as medically appropriate) or the resident's representative, interviews the resident's attending physician as needed to determine the resident's condition, interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interviews the resident's roommate, family members, and visitors, interviews other residents to whom the accused employee provides care or services, reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly; -Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. 1. Review of Resident #68's facility face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's undated facility diagnosis page showed the resident with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, dementia and sexual dysfunction. Review of the resident's facility progress notes showed staff documented the following: -On 11/14/22 at 6:58 P.M., the resident has been hard to redirect this shift; had to be redirected multiple times for sexual statements, will continue to monitor; -On 11/18/22 at 4:53 P.M., the resident was sexually inappropriate at times. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/22/22, showed the resident had a Brief Interview for Mental Status (BIMS) (screening tool to assess cognition) of 10, indicating the resident had mild cognitive impairment. The resident had verbal behaviors on two days (in a seven day look back period), transferred, walked and moved in the bed independently. Review of the resident's facility progress notes showed staff documented the following: -On 12/07/22 at 6:23 P.M., the resident has had multiple episodes of inappropriate behaviors. Resident currently sits at the dining room table talking to other residents and trying to kiss multiple (residents of the opposite sex). Resident was redirected multiple times. Resident was educated that his/her behavior was inappropriate and upsetting other residents; -On 12/8/22 at 6:39 P.M., the resident has continued to have multiple episodes of inappropriate behaviors. Noted to be sitting at the breakfast table and said (people of the opposite sex), are like whiskey, they are all good but some are better than others in bed. He/She also asked the CNA multiple times, Do you wanna take a shower with me? You can wash me and then gestured towards his/her genitals. Resident was redirected multiple times and educated that his/her behavior was inappropriate and upsetting other residents, he/she said I will try to work on it. Review of the resident's facility progress notes showed staff documented the following: (continued on next page)

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	265108	A. Building B. Wing	05/02/2023

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 - Some	-On 12/13/22 at 6:50 P.M., the resident has had five episodes of being inappropriate this shift; -On 12/16/22 at 6:03 P.M., the resident had two episodes of sexual inappropriate behavior this shift; -On 12/17/22 at 4:50 P.M., the resident had multiple episodes of sexual inappropriate behavior this shift as well as being verbal hateful, belligerent and verbally abusive to staff and residents; -On 12/18/22 5:39 P.M., the resident has been verbally sexually inappropriate and belligerent today; -On 12/30/22 at 7:11 P.M., has been verbally inappropriate this shift; -On 01/01/23 at 7:20 P.M., has been hateful, belligerent and verbally sexually inappropriate this shift. He/She looked at the table where residents of the opposite sex sat and said, Do you guys wanna get lucky tonight? Do you know what (named specific medication for sexual performance)? I use it so I get lucky; -On 01/02/23 at 6:54 P.M., the resident has been belligerent and sexually inappropriate this shift. He/She would walk around to residents of the opposite sex and try kissing them on the mouth. This nurse had to redirect him/her. Resident screamed, Damn, you just can't let me have no damn fun!; -On 01/15/23 at 7:12 P.M., was sexually inappropriate this shift with another resident. The residents were found in this resident's room on his/her bed, kissing on one another and inappropriately touching one another. The residents were separated and individually educated this was not an appropriate setting for these behaviors; -On 01/26/23 at 2:16 P.M., this resident noted to be sitting very close with another resident of the opposite sex, holding hands with each other and rubbing arms. This nurse attempted to relocate the resident, but this was unsuccessful due to this resident not wanting to move; -On 01/30/23 at 6:48 P.M., orders received, resident not to be alone with staff or residents of the opposite sex. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 14 (cognitively intact), the resident had verbal behaviors one to three days of the seven day look back period, and was independent with walking, transfers and bed mobility. Review of the resident's facility progress notes showed staff documented the following: -On 02/21/23 at 9:35 A.M., the social worker documented in the last seven days, the resident had one incident of sexually inappropriate behavior. Earlier in February the resident had three incidents of sexually inappropriate behavior, in January-19 incidents, and in December-15 incidents of sexually inappropriate behavior; -On 02/22/23 at 6:22 P.M., the resident walked up to another resident of the opposite sex and asked the other resident to give him/her a kiss; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/06/23 at 2:57 P.M., the resident went up to another resident and kissed that resident on the forehead; and was noted to do this twice during this shift; -On 03/08/23 at 8:20 A.M., noted to go up to another resident of the opposite sex while he/she was eating his/her breakfast and grab the collar of this resident's shirt and ask if he/she could see what was under there; -On 03/08/22 at 11:28 A.M., when another resident of the opposite sex was returning to his/her seat from the bathroom, this resident asked this resident, Can I rub them (breasts)? The other resident replied that no, Resident #68 could not rub his/her breasts; -On 03/10/23 at 1:20 P.M., the resident asked a resident of the opposite sex if they liked to have sex. Staff redirected the resident. The resident then went to another resident and asked him/her the same question. When attempting to redirect, he/she asked if staff was married and had sex; -On 03/11/23 at 10:58 A.M., the resident asked a resident of the opposite sex if he/she has had sex since he/she has been at the facility; -On 03/12/23 at 4:27 P.M., resident noted to rub another resident of the opposite sex's back and he/she asked him/her if he/she had ever had sex. This resident told the resident of the opposite sex, If you come to room [ROOM NUMBER], I'll rub on your breast and I'll rub down there so you will know what it feels like; -On 03/15/23 at 1:41 P.M., resident has had sexual behaviors towards other residents this shift. The resident told another resident He/She would like to have some good clean sex with (opposite sex) residents, while (opposite sex) residents sat at the table eating lunch. One of the residents told him/her he/she was a dirty old (person) and that he/she didn't appreciate the way he/she was talking to him/her, and not to speak to him/her anymore. This resident said okay and that he/she really looked good in his/her shirt. Staff informed this resident that he/she could not talk to other residents in that manner because it made them feel uncomfortable; -On 03/21/23 at 2:03 P.M., the resident has had some inappropriate remarks towards other residents. This resident asked a resident of the opposite sex if he/she had sex recently while being in this nursing home and if he/she wanted to do so, then come to room [ROOM NUMBER] and they could have some. Resident of the opposite sex told him NO they can't do that in here; -On 03/25/23 at 3:04 P.M., this nurse witnessed this resident kiss another resident on the forehead; -On 03/26/23 at 3:07 P.M., this nurse overheard this resident tell a resident of the opposite sex that he/she could sit on his/her lap. Review of the resident's facility progress notes showed staff documented the following: -On 04/03/23 at 6:58 P.M., resident noted to make multiple sexual comments towards other residents; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/13/23 at 6:37 P.M., the resident made multiple sexual comments during this shift to residents. Unable to redirect. During morning meal, this resident was noted to be rubbing a resident of the opposite sex's breast while the other resident attempted to push the resident's hand away. Resident #68 said, Doesn't that feel good?; -On 04/17/23 at 6:28 P.M., continues with inappropriate sexual comments to residents multiple times; -On 04/23/23 at 11:35 A.M., resident exhibiting inappropriate behaviors today. Resident observed in a resident of the opposite sex's room, standing over him/her and touching him/her. This resident was redirected by CNA staff and was given education on why this was not appropriate; -On 04/23/23 at 11:42 A.M., regarding previous nurse's note - CNA defined touching as the resident had his/her hand on the other resident's lap, was rubbing his/her back, and their faces were touching; -On 04/25/23 at 6:34 P.M., resident noted to be asking multiple different residents of the opposite gender to give me a kiss. Resident redirected and reminded of possible germs & infection. Resident acknowledged understanding, but has been noncompliant; -On 04/26/23 at 7:24 P.M., resident noted to be very inappropriate sexually with other residents this shift. Resident grabbed a resident of the opposite gender's breast and told him/her he/she had very nice boobies; -On 04/27/23 at 6:30 P.M., resident has had a couple of inappropriate sexual behaviors this shift; trying to kiss other residents; -On 05/11/23 at 3:04 P.M., noted during after morning meal to have his/her hands under another resident's shirt. Review of the resident's facility progress notes showed staff documented the following: -On 05/19/23 at 7:13 A.M., the social worker documented in the last seven days he/she had five incidents of sexually inappropriateness. Earlier in May he/she had one incident of grabbing and nine incidents of sexually inappropriateness. In April he/she had 15 incidents of sexually inappropriateness and in March, 26 incidents of sexually inappropriateness; -On 05/29/23 at 7:37 P.M., the resident stood up at the table and unzipped his/her pants and asked to feel this. Told the resident this was inappropriate to do that and asked him/her to zip his/her pants back up; -On 05/31/23 at 11:09 A.M., resident noted to have inappropriate sexual behavior toward other residents this shift; -On 06/09/23 at 5:14 P.M., staff reported that this resident and a resident of the opposite sex were in this resident's room participating in inappropriate sexual behaviors; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/10/23 at 6:23 P.M., resident made frequent sexual remarks to residents of the opposite sex, and asked them if they would give him/her a kiss on the cheek; -On 06/27/23 at 5:37 P.M., resident was kissing another resident; -On 07/01/23 at 6:36 P.M., resident walked up behind a resident of the opposite sex and put his/her hands around his/her shoulders for a hug; the other resident became upset and yelled at this resident to get off of him/her; -On 07/08/23 at 6:53 P.M., resident was noted to compliment the residents and the workers frequently and requested another resident give him/her a kiss. 2. Review of Resident #501's undated face sheet showed the resident had diagnoses including mild cognitive impairment and unspecified dementia. Review of the resident's facility progress notes showed staff documented the following: -On 12/04/2022 at 6:01 P.M., this resident came to this nurse this evening and said he/she did not like another resident (of the opposite sex) and the next time the other resident came near him/her, he/she was going to hit him/her in the stomach; -On 01/04/23 at 11:44 A.M., the resident walked up to the desk while this nurse was having a conversation with another resident. He/She snapped at the other resident saying, Shut up you rude old (person of the opposite sex). This nurse told this resident, This is not a situation that involves you so let's please leave him/her alone and I will come talk to you in just a moment. This resident screamed at this nurse and CNA saying, This does involve me, I live here, he/she makes my life a living hell, I am so fed up with all of you. Review of the resident's census sheet showed he/she moved from the dementia unit (where Resident #68 resided) on 01/04/23 to a room in another part of the facility. Review of the resident's annual MDS dated [DATE] showed the following: -BIMS of 15, cognitively intact; -Adequate hearing; -No behaviors; -Has clear comprehension of others. Review of the resident's care plan, revised 05/26/23, showed the following: -He/She wanted to feel that he/she was in control of his/her life; -He/She has alteration in his/her thought process related to dementia; he/she would like to feel safe. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/13/23, at 2:36 P.M., Resident #501 said the following: -He/She resided on the locked unit for about a year; -He/She demanded to move off of the unit because of Resident #68; -Resident #68 would not leave him/her alone, he/she would follow Resident #501 around constantly; -Resident #68 drove me nuts; -Resident #68 would say sexual things all the time, he/she still shivers at the thought of it; -Resident #68's hands were always on somebody; -Resident #68 tried to touch Resident #501 several times; -The more Resident #501 turned Resident #68 away the more he/she tried; -If Resident #68 wasn't bugging Resident #501 he/she was staring at Resident #501; -He/She was mad at the staff because they wouldn't make Resident #68 stop, the staff would say, He/She is not hurting anyone, but the resident said, He/She was hurting me; -He/She was being sexually harassed by Resident #68, you don't have to touch someone to be sexually abused; -It is not right; -Resident #68 would try to come in his/her room; -He/She can't understand why the staff didn't make him/her leave the resident alone; -It got to the point Resident #501 was scared he/she was going to hurt Resident #68; -Even now, when Resident #68 comes out for events in the main area of the facility he/she will stare at Resident #501 from across the room; -Resident #68 hurts you in a mental way that destroys you and it turns Resident #68 on; -I wanted to pick up a chair and smash it over his/her head, like I was losing myself, I do not have those kind of thoughts; -Resident #68 knew he/she was conquering me, killing me emotionally, and following me around so much I couldn't breathe, like a prisoner; -That is why he/she demanded to move off of the unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #54's facility diagnosis page showed the resident had a diagnosis of dementia. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 13, (a BIMS of 15 indicates intact cognition). Review of the resident's progress notes showed staff documented on 01/15/23 at 7:14 P.M., the resident was sexually inappropriate this shift with another resident. They were found in the other resident's room on his/her bed, kissing on one another and inappropriately touching one another. Residents were separated and individually educated on this not being an appropriate setting for this behavior. Review of the resident's progress notes showed the facility Social Worker documented on 02/13/23 at 8:02 A. M. that the resident's BIMS score was 13 and he/she had had one incident of being sexually inappropriate in January (2023). Review of the resident's progress notes showed staff documented on 05/11/23 at 3:06 P.M., the resident was noted to have inappropriate behaviors with another resident. Review of the resident's quarterly MDS, dated [DATE], showed the following: -BIMS of 3 indicating severe cognitive impairment; -Had the ability to clearly comprehend; -Made self understood. Review of the resident's progress notes showed staff documented the following: -On 05/12/23 at 1:00 P.M., the Social Worker documented that the resident's BIMS score was three and he/she had two incidents of sexually inappropriate behavior in the last seven days. Earlier in May, he/she had two incidents of sexually inappropriate behavior. In April, he/she had ten incidents of sexually inappropriate behavior and in March, three incidents. -On 06/09/23 at 5:30 P.M., staff reported this resident and another resident of the opposite sex were in the other resident's room participating in inappropriate sexual behavior. This resident appeared to have his/her shirt up and the other resident had his/her mouth on this resident's breast. 4. Review of Resident #500's facility face sheet showed he/she has diagnoses that include age related cognitive decline. Review of the resident's annual MDS, dated [DATE], showed the following: -BIMS of 9; the resident was cognitively impaired; -Had clear comprehension of others; -Able to make self understood. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/13/23 at 4:22 P.M., the resident said the following: -He/She knew who Resident #68 was; -Resident #68 had tried some hanky panky stuff with him/her before, but he/she always told him/her to get lost; he/she didn't do that kind of stuff; -Resident #68 would try and grab at his/her chest, and kiss or touch him/her. 5. Review of Resident #59's facility diagnoses page showed he/she has diagnoses that include Alzheimer's disease and other symptoms and signs involving cognitive functions and awareness. Review of the resident's significant change MDS, dated [DATE], showed the resident had a BIMS of 4; the resident was cognitively impaired. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 99; the resident was severely cognitively impaired. 6. During an interview on 07/14/23 at 4:14 P.M., Registered Nurse (RN) E said he/she had made the entries in Resident #68's progress notes on 04/23/23 at 11:35 A.M. and 11:42 A.M. He/She could not recall who the resident of the opposite sex was. He/She could only recall making the documentation and that an aide had reported it to him/her. He/She would not consider this abuse after he/she got the clarification he/she documented. He/She did not recall checking on either resident after the reporting. Residents in the dementia unit would not be able to give any type of consent; that is why staff needed to redirect when possible. He/She had not reported this to anyone because he/she did not think it was abuse. During an interview on 07/13/23 at 9:45 A.M., Licensed Practical Nurse (LPN) A said the following: -The documentation in Resident #54's progress notes on 01/15/23 documented an incident between Resident #54 and Resident #68 that occurred in Resident #68's room; -He/She was sure Resident #54's progress note of 05/11/23 also documented an incident with Resident #68 that was also of a sexual nature; -The documentation in Resident #54's progress notes on 06/09/23 was again with Resident #68; this was the second time the residents had been found together in Resident #68's room engaging in inappropriate behavior; -He/She had made the documentation in Resident #68's progress notes for 03/08/23 and could recall that the resident of the opposite sex was Resident #59; -He/She had also documented in Resident #68's progress notes the incident on 03/08/23; that incident was with Resident #500; -Resident #68 flirted with several of the residents of the opposite sex; Resident #500 never took any crap from Resident #68 and it always seemed to be Resident #54 that he/she was more attracted to; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had documented the entry in Resident #68's progress notes on 07/01/23 at 6:36 P.M. but could not recall if the other resident was Resident #54 or Resident #500; -He/She had shared these behaviors with the social worker, the Director of Nursing and administration. During an interview on 07/13/23 at 10:28 A.M., LPN D said the following: -He/She had made the entry in Resident #68's progress notes on 03/11/23 at 10:58 A.M.; the resident she was referring to was Resident #54; Resident #68 and #54 he/she thought had been found together in inappropriate acts a couple of different times; he/she was not sure if he/she would consider Resident #68's behavior abuse or not; he/she was familiar with what verbal and sexual abuse were; the residents had dementia so he/she was not sure if that made a difference or not; -He/She had also made the entry in Resident #68's progress notes on 03/12/23 at 4:27 P.M., this incident also documented the concern between Resident #68 and #54. During an interview on 07/13/23 at 11:15 A.M., LPN B said the following: -He/She had made the entry in Resident #68's progress notes on 03/15/23 at 1:41 P.M. He/She could not recall who the other resident was that he/she documented about. He/She did document that his/her behavior made other residents uncomfortable and that it was of a sexual nature, but he/she was not sure if it classified as abuse; he/she could not tell if Resident #68's behaviors really affected other residents because they had diagnoses of dementia, he/she just knew he/she would not like to be treated that way; -He/She had also made the entry for 03/21/23 at 2:03 P.M.; he/she could not recall the opposite sex resident who was invited back to Resident #68's room; -On 06/09/23 at 5:14 P.M., he/she made the entry in Resident #68's progress notes; the incident documented was between Resident #54 and Resident #68; Resident #54 was in Resident #68's room; Resident #54 had his/her shirt pulled up and under garment pulled down and Resident #68 had his/her mouth on Resident #54's breast. During an interview on 07/14/23 at 3:05 P.M., the Social Service Director said the following: -She had heard that Resident #68 had made sexually inappropriate comments and had behaviors. She heard this from staff who reported it to her but she had been told Resident #68 was re-directable, so she had no further concerns and had not reported these things to anyone; -She does recaps quarterly and documents in the resident progress notes; she had read the documentation that staff completed that showed the resident had sexually inappropriate behaviors; -She was aware of the incident between Resident #54 and Resident #68 that occurred on 06/09/23 when Resident #68 had his/her mouth on Resident #54's breast, but did not recall the incident when Resident #68 and #54 were found in Resident #68's bed touching and kissing; -She was not sure if these incidents were considered abuse; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She had made Resident #68's family aware of his/her behaviors, but had not completed any investigation; -She had attempted to notify Resident #54's family member of the incident with Resident #68 in June but had not completed an investigation; -She had not completed an investigation for Resident #501's concerns; he/she just knew Resident #501 did not like Resident #68, but did not know why. During an interview on 07/11/23 at 5:30 P.M. and 07/12/23 at 12:22 P.M., the Administrator said the following: -She was aware of Resident #68's behaviors, both verbally and physically of a sexual nature; -Was aware Resident #54 and Resident #68 were found in bed together in January and also aware of an incident in June when Resident #68 has his/her mouth on Resident #54's breast; -She had received complaints about Resident #68 from Resident #501, she had spoken with Resident #501 but did not document an investigation; -She did not know there had been an incident between Resident #68 and Resident #59; -She was aware Resident #68 made advances toward Resident #500 but nothing was acted on; Resident #68 just tried to touch him/her; -She did not consider Resident #68's behavior to be abuse; -She thought Resident #54 had sexual inappropriate behaviors towards Resident #68; specifically when he/she exposed him/herself to Resident #68 and came out of his/her room either with no clothes on or when he/she opened up his/her robe; -She did not know who the aggressor was in these incidents; -Someone with a BIMS of 3 and had an active POA would not be able to make a determination or consent; -Sexual abuse can be both verbal and physical; -If the behavior happens over and over, it would be considered abuse; She felt like staff re-directed Resident #68 and his/her behaviors were not considered abuse; -Any suspected abuse should be reported to at least the Director of Nursing and then the administrator; -Once reported, the concern should be investigated and harm determined; -She did not feel that any harm had been done so these incidents were not considered abuse and no further investigation was needed.

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	265108	A. Building B. Wing	05/02/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview and record review, the facility failed to update interventions in the resident's care plan to reflect current care needs for three residents (Residents #68, #54 and #8), in a review of 27 sampled residents. The facility census was 73. Review of the facility's Care Plans, Comprehensive Person-Centered, Revised March 2022, showed the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Review of Resident #68's facility face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's undated facility diagnosis page showed the resident with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, dementia and sexual dysfunction. Review of the resident's facility progress notes showed staff documented the following: -On 11/14/22 at 6:58 P.M., the resident has been hard to redirect this shift; had to be redirected multiple times for sexual statements, will continue to monitor; -On 11/18/22 at 4:53 P.M., the resident was sexually inappropriate at times. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/22/22, showed the resident had a Brief Interview for Mental Status (BIMS) (screening tool to assess cognition) of 10, indicating the resident had mild cognitive impairment. The resident had verbal behaviors on two days (in a seven day look back period), transferred, walked and moved in the bed independently. Review of the resident's facility progress notes showed staff documented the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/07/22 at 6:23 P.M., resident currently sits at the dining room table talking to other residents and trying to kiss multiple (residents of the opposite sex). Resident was redirected multiple times. Resident was educated that his/her behavior was inappropriate and upsetting other residents; -On 12/8/22 at 6:39 P.M., the resident has continued to have multiple episodes of inappropriate behaviors. Noted to be sitting at the breakfast table and said (people of the opposite sex), are like whiskey, they are all good but some are better than others in bed. Resident was redirected multiple times and educated that his/her behavior was inappropriate and upsetting other residents, he/she said I will try to work on it. Review of the resident's care plan, dated 12/8/23, showed no evidence the resident presented with behaviors or direction for staff to address the resident's sexually inappropriate behaviors. Review of the resident's facility progress notes showed staff documented the following: -On 12/13/22 at 6:50 P.M., the resident has had five episodes of being inappropriate this shift; -On 12/16/22 at 6:03 P.M., the resident had two episodes of sexual inappropriate behavior this shift; -On 12/17/22 at 4:50 P.M., the resident had multiple episodes of sexual inappropriate behavior this shift as well as being verbal hateful, belligerent and verbally abusive to staff and residents; -On 12/18/22 5:39 P.M., the resident has been verbally sexually inappropriate and belligerent today; -On 12/21/22 at 7:27 P.M., the resident has been verbally sexually inappropriate with staff and got upset when he/she was redirected; -On 12/30/22 at 7:11 P.M., has been verbally inappropriate this shift; -On 01/01/23 at 7:20 P.M., has been hateful, belligerent and verbally sexually inappropriate this shift. He/She looked at the table where residents of the opposite sex sat and said, Do you guys wanna get lucky tonight? Do you know what (named specific medication for sexual performance)? I use it so I get lucky; -On 01/02/23 at 6:54 P.M., the resident has been belligerent and sexually inappropriate this shift. He/She would walk around to residents of the opposite sex and try kissing them on the mouth. This nurse had to redirect him/her. Resident screamed, Damn, you just can't let me have no damn fun!; -On 01/15/23 at 7:12 P.M., was sexually inappropriate this shift with another resident. The residents were found in this resident's room on his/her bed, kissing on one another and inappropriately touching one another. The residents were separated and individually educated this was not an appropriate setting for these behaviors; -On 01/26/23 at 2:16 P.M., this resident noted to be sitting very close with another resident of the opposite sex, holding hands with each other and rubbing arms. This nurse attempted to relocate the resident, but this was unsuccessful due to this resident not wanting to move; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 01/30/23 at 6:48 P.M., orders received, resident not to be alone with staff or residents of the opposite sex. Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 14 (cognitively intact), the resident had verbal behaviors one to three days of the seven day look back period and was independent with walking, transfers and bed mobility. Review of the resident's facility progress notes showed staff documented the following: -On 02/21/23 at 9:35 A.M., the social worker documented in the last seven days, the resident had one incident of sexually inappropriate behavior. Earlier in February the resident had three incidents of sexually inappropriate behavior, in January 19 incidents, and in December 15 incidents of sexually inappropriate behavior; -On 02/22/23 at 6:22 P.M., the resident walked up to another resident of the opposite sex and asked the other resident to give him/her a kiss; -On 03/06/23 at 2:57 P.M., the resident went up to another resident and kissed that resident on the forehead; noted to do this twice during this shift; -On 03/08/23 at 8:20 A.M., noted to go up to another resident of the opposite sex while he/she was eating his/her breakfast and grab the collar of this resident's shirt and ask if he/she could see what was under there; -On 03/08/22 at 11:28 A.M., when another resident of the opposite sex was returning to his/her seat from the bathroom, this resident asked this resident, Can I rub them (breasts)? The other resident replied that no, Resident #68 could not rub his/her breasts. After this incident the resident was redirected and shortly after this; -On 03/10/23 at 1:20 P.M., the resident asked a resident of the opposite sex if they liked to have sex. Staff redirected the resident. The resident then went to another resident and asked him/her the same question. When attempting to redirect, he/she asked if staff was married and had sex; -On 03/11/23 at 10:58 A.M., the resident asked a resident of the opposite sex if he/she has had sex since he/she has been at the facility; -On 03/12/23 at 4:27 P.M., resident noted to rub another resident of the opposite sex's back and he/she asked him/her if he/she had ever had sex. This resident told the resident of the opposite sex, If you come to room [ROOM NUMBER], I'll rub on your breast and I'll rub down there so you will know what it feels like; -On 03/15/23 at 1:41 P.M., resident has had sexual behaviors towards other residents this shift. The resident told another resident He/She would like to have some good clean sex with (opposite sex) residents, while (opposite sex) residents sat at the table eating lunch. One of the residents told him/her he/she was a dirty old (person) and that he/she didn't appreciate the way he/she was talking to him/her, and not to speak to him/her anymore. This resident said okay and that he/she really looked good in his/her shirt. Staff informed this resident that he/she could not talk to other residents in that manner because it made them feel uncomfortable; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/21/23 at 2:03 P.M., the resident has had some inappropriate remarks towards staff and other residents. This resident asked a resident of the opposite sex if he/she had sex recently while being in this nursing home and if he/she wanted to do so, then come to room [ROOM NUMBER] and they could have some. Resident of the opposite sex told him NO they can't do that in here; -On 03/25/23 at 3:04 P.M., this nurse witnessed this resident kiss another resident on the forehead; -On 03/26/23 at 3:07 P.M., this nurse overheard this resident tell a resident of the opposite sex that he/she could sit on his/her lap. Review of the resident's care plan, revised 03/28/23, showed the resident presented with sexual behaviors and now took estrogen (hormone) therapy related to sexual behaviors. The care plan did not identify any other action, other than monitoring for medication side effects, to address the resident's behaviors. Review of the resident's facility progress notes showed staff documented the following: -On 04/03/23 at 6:58 P.M., resident noted to make multiple sexual comments towards staff and other residents; -On 04/13/23 at 6:37 P.M., the resident made multiple sexual comments during this shift to residents and staff. Unable to redirect. During morning meal, this resident was noted to be rubbing a resident of the opposite sex's breast while the other resident attempted to push the resident's hand away. Resident #68 said, Doesn't that feel good?; -On 04/17/23 at 6:28 P.M., continues with inappropriate sexual comments to residents and staff multiple times; -On 04/23/23 at 11:35 A.M., resident exhibiting inappropriate behaviors today. Resident observed in a resident of the opposite sex's room, standing over him/her and touching him/her. This resident was redirected by CNA staff and was given education on why this was not appropriate; -On 04/23/23 at 11:42 A.M., regarding previous nurse's note - CNA defined touching as the resident had his/her hand on the other resident's lap, was rubbing his/her back, and their faces were touching; -On 04/25/23 at 6:34 P.M., resident noted to be asking multiple different residents of the opposite gender to give me a kiss. Resident redirected and reminded of possible germs & infection. Resident acknowledged understanding, but has been noncompliant; -On 04/26/23 at 7:24 P.M., resident noted to be very inappropriate sexually with other residents this shift. Resident grabbed a resident of the opposite gender's breast and told him/her he/she had very nice boobies; -On 04/27/23 at 6:30 P.M., resident has had a couple of inappropriate sexual behaviors this shift; trying to kiss other residents, and asked staff if they had been sexually active before coming to work today; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/11/23 at 3:04 P.M., noted during after morning meal to have his/her hands under another resident's shirt. Review of the resident's quarterly MDS, dated [DATE], showed the following: -BIMS of 10, the resident had mild cognitive impairment; -Verbal behaviors occurred on four to six days during the seven day look back period; -Independent with bed mobility, transfers and walking. Review of the resident's facility progress notes showed staff documented the following: -On 05/19/23 at 7:13 A.M., the social worker documented in the last seven days he/she had five incidents of sexually inappropriateness. Earlier in May he/she had one incident of grabbing and nine incidents of sexually inappropriateness. In April he/she had 15 incidents of sexually inappropriateness and in March, 26 incidents of sexually inappropriateness; -On 05/29/23 at 7:37 P.M., the resident stood up at the table and unzipped his/her pants and asked to feel this. Told the resident this was inappropriate to do that and asked him/her to zip his/her pants back up; -On 05/31/23 at 11:09 A.M., resident noted to have inappropriate sexual behavior toward other residents this shift; -On 06/09/23 at 5:14 P.M., staff reported that this resident and a resident of the opposite sex were in this resident's room participating in inappropriate sexual behaviors; -On 06/10/23 at 6:23 P.M., resident made frequent sexual remarks to residents of the opposite sex, and asked them if they would give him/her a kiss on the cheek; -On 06/27/23 at 5:37 P.M., resident was kissing another resident; -On 07/01/23 at 6:36 P.M., resident walked up behind a resident of the opposite sex and put his/her hands around his/her shoulders for a hug; the other resident became upset and yelled at this resident to get off of him/her; -On 07/08/23 at 6:53 P.M., resident was noted to compliment the residents and the workers frequently and requested another resident give him/her a kiss. 2. Review of Resident #54's facility diagnosis page showed the resident has diagnoses that includes dementia (a decline in cognitive abilities) and a traumatic brain injury (brain dysfunction that affects how the brain works). Review of the resident's quarterly MDS, dated [DATE], showed the resident had a BIMS of 13; the resident had mild cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's facility progress notes showed staff documented on 01/15/23 at 7:14 P.M. that the resident was sexually inappropriate this shift with another resident. They were found in the other resident's room on his/her bed, kissing on one another and inappropriately touching one another. Residents were separated and individually educated on this not being an appropriate setting for this behavior. Review of the resident's annual MDS, dated [DATE], showed the resident had a BIMS of 12; the resident had mild cognitive impairment. Review of the resident's facility progress notes showed the facility Social Worker documented on 02/13/23 at 8:02 A.M. that the resident's BIM score was 13 and he/she had had one incident of sexually inappropriateness in January. Review of the resident's care plan, dated 03/28/23, showed the resident has alteration in thought process related to dementia and traumatic brain injury. Review of the resident's facility progress notes showed staff documented on 05/11/23 at 3:06 P.M., that the resident was noted to have inappropriate behaviors with another resident. Review of the resident's quarterly MDS, dated [DATE], showed the following: -BIMS of 3, severe cognitive -Had the ability to understand others; -Made self-understood. Review of the resident's facility progress notes showed staff documented the following: -05/12/23 at 1:00 P.M., the Social Worker documented that the resident's BIMS score was 03 and he/she had had two incidents of sexually inappropriateness in the last seven days. Earlier in May, he/she had two incidents of sexually inappropriateness. In April, he/she had ten incidents of sexually inappropriateness and in March, three incidents of sexually inappropriateness; -05/31/23 at 10:52 A.M., resident came to the core area in nothing but his/her robe, this nurse and staff asked resident to go back to his/her room to get dressed so residents of the opposite sex didn't see him/her, and told him/her it was inappropriate to be in the core area with other residents with no clothes on; he/she refused and his/her robe came open, exposing his/her breast, the nurse and staff were standing in between her and male residents sitting at the table. This nurse and staff redirected him/her and took him/her to his/her room to get dressed; -06/05/23 at 5:44 P.M., this resident was noted to come out to the common area without any clothes or underwear on. This nurse went up to the resident and attempted to get him/her dressed and he/she refused, stating he/she was proud of his/her body and wanted to show the men; this nurse was able to grab a blanket and cover him/her up, he/she sat at the table and after a few minutes had passed he/she allowed the CNA to get him/her dressed; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/09/23 at 5:30 P.M. that staff reported that this resident and another resident of the opposite sex were in the other resident's room participating in inappropriate sexual behavior. This resident appeared to have his/her shirt up and the other resident had his/her mouth on this resident's breast. Review of the resident's care plan on 07/13/23 at 7:25 P.M., last revised 04/03/23, showed it contained no updates regarding the resident's sexual inappropriate behaviors or disrobing in common areas and did not give any staff direction as to what to do in these instances. 3. Review of the Resident #8's quarterly review MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Diagnoses of asthma, Chronic Obstructive Pulmonary Disease (COPD) and respiratory failure; -Shortness of breath with exertion, when sitting at rest and when lying flat; -Requires oxygen therapy was left blank. Review of the resident's Treatment Administration Record, dated 07/01/23 through 07/31/23, showed on 07/02/23 and 07/09/23 at night, staff documented changing the resident's oxygen and nebulizer tubing weekly every night shift every Sunday. Review of the resident's care plan reviewed on 07/02/23, showed no documentation the resident had any respiratory issues or used oxygen. Review of the resident's Physician Order Summary (POS), dated 07/13/23, showed the following: -Change oxygen and nebulizer tubing weekly every night shift every Sunday mark with date of change; -Supplemental oxygen at two liters by NC, to maintain oxygen saturations above 90 percent (%) every day and night shift. Observation on 07/12/23 at 12:52 P.M., showed the the resident sat in his/her wheelchair, awake, oxygen with delivered via a NC at 2L from an oxygen concentrator into oxygen tubing. 4. During an interview on 07/18/23 at 1:45 P.M., the Assistant Director of Nursing (ADON) said the following: -The care plan is a working document that provides the current level of care for each resident and should be accurate; -He/She would expect the care plan to be updated after a fall, a change in condition, or anything that needed to be added to better care for the resident; -The MDS coordinators typically update the care plans; -He/She would expect the charge nurse to update a care plan in an acute situation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to administer insulin as ordered for one resident (Resident #53), check blood glucose levels for two residents (Resident #53 and Resident #67), collect a urine sample per physician order for two residents (Resident #25 and Resident #67), and obtain labs per physician order for three residents (Resident #53, Resident #25, and Resident #67). The facility census was 76. Review of the facility policy, Regarding Physician Orders, dated 8/19/21, showed the following: -It is the responsibility of each charge nurse to assess, document, provide and initiate interventions and to consult with that resident's Primary Care Physician with any/all abnormal findings regarding the resident; -The charge nurse is held accountable and responsible for keeping not only the family informed of potential issues found upon the resident assessment but to also keep the Primary Care Physician informed of ALL issues found concerning the resident. Review of the facility policy, Diabetes Clinical Protocol, revised November 2020, showed the following: -For the resident receiving insulin who is well controlled, monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch and as necessary); -Monitor A1C Glycolated hemoglobin (HgbA1C), (a blood test that measures your average blood sugar levels over the past 3 months) on admission (if no results from a previous test are available) or when diabetes is diagnosed , and every six months thereafter; adjust monitoring frequency depending on glucose control and resident preference. 1. Review of Resident #67's care plan, dated 11/23/22, showed the following: -Monitor the resident for signs/symptoms of high blood sugar, increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, acetone breath (smells fruity), stupor and coma. Report to his/her physician; -Monitor the resident for signs and symptoms of low blood sugar such as sweating. Review of the resident's physician orders showed an order for Accu-check (blood sugar test) and record four times a day- start date 12/19/22. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/6/23 showed the following: -Cognitively intact; -Always incontinent of bladder and bowel; (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses of UTI and diabetes. Review of the resident's physician's orders, dated 2/13/23, showed the following: -Collect urine sample; -Send sample for urinalysis then culture and sensitivity (C&S) (a test to identify bacteria that can cause infection and also identifies medications that would be used to treat the infection) if indicated; -Diagnosis of altered mental status. Review of the resident's medical record, dated 2/13/23 through 2/17/23, showed no documentation facility staff obtained or attempted to obtain the urine sample as ordered. Review of the resident's progress notes, dated 2/17/23 at 12:05 P.M., showed the following: -Called to resident's room by staff who reported the resident was not responding; -Family Member 2 who was in the room was very concerned; -Resident would not arouse or respond; -He/She would not open his/her eyes or answer questions; -Due to unresponsiveness, sternal rub performed; -Sternal rub unsuccessful; -Attempted to have resident squeeze fingers and he/she was unable to follow commands; -Staff sat resident up on side of bed and he/she opened his/her eyes; -Slightly shook head no when offered a drink; -Resident would not track with eyes, would not speak, and would not follow commands; -UA ordered at beginning of week had not yet been obtained; -Staff spoke with Family Member 2 and suggested the resident should be evaluated at the emergency room (ER); -Family Member 2 believes the resident has a UTI and has had these episodes with UTIs in the past; -Staff called nurse practitioner who gave order to send to ER for evaluation; -Called emergency medical services (EMS) to transfer resident to ER. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's hospital history and physical, dated 2/17/23, showed the following: -Resident presents to the emergency department with main complaint of altered mental status, onset morning. Associated symptoms include only responsive to pain, unable to follow commands, jaw and hands clenched tightly; -Resident is unable to communicate if he/she has any pain at this point in time; Plan: -The resident has become hypoxic (absence of enough oxygen in the tissue to sustain bodily functions) and his/her breathing was somewhat labored so he/she was placed on BiPAP (a device that helps with breathing); -UA positive for UTI. Review of the resident's UA results (obtained at the hospital) dated 2/17/23, showed the following: -White blood cell (WBC) count greater than 50 (normal range 0-5/HPF); -Clarity cloudy (normal clear); -Leukocyte Esterase 3+ (normal negative); -Protein 1+ (normal negative); -Glucose 200 (normal negative); -Urobilinogen 2.0 (normal negative); -Blood 1+ (normal negative). Review of the resident's urine culture results, dated 2/18/23, showed enterococcus species (bacteria) greater than 100,000 cfu/ml. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severely impaired cognition; -Diagnosis of diabetes and UTI; -Frequently incontinent of urine. Review of the resident's medical record, dated 4/1/23 through 4/26/23, showed the following: -No documentation staff obtained the resident's blood sugar on 4/2/23 early A.M. and supper; -No documentation staff obtained the resident's blood sugar on 4/6/23 lunch, supper and bedtime; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation staff obtained the resident's blood sugar on 4/7/23 lunch, supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/8/23 at lunch and supper; -No documentation staff obtained the resident's blood sugar on 4/9/23 early A.M. and bedtime; -No documentation staff obtained the resident's blood sugar on 4/10/23 lunch and supper; -No documentation staff obtained the resident's blood sugar on 4/11/23 supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/12/23 at lunch; -No documentation staff obtained the resident's blood sugar on 4/13/23 at lunch and supper; -No documentation staff obtained the resident's blood sugar on 4/14/23 at supper; -No documentation staff obtained the resident's blood sugar on 4/16/23 at lunch and bedtime; -No documentation staff obtained the resident's blood sugar on 4/17/23 at supper; -No documentation staff obtained the resident's blood sugar on 4/18/23 at lunch, supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/19/23 at lunch, supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/20/23 at lunch, supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/22/23 at supper; -No documentation staff obtained the resident's blood sugar on 4/23/23 at bedtime; -No documentation staff obtained the resident's blood sugar on 4/24/23 at supper and bedtime; -No documentation staff obtained the resident's blood sugar on 4/25/23 at bedtime; -No documentation staff obtained the resident's blood sugar on 4/26/23 at supper and bedtime. 2. Review of Resident #53's undated face sheet showed diagnosis included Type 2 diabetes mellitus without complications. Review of the resident's Care Plan, dated 1/19/23, showed the following: -Monitor/document/report to physician as needed for signs and symptoms of hypoglycemia including sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor/document/report to physician as needed for signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, (abnormal breathing pattern characterized by rapid, deep breathing at a consistent pace) acetone breath (smells fruity), stupor, coma. Review of the resident's physician order sheet (POS) for March 2023, showed the following: -Lantus Solostar Pen (long acting insulin for diabetes), Inject 5 units (u) sub Q (in the fatty tissue, just under the skin) at bedtime; -HgbA1C every six months starting 2/2023; -No order for blood sugar checks. Review of the resident's Medication Administration Record (MAR) for March 2023 showed no documentation to show staff administered the resident's Lantus 5 units on 3/28/23, 3/29/23, and 3/30/23 as ordered. Review of the resident's POS for April 2023, showed an order for Novolog Flexpen (fast acting insulin for diabetes) 100 u/milliliter (ml), Inject 2 units sub Q 3 times daily (A.M., mid-day and P.M.). Review of the resident's MAR for April 2023 showed no documentation staff administered the resident's Novolog 2 units on 4/5/23 for the scheduled mid-day time. Review of the resident's medical records from February 2023 to May 2nd, 2023 showed no documentation staff obtained the resident's ordered HgbA1C lab. During an interview with Licensed Practical Nurse (LPN) O on 5/1/23 at 12:35 P.M., he/she said the following: -If there is no order for blood sugar checks, he/she would only check blood sugars if the resident was showing symptoms; -The resident's HgbA1C should have been done in February and it looked like it was missed. During an interview on 5/2/23 at 7:11 P.M., the Assistant Director of Nurses (ADON) said the following: -She would expect blood sugars to be checked for any diabetic resident that receives insulin prior to giving insulin; -She would expect staff to monitor blood sugars and report abnormal blood sugar values outside of the parameters; if there are no parameters, she would expect any value below 70 or greater than 165, depending on their co-morbidities, to be reported; -The labs that were ordered for the resident in February 2023 were not drawn. During an interview on 4/27/23 at 11:15 A.M., the Director of Nurses (DON) said the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expects staff to follow any facility policy; -Blood sugar checks, assessments, and physician notifications should all be charted in the electronic medical record. During an interview on 5/2/23 at 7:11 P.M., the Administrator said she would expect staff to use their nursing judgement for diabetic residents with no Accucheck orders and to check a blood sugar prior to giving any insulin, as well as with any change in the condition of the resident. 3. Review of Resident #25's care plan, dated 10/17/22, showed the resident needed extensive assistance with bathing and toileting. He/She was unable to clean him/herself after toileting. The resident had alteration in his/her thought processes due to periods of confusion. Review of the resident's annual MDS, dated [DATE], showed the following: -Moderately impaired cognition;; -Requires staff assist of one for transfers and toilet use; -No rejection of care; -Frequently incontinent of urine. Review of the resident's physician's order sheet, dated 4/10/23, showed an order for urinalysis (UA) with culture and sensitivity (C&S) if indicated. Review of the resident's UA with C&S, dated 4/16/23, showed greater than 100,000 (colony forming units) (cfu)/milliliters (mL) of escherichia coli (E. coli) (bacteria that normally lives in the intestines). Review of the resident's physician's orders, dated 4/19/23, showed an order to place a urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) for diagnosis of urinary retention. Macrobid (antibiotic) 100 mg twice daily for seven days. During an interview on 4/26/23 at 1:53 P.M. LPN P said facility staff is responsible for obtaining lab orders. The lab picks up the specimens. He/She could remember trying to get the UA for Resident #25 and it took several days to get the specimen because the resident kept missing the hat or the specimen was contaminated. LPN B ended up obtaining the specimen by straight catheter. During an interview on 4/27/23 at 9:00 A.M. LPN B said the following: -He/She got the order for Resident #25's UA; -He/She tried to obtain the UA via clean catch several days in a row; -Staff passed it on from shift to shift that they still needed to get the UA; -Eventually he/she had to straight cath the resident to obtain the specimen; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not document his/her attempts to obtain the UA. 4. During an interview on 4/26/23 at 2:40 P.M. and 5/11/23 at 2:30 P.M., the Nurse Practitioner (NP) for Residents #25 and 67 said the following: -He would expect staff to follow physicians orders; -He would expect staff to perform treatments as ordered; -He would expect lab orders to be obtained as soon as able; -He was not aware Resident #67's UA ordered on 2/13/23 was not obtained until the resident went to the hospital; -Resident #25's UA was ordered on 4/10/23 and not obtained until 4/16/23; -He would have liked staff to obtain Resident #25's UA as soon as able; -Resident #25 was having behaviors and had urinary residual twice after voiding requiring placement of an indwelling urinary catheter. During an interview on 4/26/23 at 2:14 P.M. the previous DON/Registered Nurse (RN) A said lab orders should be obtained immediately. UAs should be obtained within 24 hours of the order. During an interview on 5/2/23 at 7:05 P.M. the ADON said the following: -She would expect staff to obtain labs are ordered; -She would expect staff to follow physician orders. 45563 47246

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to ensure staff provided the necessary care and services to maintain good personal hygiene for four residents (Residents #8, #22, #51, and #33) who required assistance to perform their activities of daily living, in a review of 22 sampled residents. The facility census was 76. Review of the facility policy, Mouth Care, revised February 2018, showed the purpose of this procedure is to keep the resident's lips and oral tissues moist, to clean and freshen the resident's mouth and to prevent oral infection. The policy did not provide direction to staff regarding frequency of mouth care. Review of the facility policy, Activities of Daily Living (ADL), Supporting, revised March 2018, showed appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). Review of the facility policy, Care of Fingernails/Toenails, revised February 2018, showed the following: -Nail care includes daily cleaning and regular trimming; -The following documentation should be recorded in the resident's medical record: date and time nail care was given, name and title of the individual(s) who administered the nail care, condition of the resident's nails and nail bed, any difficulties in cutting the resident's nails, any problems or complaints made by the resident with his/her hand or feet or any complaints related to the procedure, if the resident refused the treatment, the reason(s) why and the intervention taken, the signature and title of the person recording the data; -Reporting includes notifying the supervisor if the resident refuses the care, and reporting other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #22's care plan, revised 3/27/23, showed the following: -He/she needs extensive assistance with dressing and bed mobility; -Keep fingernails short; -He/she needs total assist with bathing and toileting needs; -No direction to staff regarding assistance required with personal hygiene needs; -Total assistance with bathing. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/17/23, showed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severely impaired cognition; -No rejection of care; -Totally dependent on one staff member for personal hygiene. Observation on 4/24/23 at 4:00 P.M. in the common area showed the following: -The resident sat in his/her wheelchair; -His/her face was covered with hair stubble; -There was dried food and a dried brown substance on the resident's chin and around his/her mouth. Observation on 4/26/23 at 5:57 A.M. in the common area showed the following: -The resident sat in his/her wheelchair; -The resident had dried tan skin hanging from his/her upper lip; -The resident's lips were dry. Observation on 4/27/23 at 9:42 A.M. in the TV room showed the following: -The resident sat in his/her wheelchair watching TV; -The resident's mouth and lips were dry; -His/her face was covered with hair stubble; -The resident's nails were long. Observation on 5/1/23 at 12:56 P.M. in the East Hall dining room showed the following: -The resident sat in his/her wheelchair feeding him/herself lunch; -The resident's face was covered with hair stubble; -The resident's fingernails were long with brown debris under the nails. 2. Review of Resident #33's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -No rejection of care; -Totally dependent of two or more staff for transfer and bed mobility; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Totally dependent of two or more staff for personal hygiene and bathing. Review of the resident's care plan, revised 3/22/23, showed the following: -The resident has impaired ADL and mobility performance; -Two staff members need to be in room at all times when providing care; -No direction to staff regarding assistance needed with oral care and face washing. Observation on 4/26/23 at 5:41 A.M. in the common area showed the following: -The resident sat in his/her wheelchair; -He/she had yellow crust in the corners of his/her eyes; -He/she had a white sticky substance on his/her mouth; -The resident rubbed his/her eyes. 3. During an interview on 4/26/23 at 6:30 A.M., Certified Nurse Assistant (CNA) Z said the following: -He/She didn't do oral care or face washing on Resident #22 or Resident #33; (she also said there was no reason why she did not do those things) -He/She doesn't do nails or shaving on his/her shift (night shift). 4. Review of Resident #8's face sheet showed diagnoses including chronic obstructive pulmonary disease with acute exacerbation, acute respiratory failure, stiffness of right shoulder, pain in left shoulder, rheumatoid arthritis, and muscle weakness. Review of the resident's Care Plan, dated 6/11/20, showed the following: -Encourage resident to complete his/her oral care in the A.M. and P.M.; Staff to complete what he/she is unable to do; -He/She prefers to take a shower in the morning. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -No rejection of cares; -Required total dependence for hygiene with two staff; -Required total dependence for bathing with two staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/24/23 at 1:15 P.M., showed the resident lay in bed. The resident had facial hair stubble. Observation on 4/25//23 at 9:00 A.M., showed the resident was in bed awake wearing the same shirt as the day before. During an interview on 4/25/23 at 9:00 A.M., the resident said he/she would like to be shaved, but staff never shave him/her. 5. Review of Resident #51's face sheet showed diagnoses included major depressive disorder, muscle weakness, stiffness of right shoulder, stiffness of left shoulder, contracture (shortening or hardening of the muscles, tendons or other tissue often leading to deformity and rigidity of joints) and unspecified osteoarthritis (most common form of arthritis). Review of the resident's Care Plan, dated 8/21/20, showed the following: -Oral care with A.M. and P.M. care and as needed (own teeth); -Prefers to shower in the morning; -Requires extensive assist with all Activities of Daily Living (ADLs). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Intact Cognition; -No rejection of cares; -Required total dependence for hygiene with one staff; -Required total dependence for bathing with one staff. Observation on 4/24/23 at 1:55 P.M. showed the resident lay in bed in his/her gown, awake with untidy hair, long nails and facial hair stubble. Observation on 4/25/23 at 10:40 A.M. showed the resident lay in bed with facial hair stubble and untidy hair. During an interview on 4/25/23 at 3:40 P.M., the resident said the following: -He/She might get a shower once a week; -Staff haven't brushed his/her teeth or combed his/her hair for a while; -He/She would like to be shaved; -He/She would like a haircut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/26/23 at 7:44 A.M. showed the resident in bed, awake, still in the same clothes from the day before and unshaven. During an interview on 4/26/23 at 7:44 A.M., the resident said he/she still had not been shaved and needed to be shaved. 6. During an interview on 4/26/23 at 5:40 A.M., Certified Nurse's Aide (CNA) W said the following: -The facility was short staffed; -Being short staffed made it difficult to get all cares done on all residents; one person could not do it all. During interviews on 4/27/23 at 3:50 P.M. and 5/2/23 at 6:35 P.M., CNA X said the following: -Showers should be charted in the electronic health record by the nurse. -Every time a resident gets a shower, they are shaved. During an interview on 5/2/23 at 8:15 P.M., the Administrator said the following: -She had heard that sometimes showers were not getting done and they have tried to adjust the shower schedules; -The facility had make up days on Sundays and some days they dedicate an aide to help with showers; -She would expect men and women to be shaved on shower days unless they refused. 45563

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45563 Based on observation, interview, and record review, facility staff failed to identify signs and symptoms of hyperglycemia (an excess of glucose in the bloodstream) on 4/25/23 for one resident, (Resident #32), who had a diagnosis of diabetes, when the resident presented with shaking and excessive thirst. The resident's care plan instructed staff to be alert to signs of high blood sugar and contact the physician as indicated. Facility staff did not check the resident's blood sugar or call the resident's physician to report the noted signs and symptoms. On the morning of 4/26/23, the facility failed to obtain a fasting blood sugar as ordered. On the afternoon of 4/26/23, the facility notified the resident's physician the resident had become lethargic, unresponsive and pale. The resident's physician instructed staff to check the resident's blood sugar and the reading on the facility meter resulted high. The resident was sent to the hospital and assessed with a blood sugar of 797 (normal range 80-120 mg/dl). The resident was admitted to the hospital under ICU (intensive care unit) care and placed on an insulin drip (insulin given through an IV (access to the vein) to lower his/her blood sugar. Interview with the resident's physician showed he would have wanted to be notified on 4/25/23 of the resident's condition and he/she would have instructed for the resident's blood sugar to be checked. The facility census was 76. The administrator was notified of the Immediate Jeopardy (IJ) on 4/27/23 at 5:00 P.M. which began on 4/25/23. The IJ was removed on 5/1/23 as confirmed by surveyor onsite verification. Review of the facility policy, Diabetes Clinical Protocol, revised November 2020, showed the following: -The staff will identify and report issues that may affect, or be affected by, a resident's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia; -Urgent notification may be indicated if the individual has not eaten well or consumed sufficient fluids for two or more days and has fever, hypotension (low blood pressure), lethargy or confusion; -The physician will help the staff clarify and respond to these episodes. Review of the facility policy, Regarding Physician Orders, revised August 2021, showed the following: -It is the responsibility of each charge nurse to assess, document, provide and initiate interventions and to consult with that resident's Primary Care Physician with any/all abnormal findings regarding the resident; -The charge nurse is held accountable and responsible for keeping not only the family informed of potential issues found upon the resident assessment but to also keep the Primary Care Physician informed of ALL issues found concerning the resident. 1. Review of Resident #32's Care Plan, dated 10/23/18, showed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Be alert to signs of high blood sugar including flushed, dry skin, drowsiness, nausea/vomiting, abnormal pain, soft sunken eye balls, red lips, decreased blood pressure, acetone breath, and increased respirations (hyperglycemia). Contact physician as indicated; -Make sure the resident's needs are met such as hunger and thirst; -Anticipate his/her needs and pay attention to nonverbal cues. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 3/31/23, showed the following: -Severely impaired cognition; -Diagnosis of diabetes mellitus; -No insulin orders. Review of the resident's April 2023 physician orders showed the following: -Accucheck (blood sugar check) three times a week before breakfast on Monday, Wednesday, and Friday. Notify the physician if the blood sugar is below 70 or above 400; -Push water/fluid intake when awake; -Assist with feeding with every meal and snack. Observation on 4/25/23 at 4:04 P.M., showed the resident was in main living room on the [NAME] hall. He/She was pale, had facial grimacing and a clenched mouth. He/She was gritting his/her teeth, his/her hands were in fists, and he/she was shaking. During an interview on 4/25/23 at 4:06 P.M., Licensed Practical Nurse (LPN) N said the following: -The resident was not diabetic; -The resident had not been eating much the past couple of days; -Yesterday, the resident ate breakfast, but not much lunch or dinner; -Today, the resident didn't eat much at breakfast and didn't eat any lunch; -The resident appears in pain, so he/she was going to give him/her some Tylenol. During an interview on 4/25/23 at 4:12 P.M., LPN N (after he/she reviewed the resident's medical record) said the resident was a diabetic, but was not insulin dependent. Review of the resident's Nurse's Note dated 4/25/23 at 4:16 P.M., showed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident refused breakfast and lunch, showing signs and symptoms of pain and discomfort with facial grimace and hands in fists. Provided as needed pain medication. Observation on 4/25/23 at 4:20 P.M. showed the following: -LPN N crushed Tylenol and mixed it with applesauce and fed it to the resident; -The resident's lips and mouth were dry/crusty, and his/her tongue was covered with a white film; -LPN N provided the resident an 8-ounce cup of water, and the resident gulped it very quickly through a straw; -LPN N provided the resident a second 8-ounce cup of water, and the resident gulped it through a straw so quickly that he/she began to cough. During an interview on 4/27/23 at 1:19 P.M., LPN N said the following: -He/She didn't check the resident's blood sugar because he/she just thought the resident was thirsty since he/she had missed a meal; -The resident was not insulin dependent; -The resident normally sat with his/her hands clenched; -Excessive thirst, dry mouth, and shaking are all signs of hyperglycemia; -He/She was still trying to learn resident's baselines; -He/She did not notify the resident's family or physician because the resident didn't continue to show signs and symptoms after the pain medication was given. Review of the resident's medical record for 4/26/23 (Wednesday) showed no documentation staff checked the resident's blood sugar before breakfast as directed in his/her physician's order. Review of the resident's progress note, dated 4/26/23 at 1:55 P.M., showed the following: -The resident became lethargic during his/her shower and began to appear as if he/she was becoming non-responsive; -The resident was pale in color, clenching his/her mouth and fists; -Staff notified the resident's primary care physician and he/she directed staff to check the resident's blood sugar. The results read HIGH; -The resident was sent to the hospital. Review of the resident's hospital records, dated 4/26/23 at 3:00 P.M., showed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Glucose, Plasma 797 (normal range between 70-100 mg/dL); -Labs notable for leukocytosis (an increase in the number of white cells in the blood, especially during an infection), hyperglycemia (an excess of glucose in the bloodstream) and hyponatremia (a lower than normal level of sodium in the bloodstream) and acute renal failure (AKI; a condition in which the kidneys suddenly can't filter waste from the blood) concerning for significant dehydration; -Fluid boluses given and started on insulin drip (administering insulin directly into the bloodstream through a thin tube in a vein). Review of the resident's progress note, dated 4/26/23 at 7:37 P.M., showed the resident was in the hospital ICU on an insulin drip. The resident's admitting diagnoses were hyperglycemia, dehydration (a harmful reduction in the amount of water in the body), and hypernatremia. During an interview on 4/27/23 at 10:45 A.M., the resident's physician said the following: -He would expect staff to notify him with signs and symptoms of hyperglycemia. He would have expected to staff to notify him on 4/25/23 when the resident first presented with signs and symptoms; -He would expect staff to check a resident's blood sugars with signs and symptoms of hyperglycemia or would have expected staff to at least call him to get an order to check the resident's blood sugar on 4/25/23; -He would expect staff to follow physician orders. During an interview on 4/27/23 at 11:15 A.M., the Director of Nursing (DON) said the following: -She expected staff to check a resident's blood sugar when the resident has signs and symptoms of hyperglycemia, and to complete a full assessment on the resident and notify the physician; -The blood sugar checks, assessment, and physician notification should all be documented in the electronic medical record. During an interview on 5/2/23 at 7:11 P.M., the Administrator said the following: -She expected staff to use their nursing judgement for diabetic residents with no Accucheck orders and to check a blood sugar prior to giving any insulin, as well as with any change in the condition of the resident. NOTE: At the time of the recertification survey, the violation was determined to be at the immediate jeopardy level J. Based on 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 G 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). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	47246

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to consistently evaluate, implement and modify interventions, in accordance with current standards of practice and as necessary to reduce the risk of falls for two residents (Residents #44 and #67) in a review of 22 sampled residents. The facility census was 76. Review of the facility policy, Falls and Fall Risk, Managing revised March 2018, showed the following: -Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions; 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant; 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; 7. In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling; 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved; 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed , the attending physician will help the staff reconsider possible causes that may not previously have been identified; 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. 1. Review of Resident #44's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 03/06/23, showed staff assessed the resident as: -Cognitively intact; -Requires extensive assistance of one person for bed mobility, transfers, dressing, toileting, and personal hygiene; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Requires total dependence of one person for locomotion on and off the unit; -Impaired range of motion (ROM) for bilateral upper extremities; -Wheelchair for mobility; -Diagnoses of cerebral vascular accident (stroke), congestive heart failure (CHF, a chronic condition in which the heart doesn't pump blood as well as it should), anemia (a condition in which the blood doesn't have enough healthy red blood cells), right hip fracture, and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking and often with personality change, resulting from organic disease of the brain); -No falls during the previous look back period to 02/03/23. Review of the resident's care plan, dated 05/18/22 showed the following: -Resident is at risk for falls due to his/her history of falls before and after admission; -Resident will not have major injuries over the next 90 days; -Call Before You Fall (sign) placed in room to remind resident to call for help before transferring or ambulating; -Attempt to bring resident to the common area when/if he/she is restless; -Do not push resident in wheelchair without having his/her feet positioned on foot pedals; -Encourage resident to request assistance with ambulation; -Ensure items resident may need (call light, water, Kleenex, etc.) are within resident's reach when he/she is in his/her room; -The resident wears glasses; ensure they are clean and free from scratches; -Keep non-skid socks or shoes on the resident at all times; -Keep pathways clear and free of clutter; -Make frequent visual checks while in room. Review of the resident's nursing progress notes, dated 01/07/23, showed staff documented the following: -At 9:30 A.M., resident was found in doorway to the bathroom; -Resident initially denied pain but then complained of pain in his/her right hip; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-X-ray of right hip obtained and positive for an acute right femoral fracture (right hip fracture); -Resident was transferred to the emergency room at 12:55 P.M. Review of the resident's care plan, dated 05/18/22, showed no evaluation of current interventions or addition of new fall prevention interventions since the resident's fall on 01/07/23 with subsequent right hip fracture. Observation on 04/25/23 at 4:35 P.M. showed the following: -Resident lay on her bed with both eyes closed; -The room was dark, no lights on, window curtains closed, with only the lights from hallway illuminating the resident's room; -A metal coat hanger was on the floor at the end of the resident's bed and in the pathway to the bathroom; -The resident's cell phone was on the bedside table and plugged in to the nearby outlet; the phone cord was coiled just beneath the bedside table and in the pathway to the resident's bathroom; -No Call Before You Fall signage in room. Observation on 04/26/23 at 5:42 A.M. showed the following: -The resident sat on the side of the bed with the bedside table in front of him/her, glasses on bedside stand and out of resident's reach; -The room was dark, no lights on, window curtains closed, only the lights from hallway illuminated the resident's room; -The resident was awake and talked nonsensically to a stuffed animal that he/she held; -A cell phone cord was attached to cell phone on the beside table and plugged in to nearby outlet, extra phone cord was coiled on the floor beneath the resident's feet; -A metal coat hanger was on the floor at the end of the resident's bed and in the pathway to the bathroom. Observation on 05/01/23 at 10:15 A.M. showed the following: -Resident lay on his/her bed, talking nonsensically,was restless and throwing his/her left leg up and out of sheet and leg over edge of bed, no gripper socks on, no glasses on; -Staff walked past the resident's room and did not enter; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's room was dark with no lights on, the window curtains were closed, and only the lights illuminating the room were from the hallway. 2. Review of Resident #67's care plan, revised 12/22/22, showed the following: -The resident is at risk for falls; -Keep all items he/she may want/need within his/her reach; -Never leave the resident unattended while restless; -The resident is at risk for activity of daily living (ADL) decline; -He/She can ambulate with his/her wheeled walker and assistance for short distances; -Perform frequent visual checks while resident in room. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Required extensive assist of two or more staff for transfers; -No history of falls since last assessment. Review of the resident's significant change MDS, dated [DATE], showed the following: -Required limited assistance of one staff for transfers; -No history of falls since last assessment. Review of the resident's progress notes, dated 4/11/23 at 8:58 A.M., showed staff documented the following: -Late entry: -The resident was found sitting on the floor in his/her room; he/she denied hitting head or in pain; -Staff did notice skin tear to left forearm; dressing applied; -The resident was assisted to a wheelchair without difficulty. Review of the resident's fall incident report, dated 4/11/23 at 8:41 A.M., showed the following: -Resident was not taken to the hospital; -Dressing applied to skin tear on left arm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan showed no evidence staff evaluated current fall interventions or implemented new interventions after the resident's fall on 4/11/23. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severely impaired cognition; -Required supervision with staff assist of one for transfers; -Walking in room occurred only one time with staff assist of one; -Two or more non-injury falls since last the assessment. Review of the resident's progress notes, dated 4/15/23 at 5:42 A.M., showed staff documented the following: -This nurse alerted to resident room per staff; -This nurse observed the resident on the floor of his/her own room, directly in front of his/her own wheelchair; -Resident alert and oriented x 1-2, displays poor safety awareness, weakness and functional decline; -The resident was last observed by staff at 4:30 A.M.; -The resident sat in his/her room in a wheelchair with bilateral (both) lower extremities (BLE) elevated on own bed; -The resident was incontinent; -Call light not in reach or in use. Review of the resident's fall incident report, dated 4/15/23 at 5:00 A.M., showed the following: -Head to toe skin assessment completed; -Staff education; -Resident shall not be left in own wheelchair or recliner unattended due to increased risk of falls and impaired cognition as well as poor safety awareness; -Bed remains in lowest position with fall mat at side; -Call light in reach. Review of the resident's care plan showed no evidence staff evaluated current fall interventions or implemented new interventions after the resident's fall on 4/15/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, dated 4/16/23 at 11:11 A.M., showed staff documented the following: -Staff called to room and found resident sitting on the floor; -Resident said he/she tried to stand up from his/her recliner and slid to the floor; -Able to extend and flex all extremities with no complaints of pain or discomfort; -Assisted back to his/her wheelchair without difficulty. Review of the resident's fall incident report, dated 4/16/23 at 11:16 A.M., showed the following: -Evaluated resident, no noted injuries present; -No abrasions or open areas; -No pain in legs or arms; -Denies hitting head; neuro checks started. Review of the resident's care plan showed no evidence staff evaluated current fall interventions or implemented new interventions after the resident's fall on 4/16/23. 3. During an interview on 4/26/23 at 12:50 P.M., Licensed Practical Nurse (LPN) P said the following: -After a resident falls, he/she makes a nurse's note entry and fills out the risk management form in the computer which goes to the Infection Preventionist (IP)'s office; -He/She doe not do anything with the resident's care plan and does not review fall interventions or implement new interventions after a resident falls. During an interview on 5/2/23 at 6:40 P.M., Registered Nurse (RN) F/Supervisor Admissions said the following: -She and the previous Director of Nursing (DON) have been updating care plans; -The charge nurses usually don't update the care plans; -She prefers the charge nurses do not update the care plans in the computers because it gets too confusing; -Falls are reviewed every Wednesday after therapy meeting; -The charge nurse has interventions they can put into place after a fall and document in the incident report; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In the weekly meeting, interventions are reviewed to ensure they are appropriate During an interview on 5/2/23 at 7:05 P.M., the Assistant Director of Nursing (ADON) said the following: -The aides are responsible for ensuring fall interventions are in place; -All staff should be aware of fall prevention; -The charge nurse is responsible for immediately re-evaluating or implementing new fall prevention interventions; -The charge nurse should also notify the MDS coordinator of the new intervention. MO216929 47246

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 36219 Based on observation, interview, and record review, the facility failed to provide proper care to a urinary catheter (a tube inserted into the bladder) for one resident (Resident #25), who had a history of urinary tract infections (UTIs) in a review of 22 sampled residents. The facility census was 76. Review of the facility policy Catheter Care, revised 9/30/2019, showed the following: -Make sure that the catheter bag and tubing is not touching the floor to help prevent the risk of infection; -The catheter bag or tubing should never be above the bladder (approximately waist height) to help prevent backflow of urine to decrease the risk of infection. 1. Review of Resident #25's care plan, dated 10/17/22, showed the resident needed extensive assistance with bathing and toileting. He/She is unable to clean him/herself after toileting. Review of the resident's annual Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/3/23, showed the following: -Moderately impaired cognition; -Requires staff assist of one for transfers and toilet use; -Frequently incontinent of urine. Review of the resident's care plan showed the urinary catheter was not addressed on the care plan. Review of the resident's physician's order sheet (POS), dated 4/10/23, showed an order for urinalysis (UA) with culture and sensitivity (C&S) if indicated. Review of the resident's urinalysis (UA) with culture and sensitivity (C&S), dated 4/16/23, showed greater than 100,000 (colony forming units) (cfu)/milliliters (mL) of escherichia coli (E. coli) (bacteria that normally lives in the intestines). Review of the resident's POS, dated 4/19/23, showed an order to place a urinary catheter for diagnosis of urinary retention (difficulty urinating and completely emptying the bladder); Macrobid (antibiotic) 100 milligrams (mg) twice daily for seven days. Observation on 4/26/23 at 5:29 A.M. in the resident's room showed the following: -The resident's bed was low; -The resident lay in bed; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's urinary drainage bag lay directly on the concrete floor. It was not in a privacy bag; -Dark yellow urine was present in the drainage bag. Observation on 4/27/23 at 10:03 A.M. in the resident's room showed the following: -The resident told staff he/she needed to go to the bathroom; -Certified Nurse Aide (CNA) D and CNA E pivot transferred the resident from the wheelchair to the toilet; -During the transfer, CNA E attached the hook of the urinary drainage bag to the top of his/her scrub pants pocket (above the level of the resident's bladder); -Urine visibly backed up in the tubing; -The urine was dark yellow with sediment; -CNA E emptied the resident's urinary drainage bag into a graduated cylinder; -The resident's urine had a very strong smell. During an interview on 4/27/23 at 2:00 P.M., CNA E said the following: -At times, the resident's catheter bag is laying on the floor when he/she comes on duty; -He/She usually hooks the catheter bag to his/her scrub pants to keep the bag off the floor during transfers. During an interview on 5/2/23 at 7:05 P.M., the Assistant Director of Nursing (ADON) said the following: -The urinary catheter bag should never be placed directly on the floor; -The urinary catheter bag should never be held above the level of the resident's bladder.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38016 Based on observation, interview, and record review, the facility failed to ensure staff followed facility policy to protect the nebulizer mouthpiece while not in use for one resident (Resident #4), and did not clean equipment by rinsing and air drying the medication cup, mouthpiece and mask of the nebulizer equipment for two residents (Resident #4 and Resident #48), according to the facility policy. The facility also failed to label oxygen and/or nebulizer tubing and the humidification bubbler for oxygen concentrators according to facility policy and physician orders for three residents (Resident #4, Resident #8 and Resident #48) in a review of 27 sampled residents. The facility census was 73. Review of the facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection, revised November 2011, showed the following: -The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff; -Use distilled water for humidification per facility protocol, marking the bottle (bubbler) with date and initials upon opening and discard after twenty-four (24) hours, changing the oxygen cannula and tubing every seven days, or as needed, keeping the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use; -After completion of nebulizer therapy, remove the nebulizer container, rinse the container with fresh tap water, dry on a clean paper towel or gauze sponge, reconnect to the administration set-up when air dried, wipe the mouthpiece with a damp paper towel or gauze sponge, store the circuit in plastic bag marked with date and resident's name between uses, and discard the administration set-up every seven days. 1. Review of Resident #4's care plan, revised on 04/03/23, showed the following: -The resident utilizes oxygen therapy; -The resident wishes to have no signs or symptoms of poor oxygen absorption or respiratory decline; -Give nebulizer treatments and oxygen therapy as ordered to maintain oxygen saturations (oxygen levels) between 91% and 95%. Review of the resident's Quarterly Review Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 04/20/23, showed the following: -Cognitively intact; -Diagnoses of asthma (a respiratory condition marked by spasms in the airways of the lungs, causing difficulty breathing), chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways and difficulty or discomfort in breathing) and respiratory failure (a condition that makes it difficult to breathe); (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Requires oxygen therapy. Review of the resident's Physician Order Summary (POS), dated July 2023, showed orders for the following: -Change oxygen and nebulizer tubing weekly, every night shift every Sunday, mark with date of change; -Oxygen (O2) at three liters by nasal cannula (NC, a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) to maintain oxygen saturations above 90% every day and night shift; -Ipratropium/Albuterol Solution (inhaled lung medications that help to open up the airways) 0.5/2.5 milligrams (mg) in 3 milliliters (ml), inhale 3 ml orally every six hours as needed for shortness of breath. Observation on 07/12/23 at 1:36 P.M. and 7/13/23 at 11:54 A.M. showed the following: -The resident sat in his/her wheelchair, awake, oxygen delivered via a NC at three liters (3L) from an oxygen concentrator (a medical device that delivers almost pure oxygen through the nasal cannula tubing), oxygen tubing was not labeled with date of application; -A humidification bubbler, supplying humidification to the oxygen concentrator, was not labeled; -A nebulizer mouth piece, T-piece (a connector for mouthpiece) and medication cup (which are designed to deliver medications via an inhalation method to the lungs) was attached to the tubing that was connected to a nebulizer machine (a small machine that turns liquid medication into a mist that can be easily inhaled). The nebulizer mouth piece and connector lay on the bedside table. A small amount of liquid was in the medication cup and condensation was seen in the T-piece connector. The tubing and connector were not labeled with the date of application and not in a plastic bag; -The plastic bag on the side of the concentrator was labeled 6/06/23 (33 days before the last documented tubing change); -The NC tubing the resident was wearing was labeled 6/26/23 (13 days before the last documented tubing change); -The NC tubing that was wrapped around an oxygen canister that was sitting on the wheelchair was labeled 3/19/23 (115 days before the last documented tubing change) and was not in a plastic bag. During an interview on 07/12/23 at 1:36 P.M., the resident said the following: -He/She last used the oxygen tank that was on the wheelchair during the weekend; -He/She always uses the oxygen tank on the back of the wheelchair when he/she takes a shower; -He/She has been receiving nebulizer treatments when needed for shortness of breath; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The staff does not rinse the mouth piece or medication cup and let them dry after medication administration; -The staff replaces the medication cup when it gets clogged up and does not work correctly. 2. Review of Resident #8's quarterly review MDS, dated [DATE], showed the following: -Diagnoses of asthma, COPD and respiratory failure; -Shortness of breath with exertion, when sitting at rest and when lying flat; -Requires oxygen therapy was left blank. Review of the resident's POS, dated July 2023, showed the following: -Change oxygen and nebulizer tubing weekly, every night shift every Sunday, mark with date of change; -Supplemental O2 at two liters by NC, to maintain oxygen saturations above 90% every day and night shift. Observation on 07/12/23 at 12:52 P.M. showed the following: -The resident sat in his/her wheelchair with oxygen delivered via a NC at 2L from an oxygen concentrator into oxygen tubing; -A humidification bubbler, supplying humidification to the oxygen concentrator, was not labeled; -The plastic bag on the side of the concentrator was labeled 6/06/23 (33 days before the last documented tubing change); -The NC tubing the resident was wearing was labeled 6/30/23 (9 days before the last documented tubing change). 3. Review of Resident #48's quarterly review MDS, dated [DATE], showed the following: -Diagnoses of asthma, COPD, and respiratory failure; -Shortness of breath with exertion, when sitting at rest and when lying flat; -Requires oxygen therapy. Review of the resident's POS, dated July 2023, showed the following: -Oxygen therapy - apply two to four liters of O2 by NC as needed to maintain oxygen saturations above 90% for shortness of breath; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ipratropium/Albuterol Solution 0.5/2.5 mg in 3 ml, inhale 3 ml orally four times a day for shortness of breath. -Ipratropium/Albuterol Solution 0.5/2.5 mg in 3 ml, inhale 3 ml orally every four hours as needed for shortness of breath. Observation on 07/12/23 at 1:22 P.M., showed the following: -The resident sat on his/her bed with oxygen delivered via a NC at 2L from an oxygen concentrator into oxygen tubing; -A humidification bubbler, supplying humidification to the oxygen concentrator, was not labeled. Observation of the resident on 07/18/23 at 11:36 A.M., showed the following: -The resident lay awake in his/her bed watching television; -A nebulizer mask (a mask that covers the mouth and nose and is held onto the face using an elastic band, used to deliver medications via an inhalation method to the lungs) was attached to tubing that was connected to a nebulizer machine (a small machine that turns liquid medication into a mist that can be easily inhaled). The nebulizer mask was sitting on top of the residents bedside table, uncovered and not placed in a storage bag. There was condensation seen in the nebulizer mask and a small amount of clear fluid in medication cup. During an interview on 07/18/23 at 11:36 A.M., the resident said he/she takes breathing treatments whenever he/she needs them for shortness of breath. He/She took a breathing treatment about one hour ago. The staff clean his/her breathing supply equipment when it needs it, not after every treatment, only when it needs it. During an interview on 07/13/23 at 1:13 P.M., LPN F said the following: -The Sunday night shift nurse was responsible for changing out the oxygen tubing, labeling it and labeling a new plastic bag for storage; -The nurse who replaces the humidification container is responsible for labeling it with the day it was changed; -After administering a breathing treatment, the mask or mouth piece is placed in a plastic bag; -He/She did not know the policy for procedure to clean the mask, mouth piece or medication cup after administering a breathing treatment; -The nurse would be responsible for rinsing the equipment after administering a breathing treatment. During an interview on 07/18/23 at 1:45 P.M., the assistant director of nursing (ADON) said the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She expected staff to clean the chamber and mouth piece of nebulizer equipment with soap, let them air dry and then store them in a baggie after each nebulizer treatment administration; -She expected staff to change and date oxygen tubing weekly on Sunday; -She expected staff to change and date a clean baggie weekly on Sunday for oxygen tubing to be placed when not in use; -She expected staff to label the humidification chamber when it is changed. During an interview on 07/18/23 at 2:07 P.M., the director of nursing (DON) said the following: -He knew there was a policy for cleaning the nebulizer equipment, but was not sure what the schedule is on cleaning and discarding or how often it should be performed; -When not in use the equipment should be stored in a baggie; -The nebulizer equipment should be dated; -He expected staff to follow the facility policy for cleaning the nebulizer equipment; -He would expect staff to follow the facility policies for the cleaning of the nebulizer equipment; -Oxygen tubing should be dated and stored in a baggie when not in use; -He was not sure of the policy of replacing the oxygen tubing or the humidification bubbler; -He did not know if the humidification bubbler should be dated.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, facility staff failed to assess residents for risk of entrapment from bed rails prior to installation and failed to maintain documentation to show sufficient information was provided to the resident or resident representative so they could provide informed consent for use of the bed rails for eleven residents (Resident #4, #10, #22, #67, #18, #32, #38, #44, #46, #48 and #66), in a review of 22 sampled residents, and for three additional residents (Residents #37, #63 and #226). The facility census was 76. Review of the Food and Drug Administration (FDA) document, Guide to Bed Safety, Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts, dated 12/11/17, showed the potential risk of bed rails may include: -Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress; -More serious injuries from falls when patients climb over rails; -Skin bruising, cuts, and scrapes; -Inducing agitated behavior when bed rails are used as a restraint; -Feeling isolated or unnecessarily restricted; -And preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. Record review of the facility's policy, Bed Safety and Bed Rails, revised August 2022, showed the following: -Policy Statement: Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup; -It is the policy of this facility to use enabler bars for increased ability and independence on all beds in the facility, with the exception the beds in the Alzheimer's unit. Enabler bars may only be used in the Alzheimer unit by resident or resident representative request after evaluation and resident-centered care planning. The facility will monitor the resident's status and adjust care, as necessary; -The use of any other bed rails is prohibited unless the criteria for use of bed rails have been met; -Policy Interpretation and Implementation: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use; 4. Bed dimensions are appropriate for the resident's size; 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the Food and Drug Administration (FDA); 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks; 7. The maintenance department provides a copy of inspections to the administrator and reports to the Quality Assurance and Performance Improvement (QAPI) committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee; 8. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications; 9. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); 10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.); 11. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment; -Use of Bed Rails: 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one quarter, or one eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed; 2. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted; 4. If attempted alternatives do not adequately met the resident's needs the resident may be evaluated for the use of bed rails; 5. The resident assessment to determine risk of entrapment; 6. The resident assessment also determines potential risks to the resident associated with the use of bed rails; 7. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent; 8. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the frame, side or bed rails, and mattresses. The administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act. 1. Review of Resident #4's care plan, dated 09/16/21, showed the following: -The resident is at a high risk for falls; -No documentation related to bed rail use or assessment. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 04/20/23, showed the following: -Cognitively intact; -Independent with bed mobility and transfers; -No functional limitation in range of motion (ROM) for upper and lower extremities; -Diagnoses of psychotic disorder other than schizophrenia (a mental disorder characterized by a disconnection from reality); -No bed rail use. Observation on 04/25/23 at 4:35 P.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails (attached to the bed to aid mobility) were attached on both sides of the resident's bed. Observation on 04/26/27 at 5:40 A.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached to both sides of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 2. Review of Resident #38's care plan, dated 02/17/21, showed the following: -The resident was a high risk for falls; -The resident had a diagnosis of Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors) and had mobility issues; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Requires extensive assistance of one person for bed mobility and transfer; -Diagnoses of cerebral vascular accident (CVA, stroke) and Parkinson's disease; -No bed rail use. Observation on 04/24/23 at 1:40 P.M. showed inverted U-shaped non-adjustable bed rails were attached on both sides of the resident's bed. Observation on 04/26/23 at 5:30 A.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 3. Review of Resident #44's care plan, dated 05/18/22, showed the following: -The resident was at risk for falls; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Requires extensive assistance of one person for bed mobility and transfers; -Impaired ROM for upper extremities; -Diagnoses of CVA and dementia; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No bed rail use. Observations on 04/24/23 at 1:40 P.M., 4/25/23 at 9:07 A.M. and 4:35 P.M., 4/26/23 at 5:30 A.M., and on 5/1/23 at 10:15 A.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 4. Review of Resident #48's care plan, dated 12/06/22, showed the following: -Resident was at risk for falls; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognition moderately impaired; -Requires extensive assistance of one person for bed mobility and transfers; -Diagnoses of CVA; -Has had one fall without injury in the look back period; -No bed rail use. Observations on 04/24/23 at 12:25 P.M., 4/25/23 at 4:30 P.M., 4/26/23 at 5:30 A.M., and 4/27/23 at 10:40 A.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 5. Review of Resident #63's care plan, dated 08/13/22, showed the following: -Resident was at high risk for falls; -Resident had a history of convulsions and was on a seizure medication; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Requires limited physical assistance of one staff for bed mobility and transfers; -Impaired ROM for upper and lower extremities; -Diagnoses of CVA, hemiplegia (paralysis of one side of the body), and seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain); -Has had one fall without injury in the look back period; -No bed rail use. Observations on 04/26/23 at 05:50 A.M. and on 5/1/23 at 9:45 A.M. showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the resident's bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 6. Review of Resident #66's care plan, dated 09/18/22, showed the following: -The resident was at high risk for falls related to impaired vision; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Totally dependent on two or more staff for bed mobility; -Required two or more staff for transfers; -Impaired ROM of upper extremities; -No bed rail use. Observations on 04/24/23 at 3:50 P.M., 4/25/23 at 9:45 A.M., 4/26/23 at 6:30 A.M., 4/27/23 at 10:00 A.M., and on 5/1/23 at 9:45 A.M., showed the resident lay in his/her bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 7. Review of Resident #37's face sheet showed the resident's diagnoses included unspecified dementia, restlessness and agitation, repeated falls, and weakness. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Unable to interview; -Independent with bed mobility and transfers; -No bed rail use. Review of the resident's care plan, revised 03/30/23, showed the following: -The resident has dementia with behavioral disturbances and delusional disorder; -The resident has potential risk for falls; -Review showed no documentation related to bed rails on the resident's bed. Observation on 04/24/23 at 12:45 P.M., showed the resident had assist bars (bed rails) on both sides of his/her bed. During an interview on 04/27/23 at 9:35 A.M., Licensed Practical Nurse (LPN) H said the resident used the assist bars for transfers and repositioning. During an interview on 04/27/23 at 9:35 A.M., LPN J said the resident used the assist bars for transfers and repositioning. During an interview on 04/27/23 at 8:50 A.M., the Director of Rehabilitation said she did not know the resident had assist bars on his/her bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 8. Review of Resident #46's face sheet showed the resident's diagnoses included unspecified Alzheimer's disease and dementia, unspecified abnormalities of gait and mobility, restlessness and agitation, and generalized muscle weakness. Review of the resident's care plan, revised 1/16/23, showed the following: -Depression, dementia with behavioral disturbances, and bipolar disorder; -The resident has potential risk for falls; -Review showed no documentation related to assist bars or bed rails on the resident's bed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Unable to interview; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required assistance from one staff for bed mobility; -Required extensive assistance from one staff with transfers. -No bed rail use. Observations on 04/24/23 at 1:40 P.M., 4/27/23 at 9:20 A.M., and on 5/1/23 at 11:45 A.M. showed the resident lay in his/her bed. The resident had assist bars on both sides of his/her bed. During an interview on 04/27/23 at 3:15 P.M., Certified Nurse Assistant (CNA) J said the resident used the assist bars to transfer out of his/her bed. During an interview on 04/27/23 at 9:35 A.M., LPN J said the resident used the assist bars for transfers and repositioning. During an interview on 04/27/23 at 8:50 A.M., the Director of Rehabilitation said she did not know the resident had assist bars on his/her bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 9. Review of Resident #226's face sheet showed the resident's diagnoses included neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function), unspecified dementia with agitation, and rapid eye movement (REM) sleep behavior disorder (a sleep disorder in which you physically act out your dreams unknowingly while you are asleep). Review of the resident's care plan, dated 4/10/23, showed the following: -Neurocognitive disorder with Lewy Bodies; -Unable to follow simple instructions; -Advanced dementia; -Monitor so resident is safe in his/her surroundings; -Review showed no documentation related to assist bars on the resident's bed. Observations on 04/24/23 at 1:10 P.M. and on 4/27/23 at 9:29 A.M., showed assist bars were attached on both sides of the resident's bed. During an interview on 04/27/23 at 3:15 P.M., CNA J said the resident used the assist bars to transfer out of his/her bed. During an interview on 04/27/23 at 9:35 A.M., LPN H said the resident used the assist bars for transfers and repositioning. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/27/23 at 8:50 A.M., the Director of Rehabilitation said she did not know the resident had assist bars on his/her bed. Review of the resident's medical record showed no documentation that staff obtained informed consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 10. Review of Resident #67's care plan, dated 11/23/22, showed the following: -The resident is at risk for falls; -The care plan did not address the use of bed rails for bed mobility and/or transfers. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severely impaired cognition; -Required set up help with staff assistance of one for transfers; -Two or more non-injury falls since last assessment; -Diagnoses of dementia; -Bed rails not used. Observation on 05/1/23 at 10:25 A.M. showed the resident lay in bed awake. Assist bars (bed rails) were attached on both sides of the resident's bed. The resident could not answer when asked how he/she used the assist bars. Review of the resident's medical record showed no documentation that staff obtained consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 11. Review of Resident #18's care plan, revised 09/18/22, showed the following: -The resident is unsteady on his/her feet and is at risk for falls due to history of falls; -No documentation regarding the use of bed rails. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Required extensive assistance of one staff for bed mobility; -Required extensive assistance of two or more staff for transfers; -Bed rails not used. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/1/23 at 10:22 A.M. showed the resident lay in bed with his/her eyes closed. Assist bars were attached on both sides of the resident's bed. Review of the resident's medical record showed no documentation that staff obtained consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 12. Review of Resident #22's care plan, revised 03/27/23, showed the following: -The resident is at risk for falls; -The resident is unable to turn and reposition himself/herself when he/she is in bed; -He/She needs extensive assistance with bed mobility; -The resident has seizures; -The resident may have alteration in his/her thought process related to dementia; -No documentation regarding the use of bed rails. Review of the resident's admission MDS, dated [DATE], showed the following: -Severely impaired cognition; -Diagnoses of stroke, dementia and seizure disorder; -Totally dependent on two or more staff for bed mobility and transfers; -Bed rails not used. Observation on 4/26/23 at 5:30 A.M. showed the resident lay in bed. Assist bars were attached on both sides of the resident's bed. Review of the resident's medical record showed no documentation that staff obtained consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 13. Review of Resident #10's face sheet showed the resident's diagnoses included cerebral infarction (stroke), muscle weakness, and repeated falls. Review of the resident's care plan, dated 11/16/18, showed the following: -Resident is at risk for falls; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Required extensive assistance from one staff for bed mobility; -Totally dependent on two staff to transfer; -Range of motion lower extremity impairment on both sides; -No bed rail use. Observation on 04/26/23 at 5:36 A.M. showed the resident lay in bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the resident's bed. Review of the resident's medical record showed no documentation that staff obtained consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. 14. Review of Resident #32's face sheet showed the resident's diagnoses included Alzheimer's disease, contracture of the left hand, unspecified lack of coordination, muscle weakness, other symptoms and signs involving cognitive functions and awareness, unspecified abnormalities of gait and mobility, unspecified dementia, and history of falling. Review of the resident's care plan, dated 10/23/18, showed the following: -He/She is at risk for falls; -He/She has impaired ADL and mobility performance; -He/She has a contracture to right leg; -No documentation related to bed rail use or assessment. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired cognition; -Total dependence of two staff for all activities of daily living (ADLs); -Lower extremity impairment on one side; -No bed rail use. Observations on 04/24/23 at 1:58 P.M. and on 4/25/23 at 10:45 A.M., showed the resident lay in bed. Inverted U-shaped non-adjustable bed rails were attached on both sides of the resident's bed. Review of the resident's medical record showed no documentation that staff obtained consent or assessed the bed rails prior to use. Review showed no documentation staff conducted regular inspections of the bed frame, mattress, and bed rails to identify possible areas of entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. During an interview on 04/26/23 at 1:05 P.M., LPN G said she did not know if staff completed assessments of the assist bars. During an interview on 04/27/23 at 2:55 P.M., LPN H said the following: -Therapy should assess a resident for the use of assist bars; -After finding a resident would benefit from an assist bar, the maintenance department would be notified to place the assist bar on the bed. During an interview on 4/27/23 at 11:35 A.M., the Maintenance Director said the following: -Nursing notifies him to place assist bars on a resident's bed; -Evaluating bed frames, mattresses, routine bed maintenance, and assessing for possible entrapment is an informal process at the facility; -He does not have, or use an entrapment tool to evaluate the residents' beds; -He does not use maintenance logs to document evaluation of bed frames, mattresses, routine bed maintenance, or assessment for entrapment. During an interview on 05/2/23 at 7:11 P.M., the Assistant Director of Nursing (ADON) said the following: -The assist bars on the residents' beds were called an enabler bar and were not bed rails; -She thought the enabler bar (assist bar) was not considered a bed rail and did not require resident use assessments or entrapment assessments; -The facility had not performed entrapment assessments due to not realizing these were considered bed rails; -She expected someone from the facility to review the risks and benefits of the bed rails with the resident and their family; -The staff should get informed consent from the resident or family for the use of a bed rail. During interviews on 04/27/23 at 10:49 A.M. and 05/2/23 at 8:15 P.M., the Administrator said the following: -She expected staff to review the risks and benefits of bed rails with the resident, or responsible party; -She expected facility staff to get an informed signed consent from the resident, or responsible party for use of the bed rails; -She did not think the assist bars were under the same guidance as bed rails; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She and staff were unable to find documentation to show staff assessed the use of the assist bars or obtained consent for the use of the assist bars. 44610 45563 47246

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36219 Based on interview and record review, the facility failed to provide a Registered Nurse (RN) eight consecutive hours a day, seven days a week. The facility census was 76. Review of the facility policy Nursing Department Supervision, revised August 2022, the following: -A licensed nurse is on duty twenty-four hours per day, seven days per week, to provide resident care services and supervise the nursing services activities provided by unlicensed staff. A licensed nurse is designated as a charge nurse on each shift. 1. Review of the RN/Licensed Practical Nurse (LPN)/Certified Medication Technician (CMT) schedule dated 10/1/22 through 10/31/22 showed no RN coverage on 10/1/22, 10/2/22, 10/8/22, 10/9/22, 10/15/22, 10/16/22, 10/22/22, 10/23/22, 10/29/22, 10/30/22. Review of the RN/LPN/CMT schedule dated 11/1/22 through 11/30/22 showed no RN coverage on 11/5/22, 11/12/22, 11/19/22, 11/26/22 and 11/27/22. Review of the RN/LPN/CMT schedule dated 12/1/22 through 12/31/22 showed no RN coverage on 12/10/22, 12/11/22, 12/17/22, 12/18/22, 12/24/22, 12/25/22, and 12/31/22. Review of the RN/LPN/CMT schedule dated 1/1/23 through 1/31/23 showed no RN coverage on 1/1/23, 1/7/23, 1/8/23, 1/14/23, 1/15/23, 1/21/23, 1/22/23, 1/28/23 and 1/29/23. Review of the RN/LPN/CMT scheduled dated 2/1/23 through 2/28/23 showed no RN coverage on 2/18/23, 2/19/23, 2/25/23 and 2/26/23. Review of the RN/LPN/CMT schedule dated 3/1/23 through 3/31/23 showed no RN coverage on 3/4/23, 3/5/23, 3/11/23, 3/12/23, 3/18/23, 3/19/23, 3/25/23 and 3/26/23. Review of the RN/LPN/CMT schedule dated 4/1/23 through 4/27/23 showed no RN coverage on 4/9/23, 4/15/23 and 4/16/23. During interview on 06/09/23 at 11:02 A.M., the Administrator said the following: -She was aware the facility was required to have eight consecutive hours of RN coverage seven days a week; -She, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) are all responsible for making the nursing schedule and are aware of the regulation and expectation; -The facility only employees three RNs (the DON, one day shift RN supervisor and one part time RN that works every other weekend); (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility utilizes agency staff, but no RN coverage had been available to staff to meet the regulation.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36219 Based on interview and record review, the facility failed to complete a performance review of each nurse aide at least once every 12 months and provide regular in-service education based upon the outcome of the reviews. The facility census was 76. Review of the facility policy Nurse Aide In-Service Training, revised August 2022, showed the following: -The facility completes a performance review of nurse aides at least every 12 months; -In-service training is based on the outcome of the annual performance reviews. 1. Record review showed no documentation of nurse aide evaluations/competencies or annual performance reviews. During an interview on 5/2/23 at 7:05 P.M., the Assistant Director of Nursing (ADON) said she had not done any nurse aide evaluations/competencies or annual performance reviews. During an interview on 5/1/23 at 10:30 A.M., the administrator said the facility did not have nurse aide evaluations/competencies/annual performance reviews.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36219 Based on observation, interview, and record review, the facility failed to post required nurse staffing information, which included the facility name, resident census, and total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis. The facility census was 76. Review of the facility policy Posting Direct Care Daily Staffing Numbers, revised August 2022, showed the following: -The facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents; -Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format; -Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the name of the facility, current date, resident census at the beginning of the shift for which the information is posted, type and category of nursing staff working during that shift, actual time worked for each category and type of nursing staff, total number of licensed and non-licensed nursing staff working for the posted shift; -Within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. 1. Observation on 4/24/23 at 2:44 P.M., showed no posted nurse staffing information in the facility, including the facility name, resident census, and total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. Observation on 4/25/23 at 10:03 A.M., showed no posted nurse staffing information in the facility, including the facility name, resident census, and total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. Observation on 4/26/23 at 8:05 A.M., showed no posted nurse staffing information in the facility, including the facility name, resident census, and total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. Observation on 4/27/23 at 2:14 P.M., showed no posted nurse staffing information in the facility, including the facility name, resident census, and total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 4/27/23 at 9:00 A.M., Licensed Practical Nurse (LPN) B said the only staffing sheet at the nurses' station was the monthly schedule. During an interview on 5/1/23 at 10:30 A.M., the Administrator said the Director of Nursing (DON) was responsible for posting staffing information. She would expect staffing information to be posted daily.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 36219 Based on interview and record review, the facility failed to ensure timely physician response regarding pharmacist recommendations for two residents (Resident #33 and Resident #67), in a review of 22 sampled residents. The facility census was 76. Review of the facility policy Pharmacy Services-Role of the Consultant Pharmacist, revised 4/2019, showed the consultant pharmacist will provide specific activities related to medication regimen. These included appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medication and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated. 1. Review of Resident #33's Physician Orders, dated April 2023, showed an order for Novolog (short-acting insulin) injection 100 units/milliliter (ml) inject subcutaneously (under the skin) three times daily as directed per sliding scale: 201-250= 2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, greater than 400=10 units notify physician; hold pre-meal insulin if blood sugar is less than 70 or poor appetite start date 10/11/21. Review of the resident's Consultant Pharmacist Communication to Physician, dated 6/23/22, showed the following: -This resident has a routine order for sliding scale insulin. To better stabilize glucose control, and to reduce the need for this additional coverage, may he/she suggest the following: Continued or long-term use of sliding scale insulin for non-emergency use is not recommended due to the increased risk of hypoglycemia (low blood sugar). Please review and assess the risks versus benefits of the continued use of sliding scale insulin therapy and, consider discontinuing this order; -NOTE: Or, document below or in a progress note the need for continued therapy; -Physician response to recommendation finding: Please check one of the following: -No documentation of a physician response. 2. Review of Resident #67's April 2023 physician's order showed an order for Pantoprazole (medication used to treat reflux) 40 mg by mouth daily, start date 10/27/22. Review of the resident's Pharmacist Recommendation to the Physician, dated 3/16/23, showed the following: -Resident has order for Pantoprazole 40 mg by mouth daily. Recommend decrease Pantoprazole to 20 mg by mouth daily; -Physician response to recommendation finding: Please check one of the following: -No documentation of a physician response. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/23 at 7:05 P.M., the Assistant Director of Nursing said she would expect the physician to respond to pharmacist requests and provide a rationale if he/she disagrees with the pharmacist's request.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36219 44610 Based on observation, interview and record review, the facility failed to ensure gradual dose reductions (GDRs; the stepwise tapering of a medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose of medication can be discontinued) were attempted, or the physician documented the rationale for not attempting a GDR on antipsychotic medications (medications that affects brain activities associated with mental processes and behavior) for three residents (Residents #25, #33 and #61) in a review of 22 sampled residents. The facility census was 76. 1. Review of Resident #25's physician's orders showed an order forFluoxetinee (antidepressant) 40 milligrams (mg) by mouth daily, start date 5/28/19. Review of the resident's care plan, dated 10/17/22, showed the resident has alteration in his/her thought processes due to periods of confusion. Review of the resident's Consultant Pharmacist Communication to Physician, dated 1/23/2023, showed the following: -Antidepressant gradual dose reduction attempt Fluoxetine 40 mg by mouth daily; -All agents falling within the psychoactive category (without regard to indication), fall under gradual dose reduction guidelines. This includes agents within the antidepressant category. Please address the appropriate response below: -An attempted GDR is likely to result in impairment of function or increase distressed behavior-marked by the resident's physician; -Physician response to recommendation finding: Please check one of the following: -OTHER: marked by the resident's physician: (Please write a brief statement below concerning the rationale for your response to this recommendation.) No changes. Signed by the resident's physician 3/24/23; -No documentation from the resident's physician regarding the rationale for declining the GDR request. 2. Review of Resident #33's physician's orders, dated 6/17/21, showed an order for citalopram (antidepressant) 20 mg by mouth daily. Review of the resident's Consultant Pharmacist Communication to Physician, dated 5/18/22, showed 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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Antidepressant gradual dose reduction attempt - citalopram 20 mg by mouth daily; -All agents falling within the psychoactive category (without regard to indication) fall under gradual dose reduction guidelines. This includes agents within the antidepressant category. Please address the appropriate response below: -An attempted GDR is likely to result in impairment of function or increase distressed behavior-marked by the resident's physician; -Physician response to recommendation finding: Please check one of the following: -OTHER: blank: (Please write a brief statement below concerning the rationale for your response to this recommendation.) Blank. Signed by the resident's physician 10/21/22; -No documentation regarding the rationale for declining the GDR request. Review of the resident's care plan, dated 10/10/22, showed the following: -Monitor and report to charge nurse increased signs/symptoms of depression such as poor appetite, sleeping too much, tearful or agitation; -Monitor for side effects or adverse reactions such as: rigid muscles, shaking, frequent falls, decreased appetite, difficulty swallowing, self isolation, blurred vision, nausea/vomiting, weight loss, muscle cramps or behaviors that is not usual for the resident. Report to charge nurse/physician; -No direction regarding GDRs. 3. Review of Resident #61's Consultant Pharmacist Communication to Physician report, dated 3/16/23, showed the pharmacy consultant documented a Gradual Dose Reduction (GDR) recommendation to the physician, for psychotropic agents regarding quetiapine 100 mg. The facility did not provide documentation of a physician response to the pharmacist recommendations for the resident. Review of the resident's care plan, dated 3/27/23, showed the following: -Diagnosis of unspecified dementia and major depressive disorder; -Pharmacist consultant to monitor antipsychotic drugs to ensure medications are not used in excessive doses or for excessive duration. Review of the resident's April, 2023 Physician Order Sheet (POS) showed the following: -Diagnoses included dementia in other diseases classified elsewhere with behavioral disturbance, depressive disorder, and anxiety disorder; -Quetiapine (Seroquel, an antipsychotic that can treat schizophrenia, bipolar disorder, and depression), take one 100 mg tab by mouth at bedtime, original order dated 12/1/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/23 at 7:11 P.M., the Assistant Director of Nurses (ADON) said the following: -The Minimum Data Set (MDS) Coordinator was responsible for the Medication Regimen Reviews (MRR); -The Director of Nursing (DON) was responsible for making sure the GDR recommendations are done. During an interview on 5/11/23 at 2:30 P.M., the Nurse Practitioner said the following: -He and the physician receive the pharmacist recommendations by mail; -He and the physician review the recommendations and either agree to changes or disagree then sign them.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 36219 Based on observation, interview and record review the facility failed to administer insulin pens according to manufacturers' recommendations to ensure staff administered the prescribed insulin dose for one resident (Resident #33) in a review of 22 sampled residents and one additional resident (Resident #7). The facility census was 76. Review of the facility policy Administering Medication, revised April 2019, showed the following: -Medications are administered in a safe and timely manner as prescribed; -The facility policy did not provide specific directions regarding the use of insulin pens. Review of the Levemir Injection Flexpen package instructions for use, dated 12/2022, showed the following: -Before every injection a small amount of air may collect in the cartridge during normal use. To avoid injection air and to ensure proper dosing: -Turn the dose selector to select 2 units; -Hold the Levemir Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards, press the green push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. Review of the Humalog KwikPen package instructions for use, revised April 2020, showed the following: -Prime before each injection; -Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly; -If you do not prime before each injection, you may get too much or too little insulin; -To prime your pen, turn the dose knob to select 2 units; - Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top; -Continue holding your pen with needle pointing up. Push the dose knob until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #33's face sheet showed he/she had a diagnosis of diabetes. Review of the resident's April 2023 physician's orders showed the following: -Blood glucose point of care testing four times daily before meals and at bedtime; -Levemir insulin (long-acting) inject 35 units subcutaneously daily. Observation on 4/26/23 at 5:41 A.M., in the common area showed Certified Medication Technician (CMT) C: -Placed a needle on the Levemir pen; -Dialed the pen to 35 units; -Injected the 35 units of Levemir into the back of the resident's right arm; -Did not prime the insulin pen prior to administering the insulin. 2. Review of Resident #7's face sheet showed he/she had a diagnosis of diabetes. Review of the resident's April 2023 physician's orders showed the following: -Accu-checks three times daily with sliding scale insulin; -Humalog KwikPen 100 units/ml inject three times daily as directed per sliding scale insulin. 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, below 70 or above 400 notify doctor. Observation on 4/26/23 at 5:55 A.M., in the resident's room showed CMT C: -Placed a needle on the Humalog pen; -Dialed the pen to 6 units; -Injected the 6 units of Humalog into the resident's right lower abdomen; -Did not prime the insulin pen prior to administering the insulin. During an interview on 4/26/23 at 6:24 A.M., CMT C said the following: -He/She does not prime the insulin pens before giving insulin; -Insulin pens do not have to be primed; -Priming an insulin pen messes it up. During interview on 5/2/23 at 7:05 P.M., the Assistant Director of Nursing (ADON) said insulin pens should be primed before administration of insulin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 44610 Based on observation, interview, and record review, the facility failed to remove and destroy outdated medications, failed to remove and destroy expired stock medications (over-the-counter medications used for more than one resident), and medications belonging to discharged residents. The facility census was 76. 1. Observation in the medication room at the Memory Unit nurses station on 4/26/23 at 2:45 P.M., showed the following: -[NAME] RCI Nebulizer hoses, expiration date 1/24/23, total of seven, No resident name; -Myrbetiq 50 mg (milligrams), expiration date 10/20/23, seven count/one punched, no name and no date punched; -Erythromycin 5mg/gm (milligrams per gram) ointment eye-had been used, expiration date 5/22, labeled for Resident #58; -Assure Dose Solution, expiration date 12/31/19; -T-Drain Sponges, expiration date 2022; -New Sponge, expiration date 2019; -Cotton tipped applicators, six inch 100 pack box, expiration date 9/2020; -Sani Cloth bleach germicidal disposable wipe, 40/Box, expiration date 2/2021; -Ipratropium bromide and albuterol sulfate, opened with no resident name, expiration date May, 2016. Observation on 4/26/23 at 2:45 P.M., showed the following medications located in the corner of the medication room in a locked cabinet (and belonged to Resident #350, who no longer resided at the facility); -Levothyroxine 50 mcg (microgram) tablet, expiration date 7/16/17, quantity 30; -Atorvastatin 80 mg tablets, expiration date 6/2317, quantity 30; -Glimepiride 2 mg tablets, quantity 60, expiration date 6/27/17; -Effient 5 mg tablets, quantity 30, expiration date 7/6/16; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Carvedilol 3.125 mg tablets, quantity 30, expiration date 7/14/17; -Nasacort allergy 24 hr (hour), 0.57 fluid ounce (oz), Lot 6H017NA, expiration date 12/20/17; -PreserVision-Eye vitamin and mineral supplement soft gels, quantity 120, expiration date 11/2017; -Softclix lancets 100, quantity 200, expiration 6/2/17. Observation on 4/26/23 at 2:45 P.M., showed the following medications located in the corner of the medication room in a locked cabinet and belonged to current Resident #27. These medications came with him/her from another facility on, 3/6/22 (stored to be destroyed); -Hydroxyzine HCL 10 mg, expiration date 3/1/23, 30 count/1 punched; -Cefdinir 300 mg capsule, expiration date 11/17/22, 10 count/2 punched; -Hydroxyzine HCL 10 mg, expiration 2/23/23, 30 count/4 punched; -Diltiazem 24H ER (CD), expiration date 2/25/23, 16 count/2 punched; -Ondansetron HCL 4 mg tablet, expiration date 5/8/22, 10 count/0 punched; -Metformin HCL 500 mg tablet, expiration date 2/7/22, 30 count/0 punched; -Metformin HCL 500 mg tablet, expiration date 2/7/22, 30 count/18 punched; -Pantoprazole SOD DR 40 tablet, expiration date 2/6/22, 30 count/22 punched; -Clopidogrel 75 mg tablet, expiration date 1/29/23, 30 count/27 punched; -Tamsulosin HCL 0.4 mg capsule, expiration date 2/5/22, 30 count/14 punched; -Oxybutynin CL ER 5 mg tablet, expiration date 3/2/22, 30 count/1 punched; -Oxybutynin CL ER 5 mg tablet, expiration date 2/5/22, 30 count/15 punched; -Rosuvastatin calcium 20 mg, expiration date 1/30/23, 30 count/19 punched; -Donepezil HCL 10 mg tablet, expiration date 1/28/22, 30 count/26 punched; -Fluoxetine HCL 10 mg capsule, expiration date 1/28/23, 30 count/27 punched; -Allopurinal 100 mg tablet, expiration date 2/21/22, 30 count/10 punched; -Mirtazapine 7.5 mg tablet, expiration date 1/30/23, 30 count/7. During an interview on 4/26/23 2:45 P.M., Licensed Practical Nurse (LPN) G said the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Facility nurses are to check for expired medications daily; -For disposition of medications, two licensed nurses must be present; -The two nurses reconcile medications, destroy, and fill out the Disposition of Medication Sheet located at back of the narcotics book. Each nurse must sign this sheet; -As the two nurses count, the medication is placed/poured into Drug Buster (a drug disposal system used for pill disposal). 2. Observation of the medication cart at the nurse station in the Memory Unit, on 4/27/23 at 1:38 P.M., showed the following: -Skin-Prep lot 01780, expiration date 10/2022, total of 29 packets; -Albuterol sulfate inhalation aerosol PRN (as needed), expiration date 1/31/23, no name. During an interview on 4/27/23 at 1:38 P.M., LPN H said the following: -Facility nurses are to check for expired medications each shift; -The contracted pharmacy Tech Nurse checks for expired medications on weekends. During an interview on 5/2/23 at 7:11 P.M., the Assistant Director of Nurses (ADON) said the following: -Each charge nurse is responsible for disposing of expired medications every shift; -There should be no stock medications in the medication rooms. Each resident should have their own medications; -She expected the charge nurses to inspect medication room cabinets and refrigerators for expired medications; -The contracted pharmacy provides a tech nurse that comes to the facility on weekends to review for expired medications. 45563 47246

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38016 Based on observation, interview, and record review, the facility failed to follow the menu for residents on a pureed diet by not preparing pureed food by the recipe and by not serving the appropriate serving sizes as directed by the spreadsheet menu. The facility census was 73. Review of the facility policy Kitchen Weights and Measures, revised April 2007, showed the following: -Food services staff will be trained in proper use of cooking and serving measurements to maintain portion control; -Cooks and food services staff will be trained in weights and measures, volume and weights, appropriate utensil use, and food can sizes; -Staff will be trained in the comparison of volume and weight measures (e.g., 2 cups (volume) water 1 pound (weight), 1 ounce (oz) weight, 1 oz. volume, etc.); -Staff will be trained in size conversion of food cans to improve accurate measurements. Can size tables will be prominently posted for reference; -Recipes will specify consistent use of metric or U.S. measurement guidelines; -Serving utensils used will be consistent with choice of metric or U.S. measure used; -Staff will be trained in the appropriate measurement and type of serving utensil to use for each food; -The food service supervisor will ensure cooks prepare the appropriate amount of food for the number of servings required. Review of the recipe for Salisbury Steak with Mushrooms, showed ingredients including eggs, bread crumbs, garlic powder, ground black pepper, ground beef, flour, vegetable oil, water, ketchup, Worcestershire sauce, beef base, diced yellow onion, and mushrooms. Portion size is #8 dip (4 ounces). Review of the recipe for Pureed Salisbury Steak, showed the following: -Dissolve beef base and water to make broth; -Place prepared meat in a sanitized food processor; -Gradually add broth as needed, and blend until smooth; -Reheat to greater than 165 degrees Fahrenheit (F) for at least 15 seconds; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintain at 135 degrees F or better; -Portion size after pureed is #8 dip. Review of the recipe for Vegetable Medley directed to cook until vegetables are fork tender. Drain vegetables leaving enough liquid to retain heat, add margarine and salt. Maintain at 135 degrees F. Serving size is 4 ounce spoodle (serving spoon and a ladle). Review of the recipe for Pureed Garden Blend Vegetables directed to place prepared vegetables and margarine in a clean and sanitized food processor, blend until smooth. Reheat to greater than 165 degrees for at least 15 seconds and maintain at 135 degrees F. Serving size #12 dip. Review of the recipe for Mashed Sweet Potatoes, showed to heat sweet potatoes in their own juice until heated through, then drain. Place potatoes and remaining ingredients (salt, nutmeg, milk, margarine, and brown sugar) in a large mixing bowl. Whip on high speed until light and creamy. Reheat to 165 degrees F for at least 15 seconds, then maintain at 135 degrees F. The portion size is #8 dip. During the observation of the kitchen on 07/12/23, the above recipes were not available for review and per [NAME] K's interview, recipes were locked up in the Dietary Manager's office. The Dietary Manager later provided copies of the above menus to the state agency when they were requested. Observation in the kitchen on 07/12/23, from 11:35 A.M.-11:59 A.M., showed the following: -Cook K picked up a black scoop (this scoop was 6 oz.) with his/her gloved hands and put three scoops, that were not full, of mixed vegetables into the food processor, to prepare three servings; -Cook K went to the refrigerator with the same gloves on and grabbed a carton of milk; -Cook K, with the same gloves, poured unmeasured milk into the food processor; -Cook K turned the food processor on, then poured the pureed mixed vegetables into a metal pan and placed the the pan in the oven; -Cook K did not follow the pureed garden blend vegetable recipe; no margarine was added and the recipe did not call for milk to be added; -Cook K put on oven mitts over his/her gloves and picked up a metal pan with sweet potatoes; -Cook K picked up a blue scoop (2.375 oz) with the same gloved hands and put three scoops of sweet potatoes into the food processor to prepare three servings; -Cook K used his/her gloved finger to wipe the edge of the food processor to move sweet potatoes into the food processor that were on the edge of the food processor with same the same gloves; -The food processor had soap bubbles on the lid of the food processor; -Cook K poured unmeasured milk into the food processor; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cook K put pureed sweet potatoes into a metal container and placed it into the oven; -Cook K did not follow the mashed sweet potato recipe; salt, nutmeg, milk, margarine, and brown sugar were not added to the sweet potatoes and the recipe did not call for milk to be added. Observation on 07/12/23, at 12:20 P.M., showed the following: -Three carts were loaded with pans of food including Salisbury steak, sweet potatoes, mixed vegetables, and blueberry crumble, in the kitchen to take to the three facility dining rooms; -Cook L put one black perforated spoodle, one black dip, and tongs onto the first cart going to the Gardens dining room; -Cook L put one black dip, a black handled slotted spoon and a pair of tongs on the second cart going to the East dining room; -Cook L put one gray perforated spoodle, one dark blue scoop, and a pair of tongs onto the third cart going to the [NAME] dining room. -The serving spoons sent to each unit were different sizes. Observation of the [NAME] dining room on 07/12/23, at 12:41 P.M., showed the following: -Domestic Service Aide (DSA) O plated the residents' meal; -DSA O used a dark blue scoop (2 oz.) to serve sweet potatoes (the recipe instructed for a #8 dip to be used which is 4 oz) and a light gray (3.75 oz.) perforated spoodle to serve the mixed vegetables (the recipe instructed for a 4 oz spoodle to be used); Observation and interview on 07/12/23, at 1:05 P.M., showed Dietary Aide (DA) P said the following: -He/She took each scoop used and read the sizes as follows: -The serving utensil in the vegetables was 8 ounces (the recipe called for a 4 oz serving), the scoop for the sweet potatoes was 2 ounces (the recipe called for a #8 dip serving which is 4 oz) and the one in the mechanical soft Salisbury steak, also used in the pureed Salisbury steak, was 3 ounces (the recipe called for a #8 dip serving, 4 oz); -There was no information to tell staff how many ounces to serve, so staff just made it an average size portion; he/she was not aware the recipes included the portion sizes and scoops to use; -Staff did not serve the correct portions at meal service. Observation on 07/12/23, at 1:15 P.M., showed the following: -Staff finished plating the last tray in the [NAME] Dining Room; -A test tray was obtained; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The mechanical soft Salisbury steak was bland and did not have the same flavor as the regular Salisbury steak; -The mixed vegetables were bland and mushy in texture. During an interview on 7/12/23, at 12:10 P.M. and 1:45 P.M., [NAME] K said the following: -He/She has not used recipes, he/she was not sure where they were, probably locked in the Dietary Managers office; -He/She does not know what the menu spreadsheet was; -He/She was not aware of anything that provided serving sizes; -He/She made the pureed Salisbury steak with plain ground beef and beef gravy; -He/She did not use the prepared Salisbury steak; -He/She pureed the vegetables and sweet potatoes with milk; -He/She was trained to use milk if needed to thin down any puree that did not have gravy; -He/She did not know there were pureed recipes; -Vegetables get mushy in the steam table if held too long. During an interview on 07/12/23, at 1:47 P.M., [NAME] L said the following: -There was menu spreadsheets available, and staff do not use the recipes unless it is something they have not cooked before; -Staff are expected to serve a 4 ounce portion of meat, and a 3 ounce portion of vegetables as far as he/she knew; -Cook K was present during the interview and in agreement. During an interview on 07/13/23, at 10:17 A.M., the Dietary Manager said the following; -Pureed vegetables are expected to be pureed with something to maintain taste like the broth off the vegetables and margarine; -Pureed Salisbury steak should be pureed with the prepared meat, not plain ground beef and gravy; -Staff are expected to use recipes, and if not available they can call to get them; -The kitchen does not have enough serving spoons; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The residents are not currently getting the correct portion sizes, since the facility started serving from three dining rooms, after the last survey (not sure exact date); -Utensils have been ordered but have not arrived; -She was not sure when she ordered the utensils or when they will arrive; -Staff are expected to look at the recipe or menu for correct serving sizes and use the correct size utensil to serve the food; -Staff are expected to use the menu from the dietary company for portion sizes; -She was off yesterday and did not leave them out. During an interview on 7/12/23, at 2:05 P.M., the Registered Dietitian said the following: -There are some recipes on the door to the dietary manager's office, but they did not contain the recipes for today; -The menu spreadsheets must be locked in the Dietary Manager's office. During an interview on 7/12/23, at 3:12 P.M., the Administrator said she expects staff to use recipes to prepare and cook food items and review menu spreadsheets, prepared by the Registered Dietitian, for serving sizes.

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Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44610 Based on observation, interview, and record review, the facility failed to ensure food was palatable and served at an appetizing temperature. The facility census was 76. Review of the facility policy, Food Preparation and Service, dated November 2022, showed the following: -Proper hot and cold temperatures are maintained during food distribution and service; -The temperature of foods held in steam tables are monitored throughout the meal service by food and nutrition services staff. 1. During interview on 4/24/23 at 3:25 P.M., Resident #2 said the food is terrible. During interview on 4/25/23 at 10:03 A.M., Resident #18 said the following: -His/her biscuits and gravy were cold; -The gravy was too greasy; -His/her fried eggs were cold and hard. 2. Review of the menu for the supper meal on 4/25/23 showed staff were to serve mushroom ravioli and roasted zucchini. Observation on 4/25/23 at 4:35 P.M., showed dietary staff took the temperature of the food items on the steamtable prior to the meal service. The temperature of the mushroom ravioli was 191 degrees Fahrenheit (F). Staff took the temperature of two pans of zucchini. The temperature of the zucchini in one pan was 158 degrees F and the other was 151 degrees F. Observation on 4/25/23 at 4:42 P.M., showed dietary staff started serving the meal from the steamtable in the kitchen. Staff covered the plates with an insulated plate cover and placed the trays in enclosed metal carts. Observation on 4/25/23 at 5:13 P.M., showed staff prepared the last meal tray from the steamtable. Dietary Staff U took the covered cart containing the last of the meal trays, including the test tray, to the [NAME] hall. Two certified nurse assistants (CNAs) began serving trays from the cart. They took one tray at a time from the cart to the residents' rooms. At 5:42 P.M., staff said some of the trays left on the cart were for residents who required assistance; staff have to feed these residents so it may take awhile since the staff are feeding other residents. Observation on 4/25/23 at 5:47 P.M., showed three residents' meal trays remained on the cart. Observation of the test tray showed the temperature of the mushroom ravioli was 104 degrees F and the temperature of the zucchini was 100 degrees F. Both food items were cool to taste. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/2623 at 9:50 A.M., the Dietary Supervisor said the following: -The temperature of the food has always been a concern; -The facility has a plate warmer. She expected staff to use the plate warmer but the plates get so hot that staff have to wear gloves when handling the plates, so they do not use it; -When the meal trays go to the halls on the carts, they sit for quite awhile waiting for nursing staff to serve them; -She would like nursing to notify her if they need help serving so dietary staff could assist if needed; -She expected the temperature of food to be 150 degrees F at the time of service.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44610 Based on observation, interview, and record review, the facility failed to ensure sanitary practices in the kitchen. The facility failed to ensure all areas of the kitchen were clean and in good repair; failed to ensure staff washed their hands and changed their gloves to prevent the potential for contamination; and failed to ensure staff wore hair nets and beard restraints when in the kitchen and preparing food. The facility census was 76. Review of the facility policy, Sanitation, dated November 2022, showed all kitchen areas are to be kept clean, free from garbage and debris, and protected from rodents and insects. Review of the facility policy, Preventing Food borne Illness - Employee Hygiene and Sanitary Practices, dated November 2022, showed the following: -Employees must wash their hands: -After personal body functions; -After using tobacco, eating or drinking; -Whenever entering or re-entering the kitchen; -Before coming in contact with any food surfaces; -After handling raw meat, poultry, fish and when switching between working with raw food and working with ready-to-eat food; -After handling soiled equipment and utensils; -During food preparation, as often as necessary to remove soiled and contamination and to prevent cross contamination when changing tasks; -After engaging in other activities that contaminate hands.; -The use of disposable gloves does not substitute for proper handwashing; -Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. 1. Observation on 4/25/23 at 10:35 A.M., showed the Dietary Supervisor wore gloves. She turned on the range by turning the knob with her gloved hand, obtained a package of brown sugar and opened it with a pair of scissors. She poured brown sugar from the bag into a steamtable pan and then spread out the brown sugar in the pan with her gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 4/25/23 at 11:21 A.M., showed Dietary Aide Q opened the kitchen door, and entered the kitchen wearing gloves and carrying a cardboard box of frozen carrots. He/She opened the box and used his/her gloved hands to pick up carrots from the box and put them in a pan. Observation on 4/25/23 at 11:25 A.M., showed the Dietary Supervisor wore gloves and opened the door to the steamer. Without removing her gloves, she placed her gloved hands in a bowl of cut green onion and sprinkled the green onions over the meat in the steamtable pan. Observation on 4/25/23 at 11:30 A.M., showed Dietary Aide Q prepared ice cream shakes in the food processor. He/She wore gloves and obtained a container of ice cream from the freezer. He/She scooped ice cream from the container and placed it into the food processor. He/She touched the ice cream with his/her gloved hands with each scoop. He/She removed his/her gloves, turned on the water in the three-compartment sink and rinsed the blender. He/She turned off the water and then put on gloves without washing his/her hands. He/She moved the trash can by grabbing it with his/her gloved hand and then obtained a stack of plates from the plate warmer for the meal service. Observation on 4/25/23 at 11:45 A.M., showed Dietary Aide R wore gloves. He/She put on oven mitts and removed a pan of rolls from the oven. He/She removed the oven mitts and then touched the rolls with his/her gloved hands. He/She said the rolls were not done yet. He/She put on the oven mitts, and put the pan of rolls back in the oven. Wearing the same gloves, he/she removed the pan of rolls from the oven, removed the mitts and then touched the rolls with his/her gloved hands. He/She then placed individual rolls onto the residents' meal trays with his/her gloved hand. He/She opened the warmer and obtained a pan of pasta, touched the pasta with his/her gloved hand, moved a covered cart and then proceeded to place rolls onto meal trays with his/her gloved hands. He/She also placed scoops of carrots onto the meal trays and touched the carrots with his/her gloved hand. Observation on 4/25/23 at 12:00 P.M., showed Dietary Aide S put on oven mitts over his/her gloves and removed a pan of carrots from the oven. He/She removed the oven mitts and did not remove his/her gloves. He/She opened the refrigerator doors and obtained cheese slices wrapped in plastic wrap. Wearing the same gloves, he/she obtained a slice of cheese from the package with his/her gloved hand, and then handled a frozen hamburger patty and placed it on the griddle. He/She wrapped up the remaining cheese slices in the plastic wrap, opened the refrigerator door and placed the cheese inside. Wearing the same gloves, he/she obtained a bun from a package and placed it on a plate. Observation on 4/25/23 at 4:32 P.M., showed Dietary Aide Q wore gloves. He/She opened the refrigerator door with his/her gloved hands, obtained two hamburger patties from a bag with his/her gloved hands and placed the patties on the griddle. Observation on 4/25/23 at 4:42 P.M., showed Dietary Aide T performed the following: -He/She wore gloves and grilled a cheeseburger on the griddle; -He/She removed his/her right glove and answered the phone; -He/She entered the dry food storage room and obtained a can of cream soup, opened three of the refrigerator doors, and then removed his/her left glove; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/She placed the burgers on the griddle, opened the can of cream soup with the can opener, placed soup in a pan, opened a container of milk and added it to the pot with the soup; -He/She did not wash his/her hands and then put on gloves; -He/She removed a bun from the package and put the cheeseburger on the bun for a resident; -He/She removed his/her gloves and left the kitchen; -He/She returned to the kitchen, did not wash his/her hands, and put on gloves; -He/She opened the refrigerator and obtained two eggs; -He/She cracked the eggs onto the griddle and held the broken shells in his/her gloved hands prior to throwing them away; -He/She placed meal tickets and plates on the plate warmer in the meal line, grabbed the scoop from the pan of ravioli and prepared plates for residents; -He/She removed his/her right glove and placed a burger on a plate and put it in the warmer and then removed his/her left glove; -Without washing his/her hands, he/she put on new gloves and sprinkled seasoning with his/her gloved hand onto the eggs as they cooked. Observation on 4/25/23 at 5:05 P.M., showed the Dietary Supervisor answered the phone in the kitchen. Without washing his/her hands, she put on gloves, opened the refrigerator door and obtained a salad mix. He/She placed his/her gloved hand into the salad mix and placed the lettuce salad into four bowls. 2. Observation on 4/25/23 at 11:15 A.M., showed Dietary Aide Q prepared pureed rice in the food processor. Dietary Aide Q had facial hair and did not wear a beard restraint. Observation on 4/25/23 at 11:30 A.M., showed Dietary Aide Q prepared ice cream shakes for residents in the food processor. Dietary Aide Q had facial hair and did not wear a beard restraint. Observation on 4/25/23 at 11:37 A.M., showed Dietary Aide Q served rice during the meal service from the steam table. Dietary Aide Q did not wear a beard restraint. Observation on 4/25/23 at 4:30 P.M., showed Dietary Aide T made grilled cheese sandwiches on the griddle. Dietary Aide T had facial hair and did not wear a beard restraint. Observation on 4/25/23 at 4:31 P.M., showed Dietary Aide U was in the kitchen during the meal preparation. He/She did not wear a hair restraint. Observation on 4/25/23 at 4:32 P.M., showed Dietary Aide Q prepared pureed break in the food processor. Dietary Aide Q did not wear a beard restraint. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 4/25/23 at 4:42 P.M., during the meal service, showed the following: -Dietary Aide Q placed breadsticks and scoops of zucchini on resident plates. Dietary Aide Q did not wear a beard restraint; -Dietary Aide U covered the residents' plates with plate covers and loaded them onto a covered cart. He/She did not wear a hair restraint to cover his/her hair; -Dietary Aide T prepared cheeseburgers for residents. Dietary Aide T did not wear a beard restraint. 3. Observations on 4/25/23 between 10:20 A.M. and 4:45 P.M., showed the following: -A buildup of grease and debris on the rangehood baffle filters and on other metal surfaces under the rangehood; -The metal backsplash behind the range and deep fat fryer was soiled with grease and debris; -A piece of wood (similar to a yard stick) was suspended from the ceiling and hung horizontally directly over the steam table. The wood and the strings used to suspend the piece of wood were heavily soiled with debris and a heavy buildup of loose dusty debris; -The cove base in the dishwashing area was pulled away from the wall and lay on the floor. A heavy buildup of black, mold-like substance was visible on the cove base and on the wall under the dishwashing counter; -The flooring under the dishwashing counter was heavily soiled with a thick buildup of black debris, dead bugs, and trash; -The piping and dishwashing components under the dishwashing sink were heavily soiled with debris; -The drain pipe for the three-compartment sink was leaking. A pan was placed under the pipe to catch the water. Water was on the floor around the pan and towel lay on the floor around the pan; -The counter under the wire drying rack on the three-compartment sink was soiled with dried and loose debris. A knife, a scoop, and a pan were drying on the wire rack; -The knobs on the range were soiled with a buildup of debris. Observations on 4/25/23 at 10:21 A.M. and 4:10 P.M., showed a scoop was stored in the bulk flour bin. The scoop handle was in direct contact with the flour. The flour bin was located on the preparation counter where staff prepared the pureed food items. The exterior surfaces of the flour bin and the lid were visibly soiled with dried food debris. 4. Observation on 4/25/23 at 10:15 A.M., showed three ceiling tiles in the dry food storage area were not in the ceiling tile metal grid in the dry food storage room. Two ceiling tiles were water stained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 4/25/23 at 10:30 A.M., showed the ceiling light cover located by the steamtable and range was soiled with dusty debris. Observation on 4/25/23 at 10:59 A.M., showed three ceiling tiles and two light fixtures by the three-compartment sink and the preparation counter were soiled with a buildup of dusty debris. Observation on 4/25/23 at 12:55 P.M., showed six water damaged or physically damaged (cracked) ceiling tiles in the dishwashing area. Observation on 4/25/23 at 3:45 A.M., showed two water damaged ceiling tiles over the drying rack for the three-compartment sink and stand mixer. Observation on 4/25/23 at 4:00 P.M., showed a ceiling tile was out of the grid and another ceiling tile was water damaged and sagging in the ceiling above the refrigerator. The ceiling tiles and the vent in the ceiling near the refrigerators were soiled with dusty debris. 5. During interview on 4/26/23 at 9:50 A.M., the Dietary Supervisor said the following: -Staff are to mop the floor in the dishwashing area daily; -She had not addressed cleaning the wall under the dishwashing area with dietary staff; -She leaves a cleaning list for staff, however, the cleaning does not always get done. The majority of the cleaning should be completed on the weekends; -Cleaning of the ceiling tiles and vents was never addressed with her to tell her this was part of her responsibility; -Staff clean the rangehood filters in the dishwasher once every three weeks. A company professionally cleans the rangehood every 90 days; -The last deep cleaning in the kitchen was completed in September 2022. At that time, staff wiped down the walls and the backsplash; -The dietician hasn't said anything about staff needing to wear beard restraints. She wasn't aware this was an issue. She would expect staff to wear hair restraints when in the kitchen; -Staff should wash their hands when they return to the kitchen and before putting on gloves. During interview on 5/1/21 at 11:56 P.M., the maintenance supervisor said he was unaware if maintenance would be responsible for maintaining the ceilings in the kitchen. Maintenance was primarily responsible for making repairs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview and record review, the facility failed to ensure staff changed gloves and washed hands as indicated during the provision of care for one resident (Resident #33), in a review of 22 sampled residents, and also failed to ensure infection control measures were appropriately followed when staff failed to utilize protective barriers and properly sanitize the glucometer (a device used to evaluate blood glucose levels) in between use and after becoming soiled for four residents (Residents #7, #33, #401 and #59). Additionally, the facility failed to ensure proper infection control was utilized for respiratory care supplies for one resident (Resident #68). The facility census was 76. Review of the undated facility policy, Handwashing and Hand Antisepsis Guidelines, showed the following: -When hands are visibly dirty or contaminated or potentially contaminated or are visibly soiled with blood or other body fluids, wash hands with an antimicrobial soap and water; -If hands are not visibly soiled, use an alcohol-based hand rub or an antimicrobial soap and water for routinely decontaminating hands in all other clinical situations described below: -Before having direct contact with residents; -Handwashing is indicated anytime there is contact with body fluids or excretions, mucous membranes, non intact skin, wound dressing, or moving from a contaminated body site to a clean body site, during resident care; -After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident; -Before and after removing gloves or moving from a contaminated body site to a clean body site, during resident care. Review of the facility policy, Infection Control for the ChemStick (Accucheck) (finger stick procedure where a droplet of blood is obtained for testing the sugar in the blood) Procedure, dated 8/2007, showed the following: -Wash hands; -Apply gloves; -Insert strip in chemstick machine and set on paper towel (on bedside table); -Wipe finger with alcohol swab-allow to air dry; -Stick finger with lancet and place lancet in sharps container; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Apply drop of blood-wait 10 seconds for results; -Dispose of strip, alcohol swab and lancet in sharps container; -Lay chemstick machine on paper towels; -Remove gloves; -Wash hands; -Apply gloves; -Clean chemstick machine with alcohol swab-hold and allow to air dry. Review of the facility policy, Continuous Positive Airway Pressure (CPAP) (a machine that uses mild air pressure to keep breathing airways open while you sleep) /Bi-Level Positive Airway Pressure (BiPAP) (non-invasive ventilator that helps with breathing) Support, revised March 2015, showed the policy did not direct staff regarding storage of CPAP/BiPAP supplies when not in use. Review of the manufacturer's cleaning and disinfecting directions for the Assure Platinum Blood Glucose Meter, revised 08/2015, showed the following: -The meter should be cleaned and disinfected after use on each patient; -The following disinfectant wipes were approved for cleaning purposes: -Clorox Professional Products Company: Clorox Healthcare Bleach Germicidal Wipes, Dispatch Hospital -Cleaner Disinfectant Towels with Bleach; -Professional Disposables International: Super Sani-Cloth Germicidal Disposable Wipes; -Metrex: CaviWipes; -Two options are available for cleaning and disinfecting the Assure Platinum meter; -Option One: Cleaning: -Wear appropriate protective gear such as disposable gloves; -Obtain a commercially available EPA registered disinfectant detergent or germicide wipe; -Open the towelette container and pull out one towelette and close the lid; -Wipe the entire surface of the meter three times horizontally and three times vertically using one towelette to clean blood and other body fluids; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Option Two: Disinfecting (the meter should be cleaned prior to disinfecting) -Wear appropriate protective gear such as disposable gloves; -Open the towelette container and pull out one towelette and close the lid; -Wipe the entire surface of the meter three times horizontally and three times vertically to remove blood-borne pathogens; -Dispose of the used towelette in a trash bin; -Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth; -Drying time requirement: -Clorox Germicidal Wipes: one minute; -Dispatch Hospital Cleaner Disinfectant Towels with Bleach: one minute; -Super Sani-Cloth Germicidal Disposable Wipe: two minutes; -CaviWipes: two minutes. 1. Review of Resident #401's April 2023 physician orders showed the following: -He/She had a diagnosis of diabetes; -An order for Accu-checks four times a day. Observation on 04/26/23 at 5:38 A.M., in the resident's room showed the following: -The resident lay awake in bed; -Certified Medication Technician (CMT) C entered the resident's room; -He/She donned gloves without washing his/her hands with soap and water or sanitizing; -With gloved hands, CMT C placed the glucometer on the resident's over the bed table without using a barrier; -CMT C cleaned the resident's right index finger with alcohol, pricked his/her finger with a lancet and obtained a drop of blood; -CMT C placed the drop of blood on the strip in the glucometer; -CMT C left the resident's room, removed his/her gloves (did not wash or sanitize his/her hands) and sat the glucometer on the top of the medication cart without a barrier; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CMT C pulled the strip out with his/her bare hands; -CMT C sanitized his/her hands (did not wash with soap and water); -CMT C did not sanitize the glucometer. 2. Review of Resident #33's April 2023 physician's orders showed the following: -He/She had a diagnosis of diabetes; -An order for Accu-checks four times daily before meals and at bedtime. Observation on 04/26/23 at 5:41 A.M., in the common area showed the following: -The resident sat in his/her wheelchair; -CMT C donned gloves without washing his/her hands with soap and water or sanitizing; -CMT C cleaned the resident's left index finger with alcohol, pricked his/her finger with a lancet and obtained a drop of blood; -CMT C placed the drop of blood on the strip in the glucometer; -With gloved hands, CMT C removed the strip from the glucometer; -CMT C did not sanitize the glucometer and did not wash hands with soap and water or sanitize hands after the removal of his/her gloves. 3. Review of Resident #7's April 2023 physician's orders showed the following: -He/She had a diagnosis of diabetes; -An order for Accu-checks four times a day. Observation on 04/26/23 at 5:55 A.M., in the resident's room showed the following: -The resident sat on the side of his/her bed; -CMT C entered the resident's room; -CMT C placed the glucometer on the resident's over the bed table without using a barrier; -He/She donned gloves without washing his/her hands with soap and water or sanitizing; -CMT C cleaned the resident's left index finger with alcohol, pricked his/her finger with a lancet and obtained a drop of blood; -CMT C placed the drop of blood on the strip in the glucometer; (continued on next page)

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	265108	A. Building B. Wing	05/02/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-With the same gloved hands, CMT C administered the resident's morning medications; -CMT C picked up the glucometer, left the room and sat the glucometer on top of the medication cart without a barrier; -CMT C did not sanitize the glucometer and did not wash hands with soap and water or sanitize hands after the removal of his/her gloves. 4. Review of Resident #59's April 2023 physician's orders showed the following: -He/She had a diagnosis of diabetes; -An order for Accu-check daily. Observation on 04/26/23 at 6:16 A.M., in the resident's room showed the following: -The resident sat in his/her wheelchair; -A sticky substance was present on the resident's over the bed table; -CMT C placed the glucometer on the resident's over the bed table without using a barrier; -He/She donned gloves without washing his/her hands with soap and water or sanitizing; -CMT C cleaned the resident's right index finger with alcohol, pricked his/her finger with a lancet and obtained a drop of blood; -CMT C placed the drop of blood on the strip in the glucometer; -CMT C picked up the glucometer, left the room and sat the glucometer on top of the medication cart without a barrier; -CMT C removed his/her gloves and sanitized his/her hands (did not wash with soap and water); -CMT C placed the glucometer in the top drawer of the medication cart; -CMT C did not sanitize the glucometer. During an interview on 04/26/23 at 6:24 A.M., CMT C said the following: -He/She did not sanitize the glucometer between residents and after use; -There are two glucometers for the hall; -He/She cleaned both glucometers with alcohol earlier in his/her shift (night shift); -Alcohol works just as well as bleach to clean the glucometers; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There are bleach sani-wipes available for use. During an interview on 04/26/23 at 12:00 P.M., the Assistant Director of Nursing (ADON) said the following: -The residents did not have individual glucose monitors; -The facility used the Assure Platinum Glucose Monitor for all residents, there is one glucometer on each of the five medication carts; -The facility staff used a bleach wipe on the glucometer after each use, allowed it to dry on a clean paper towel for at least five minutes before they were used again; -She would expect nursing staff to clean the glucometers after each use on a resident and before using it again. 5. Review of Resident #33's care plan, revised 3/22/23, showed the resident has impaired activities of daily living (ADL) and mobility performance. Two staff members need to be in room at all times when providing care. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/29/23, showed the following: -Severely impaired cognition; -Totally dependent on two or more staff for toilet use and personal hygiene; -Always incontinent of urine and feces. Observation on 04/26/23 at 8:14 A.M., in the resident's room showed the following: -Certified Nurse Aide (CNA) D and CNA E transferred the resident from his/her wheelchair to the bed by use of mechanical lift; -The resident was incontinent of urine and feces; -With gloved hands, CNA D provided front pericare; -Without changing gloves or washing his/her hands, CNA D touched the cloth lift sling, the clean incontinence brief and tucked the clean brief under the resident's hips; -With the same gloved hands, CNA D assisted CNA E to roll the resident to his/her back; -With the same gloved hands, CNA D provided rectal pericare; -CNA D changed gloves and without washing his/her hands applied clean gloves. During an interview on 05/29/23 at 8:03 P.M., CNA D said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She should wash his/her hands after changing gloves; -He/She washes his/her hands all the time during cares. 6. Review of Resident #68's admission MDS, dated [DATE], showed: -He/She was cognitively intact; -BIPAP/CPAP use while a resident. Review of the resident's care plan, revised 3/28/23, showed the following: -Dementia with alteration in thought process; -Assist as needed; -No documentation related to CPAP machine. Review of the resident's face sheet, dated 4/26/23, showed the resident's diagnoses included: -Alzheimer's Disease; -Obstructive Sleep Apnea; -Other Disorders of Lung. Observation on 04/24/23 at 12:35 P.M., showed the following: -The resident's CPAP machine sat on his/her bedside table; -The CPAP mask, with the face side down, was uncovered and on the bedside table. Observations on 04/25/23 at 8:44 A.M. and 1:10 P.M., showed the CPAP mask, with the face side down, was uncovered and on the unmade bed. Observation on 04/26/23 at 12:45 P.M., showed the CPAP mask, with the face side down, was uncovered and on the bedside table. Observation on 04/27/23 at 9:22 A.M., showed the CPAP mask, with the face side down, was uncovered and sat in a plastic container on the bedside table. Observation on 05/01/23 at 12:00 P.M., showed the CPAP mask, with the face side down, was uncovered and sat in a plastic container on the bedside table. Observation on 05/02/23 at 10:22 A.M., showed the CPAP mask, with the face side down, was uncovered and sat on the bedside table. During an interview on 04/26/23 at 6:32 A.M., CNA I said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The CPAP is used each night by the resident; -The CPAP machine's care and storage is the responsibility of the licensed nurse staff. During an interview on 04/27/23 at 3:15 P.M., CNA J said the following: -A CPAP mask should be covered in a bag to keep it clean; -Licensed nurses are responsible for the care and storage of CPAP machines. During an interview on 04/26/23 at 1:05 P.M., Licensed Practical Nurse (LPN) G said a CPAP mask should be covered in a bag when not in use. During an interview on 04/27/23 at 2:55 P.M., LPN H said the following: -Licensed nurses are responsible for the care and storage of CPAP machines; -A CPAP mask should be covered in a bag when not in use. During an interview on 05/2/23 at 7:11 P.M., the Assistant Director of Nurses (ADON) said the following: -CNA's and licensed nurses are responsible for the infection control, care and storage of CPAP machines; -A CPAP mask should be covered in a bag if not in use. MO215462 44610 45563 47246

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44610 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when staff failed to report roaches when first identified in the kitchen which delayed treatment, and failed to ensure effective measures were implemented to ensure the potential source was eliminated. The facility census was 76. Review of the facility's policy, Pest Control, dated May 2008, showed the following: -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents; -Garbage and trash are not permitted to accumulate and are removed from the facility daily; -Maintenance services assist, when appropriate and necessary, in providing pest control services. Review of the facility policy, Sanitation, dated November 2022, showed all kitchen areas are to be kept clean, free from garbage and debris, and protected from rodents and insects. Review of the pest control company service inspection invoice, dated 4/24/23, showed the pest control company treated the interior of the facility and placed bait stations. Phorid flies and German roaches were in the kitchen where there was a water issue. (Review of previous service inspection invoices dated 4/4/23 and 3/27/23 showed no evidence the pest control company treated the facility for roaches.) Observation on 4/25/23 at 10:12 A.M., showed five roaches crawled along the floor in the dishwashing area. Staff were in the area washing dishes at this time. Observation on 4/25/23 at 11:20 A.M., showed a roach crawled out of the dishwashing area and under a cart in the kitchen near the steam table and preparation counter. Observation on 4/25/23 at 4:03 P.M., showed a small roach crawled on the floor under the food carts in the kitchen area. During an interview on 4/26/23 at 9:50 A.M., the Dietary Supervisor said she noticed little roaches in the kitchen about three weeks ago when the facility got a new garbage disposal. The facility was trying to get rid of the roaches the best they could. Staff do not leave out food and keep beverages covered. Observation on 4/26/23 at 9:55 A.M., showed a small roach crawled along the floor in the Dietary Supervisor's office (located across the kitchen from the dishwashing area). Observation on 4/26/23 at 10:28 A.M., showed the following (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The cove base in the dishwashing area was pulled away from the wall and lay on the floor. A heavy buildup of black, mold-like substance was visible on the cove base and on the wall under the dishwashing counter. A fan sat on the floor under the dishwashing counter and was not turned on; -The flooring under the dishwashing counter was heavily soiled with a thick buildup of black debris, dead roaches (whole bugs and pieces of bugs), and trash. During an interview on 4/26/23 at 10:30 A.M., Dishwasher V said he/she saw two or three roaches this morning and killed them. He/She started seeing the roaches about the time they fixed the garbage disposal. During interview on 4/26/23 at 2:05 P.M., the Administrator said the pest control company was at the facility on 4/24/23 and sprayed for bugs in the kitchen. The facility pulled back the cove base in the dishwashing area and put a fan on it. She believed the Dietary Supervisor called her on 4/20/23 or 4/21/23 to tell her staff saw bugs in the kitchen. During an interview on 4/26/23 at 2:30 P.M., the Dietary Supervisor and Dishwasher V said the following: -The garbage disposal was replaced approximately three weeks ago (verified install date was 3/17/23); -The facility had issues with water after the garbage disposal was replaced, such as standing water when the pipes came undone and needed repaired; -Dishwasher V first saw roaches in the kitchen approximately two to two and a half weeks ago. He/She did not tell anyone about the roaches since he/she only saw a roach every once in a while. He/She would step on them when he/she saw them; -The Dietary Supervisor said someone from nursing had made a comment about cockroaches in the kitchen, so they conducted deep cleaning in areas of the kitchen. She didn't think it was too bad of an issue since they only saw a roach here and there, until last week when she told the Administrator; -The facility still has standing water in the kitchen and have to shop vac the area almost every night. During an interview on 5/1/23 at 11:56 A.M., the maintenance supervisor said the pest control company had been to the facility for the roaches. They said the problem was related to the moisture in the kitchen from when the garbage disposal was replaced. The pest control company requested the facility remove the cove base and put a fan on it to dry it out. Staff needed to turn on the fan at night so the fan was constantly blowing to dry out the area. He fixed the leaky pipes the week prior but was not aware of any current leaks. If staff identify leaks, they should report this to him. The pest control company sprayed in the kitchen last Tuesday. He was unsure if the pest control company had been back to the facility again.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to ensure nurse aides received the required 12 hours of in-service education annually. The facility census was 76. Review of the facility policy Nurse Aide In-Service Training, revised August 2022, showed the following: -All personnel are required to participate in regular in-service education; -Annual in-services to ensure the competency of nurse aides are due no less than 12 hours per employment year and should address the special needs of the residents, as determined by the facility assessment. 1. Review of the facility assessment, last reviewed 12/1/22, showed the following: -The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new or existing staff; - Training needs included wound education for the wound nurse and specialized Alzheimer's disease training for all staff; -All licensed nursing staff should have regular training pertinent to their area of practice; -Skills, knowledge or abilities needed by each department's staff left blank; -No documentation regarding required in-service training for nurse aides. During an interview on 5/2/23 at 7:05 P.M., the (Assistant Director of Nursing) ADON said she hasn't been a part of the nurse aide training. During an interview on 5/1/23 at 10:30 A.M., the Administrator said the facility only has records of staff who attend in-services. They would have to go through the individual inservice sign-in sheets to see if CNA staff have completed the 12 hours of training required annually. No one tracked or monitored to ensure CNA staff receive the annual training as required. The previous Director of Nurses left the faciity on [DATE], hasn't returned to the facility and hasn't returned messages or phone calls.