| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265469 | A. Building<br>B. Wing | 05/20/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Levering Regional Health Care Center | 1734 Market Street<br>Hannibal, MO 63401 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>30813<br><br>Refer to Event ID QJHT12.<br><br>This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 3/24/21.<br><br>Based on interview and record review, the facility failed to protect one resident (Resident #140), in a review of 33 sampled residents, from physical abuse when Hall Monitor NN hit the resident in the eye resulting in a black eye. The facility also failed to protect the same resident from physical abuse when Hall Monitor LL pushed the resident resulting in the resident hitting the wall and falling to the floor. The facility census was 165.<br><br>Review of the facility's policy, Abuse, Neglect, Grievance Procedures, dated 11/28/16 and last reviewed 8/28/18, showed the following:<br><br>-It is the policy of this facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion;<br><br>-Mistreatment, neglect, or abuse of residents is prohibited by this facility;<br><br>-This facility is committed to protecting residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals;<br><br>-Physical abuse was defined as purposefully beating, striking, wounding, or injuring any consumer or any manner whatsoever mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management.<br><br>Review of the facility's Crisis Alleviations Lessons and Methods (CALM; self-protection techniques) workbook, revised 2021, showed the following:<br><br>-Remain calm: easier said than done, however, encouraging deep purposeful breaths in the face of danger will keep oxygen flowing to the brain. This will keep you calm and better prepare you for follow through on the third and fourth key points;<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Have a plan: Review in your head the plan you would like to execute. Execute the technique quickly and purposefully;<br><br>-Use teamwork: working in cooperation with fell ow staff members is a critical factor required to maintain safety, share your thoughts and strategies with your co-workers as a crisis evolves;<br><br>-Defining injury protection: These are two basic ways a staff person can get injured in a crisis. Getting struck by something and getting grabbed by someone. Protective techniques, block and move.<br><br>1. Review of Resident #140's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument to be completed by facility staff, dated 4/12/21, showed the following:<br><br>-Sometimes understands others;<br><br>-Moderately impaired cognition;<br><br>-No behaviors;<br><br>-Inattention present and fluctuated;<br><br>-Diagnoses included traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head) and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event);<br><br>-Required supervision for bed mobility, ambulation and transfers.<br><br>Review of the resident's care plan, dated 1/27/20 and last revised 5/18/21, showed the following:<br><br>-The resident had a behavior problem related to pervasive developmental disorder (a disorder characterized by delays in the development of socialization and communication skills), mood disorder, personality disorder and traumatic brain injury. Had a history of impulsiveness and verbal/physical aggression;<br><br>-When the resident becomes agitated, intervene before agitation escalates. Guide away from source of distress, and engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later. Per PASRR (Preadmission Screening and Resident Review), the resident has history of temper tantrums, over-excitability, poor sense of social boundaries and short and long-term memory impairment.<br><br>Review of the facility's Registered Nurse (RN) Investigation Report, Investigative Narrative Note, dated 5/16/21, showed on 5/15/21, the resident was verbally and physically aggressive toward staff. It was reported that Hall Monitor LL pushed the resident into the wall resulting in the resident sliding down to his/her bottom.<br><br>Review of Hall Monitor LL's written statement, dated 5/15/21, showed the following:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -He/She was walking down the hall and heard the resident yelling at him/her aggressively. Certified Nurse Assistant (CNA) E attempted to talk to the resident and was hit in the face with a water bottle thrown by the resident. CNA E called a code green. CNA SS responded to the code and tried to talk with the resident, and the resident hit CNA SS with a chair;<br><br>-Hall Monitor LL felt he/she could take a hit better than the other staff so he/she stepped in-between the resident and the other staff. As he/she did, the resident swung at Hall Monitor LL. Hall Monitor LL reacted instinctively and with no ill intent, put distance between he/she and the resident with a push, and the resident landed on his/her bottom on the floor.<br><br>During interview on 5/25/21 at 12:56 P.M., Hall Monitor LL said the resident threw a chair at one staff and threw a water bottle at another staff, so he/she stepped in. The resident hit him/her in the face with his/her hand. Hall Monitor LL instinctively put his/her hands up on the resident's chest and pushed trying to put distance between him/her and the resident. Hall Monitor LL said he/she did not push the resident hard. He/She pushed the resident back to the wall and the resident slid down to the floor. Hall Monitor LL knew it was wrong and did not push the resident with ill intent. He/She had CALM training and was taught to defend himself/herself and try to keep distance between himself/herself and the resident.<br><br>During interview on 5/19/21 at 10:37 A.M., the resident said Hall Monitor LL pushed him/her against the wall.<br><br>During interview on 5/19/21 at 3:47 P.M., Licensed Practical Nurse (LPN)/Resident Care Coordinator (RCC) A said staff called a code green. He/She did not see what happened, but the resident was on the floor when he/she got there. Staff reported Hall Monitor LL pushed the resident, and the resident slid down the wall. He/She said the resident told him/her Hall Monitor LL pushed him/her. Hall Monitor LL said he/she was just trying to defend himself/herself and keep the resident away from everyone.<br><br>During interview on 5/21/21 at 7:27 A.M., CNA QQ said the resident was in the dining room yelling and cursing at staff. Hall Monitor LL pushed the resident and the resident hit the wall with his/her back and head, then slid to the floor.<br><br>During interview on 5/21/21 at 7:45 A.M., CNA RR said Hall Monitor LL shoved the resident up against the wall and the resident dropped to the floor.<br><br>During interview on 5/21/21 at 8:02 A.M., CNA SS said he/she responded to a code green for the resident. He/She was talking to the resident. As he/she turned to go into the hallway, the resident threw a chair at him/her. He/She heard a nurse say, take him/her down, and then he/she heard a smack on the wall and saw the resident on the floor with Hall Monitor LL beside him/her. He/She was not present in the dining room when the incident happened. He/She said the resident said Hall Monitor LL put his/her hands on him/her and shoved him/her against the wall.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During interview on 5/26/21 at 1:48 P.M., the administrator said Hall Monitor LL pushing the resident was considered abuse. Staff receive CALM training upon hire to teach them how to handle residents with aggressive behaviors such as how to talk to residents, therapeutic boundaries and therapeutic communications, and removing oneself from a situation. Hall Monitor LL should have removed himself/herself from the situation if he/she was the target. Hall Monitor LL should have gotten assistance from other staff to diffuse the situation. She would have expected Hall Monitor LL to not touch the resident.<br><br>Review of the resident's nurses notes, dated 5/18/21 at 11:50 P.M., showed staff received a report that a staff member entered the resident's room and then came out. The resident complained of his/her eye hurting and stated the staff member hit him/her.<br><br>Review of the resident's care plan showed an update, dated 5/18/21. A staff member entered the resident's room then came out. The resident complained of his/her eye hurting and stated a staff member hit him/her. The charge nurse was alerted and assessed the resident. Ice applied to the resident's eye. Primary care physician contacted with order to send to hospital for evaluation and treatment. Diagnosis of contusion (bruise) to his/her eye.<br><br>Review of the facility's RN Investigation Report, Investigative Narrative Note, dated 5/19/21, showed it was reported that on 5/18/21, the resident punched LPN MM as LPN MM was trying to check on him/her after the resident was having increased anxiety. As the door opened, the resident punched LPN MM and broke his/her nose. Sometime later, Hall Monitor NN came down to the resident's room and per Resident #140, while he/she was asleep, Hall Monitor NN hit him/her in the eye. CNA OO stated he/she saw the resident come out of his/her room after Hall Monitor NN left the unit with his/her head down. CNA OO asked the resident what was wrong and the resident said Hall Monitor NN hit him/her. The area to the resident's face continued to swell and resident was sent to the hospital for evaluation. The resident returned with a contusion to his/her face.<br><br>During interview on 5/19/21 at 10:37 A.M., the resident said he/she was lying in bed and two guys came in and one hit him/her in the eye. He/She said LPN MM's family member (Hall Monitor NN) hit him/her in the eye.<br><br>During interview on 5/20/21 at 3: 23 P.M., CNA OO said he/she was one-on-one with the resident (after the code green was called on the resident on 5/18/21). The resident was getting sleepy. He/She told the resident to lay down, so the resident went to bed. He/She sat across the hall facing the resident's door. Hall Monitor NN and Hall Monitor PP walked onto the unit and went into the resident's room (a private room). He/She heard Hall Monitor NN say, If you hit my mother (LPN MM) again, I'm a beat your ass. He/She said Hall Monitor NN and Hall Monitor PP left the resident's room. CNA OO went into the resident's room. The resident had his/her head down and said his/her eye hurt. The resident said someone hit him/her.<br><br>During interview on 5/19/21 at 9:22 A.M., the administrator said LPN MM went to the resident's room, opened his/her door and the resident hit him/her in the nose. The resident was placed on one-on-one. Hall Monitor NN went to the resident's room to talk to the resident, and the resident said Hall Monitor NN hit him/her in his/her right eye. The facility immediately suspended Hall Monitor NN pending investigation and ultimately terminated him/her. Hall Monitor NN hitting the resident was considered abuse.<br><br>(continued on next page) |

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| F 0600<br>Level of Harm - Actual harm<br>Residents Affected - Few | MO185495<br>MO185444 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>30813<br><br>Refer to Event ID QJHT12.<br><br>Based on interview and record review, the facility failed to report all alleged violations involving abuse to the state survey agency immediately, but no later than two hours after the allegation was made, for three residents (Residents #33, #130, and #140), in a review of 33 sampled residents. The facility census was 167.<br><br>Review of the facility policy, Abuse and Neglect, last reviewed 7/2020, showed the following:<br><br>-Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, to define terms of abuse/neglect and misappropriation of funds and property, and to ensure that a due process for appeals to the accused is outline. To ensure immediate reporting of all abuse allegations to the Administrator or designee and the Director of Nursing (DON) or designee and outside persons or agencies. To establish actions related to the alleged perpetrator (AP) and to ensure investigation and assessment of all residents involved is completed;<br><br>-Employees are required immediately to report any occurrences of potential mistreatment including alleged violations, mistreatment, neglect, abuse, sexual assault, and injuries of unknown source and misappropriation of resident property they observe, hear about, or suspect to a supervisor or the Administrator. Anonymous reports will also be thoroughly investigated;<br><br>-It is the responsibility of our staff, facility consultants, attending physicians, family members, and visitors, etc. to promptly report any incident or suspected incident of abuse/neglect/misappropriation of funds to facility management immediately. If such incidents occur after hours the Administrator of designee and DON or designee will be notified at home or by cell phone and informed of any such incident;<br><br>-The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment, or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency) in accordance with State law through established procedures.<br><br>1. Review of Resident #33's nurse's note, dated 5/4/21 at 12:14 P.M., showed staff received report in regards to this resident. Immediate staff intervention and separation from peers. Resident states inappropriate behavior with medications. The resident states he/she got this from another resident. A room search was completed with a needle found. A head to toe assessment was completed with pin point marks found to bilateral inner arms. The primary physician was notified and consent given for a urine drug screen. The sample was obtained and sent to the lab.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's urine drug screen results, dated 5/4/21, showed the resident was positive for methamphetamine and cannabis.<br><br>Review of the resident's Physician Order Sheet (POS) for May 2021 showed he/she did not have orders for any medications that contained methamphetamine or cannabis.<br><br>Review of Resident #130's nurse's note, dated 5/4/21 at 2:45 P.M., showed the following:<br><br>-There was a report by a peer regarding this resident;<br><br>-The resident stated inappropriate behavior with medications;<br><br>-The resident refused to say where the medications came from;<br><br>-The physician gave orders for a urine drug screen which was obtained and sent to the lab;<br><br>-Consent was obtained to conduct a room search.<br><br>Review of the results of the resident's urine drug screen, dated 5/4/21, showed the resident was positive for methamphetamine.<br><br>Review of the resident's POS for May 2021 showed he/she did not have orders for any medications that contained methamphetamine.<br><br>During an interview on 5/17/21 at 5:02 P.M. Resident #118 said he/she heard from Resident #68 who was told by Resident #33 that three staff, Licensed Practical Nurse (LPN) F, Transportation Staff II, and Hall Monitor LL, brought drugs into the facility for residents. The resident told LPN JJ about what he/she heard.<br><br>During an interview on 5/17/21 at 5:12 P.M., Resident #68 (Resident #33's roommate) said he/she had heard some staff brought drugs into the facility. The resident would not provide any names of staff or who told him/her about the issue. The resident said he/she talked to LPN JJ and Certified Nurse Assistant (CNA) KK about what he/she had heard.<br><br>During an interview on 5/20/21 at 10:48 A.M., CNA KK said on 5/17/21, Resident #68 told him/her LPN F, Transportation Staff II, and Hall Monitor LL had brought drugs into the facility for residents. Resident #68 approached CNA KK again later and said LPN V's name was also mentioned as a staff member who brought drugs into the facility for residents. CNA KK told the administrator what Resident #68 reported about the staff.<br><br>During an interview on 5/20/21 at 10:52 A.M., LPN JJ said Resident #118 and Resident #68 came to him/her on 5/17/21 and said Resident #33 told Resident #68 (his/her roommate) that he/she got illegal drugs from staff members LPN F, hall monitor LL, and Transportation Staff II. LPN JJ immediately reported this to Resident Care Coordinator (RCC) A, who directed LPN JJ to call the administrator. LPN JJ called the administrator and told him/her what Resident #68 and Resident #118 reported, including the names of the staff members mentioned. The administrator said those staff had already been investigated.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/20/21 at 10:30 A.M. and 3:52 P.M., the administrator said CNA KK told him/her that he/she heard staff members, LPN V and Transportation Staff II, brought drugs into the facility. CNA KK did not say what kind of drugs or how he/she found out about it. The administrator could not remember the exact date CNA KK told him/her this, but said it was a couple of days ago. LPN JJ also talked with the administrator and said he/she heard LPN F and Hall Monitor LL had also brought drugs into the facility for residents. The administrator spoke with all four staff named and had them provide written statements. All four staff denied ever bringing any drugs into the facility. The administrator did not think to report the allegation of the four staff bringing in drugs to the state agency because LPN JJ did not tell the administrator he/she had heard this information from a resident. The administrator spoke to the four staff named and they all denied bringing drugs into the facility. There was no evidence, only hearsay. The state agency was already aware of Resident #33 and Resident #130 testing positive for methamphetamine on 5/4/21 and were already investigating the issue.<br><br>2. Review of the facility's Registered Nurse (RN) Investigation Report, Investigative Narrative Note, dated 5/19/21, showed the following:<br><br>-It was reported that Resident #140 punched Licensed Practical Nurse (LPN) MM as he/she was trying to check on him/her after he/she was having increased anxiety, and as the door opened Resident #140 punched LPN MM and broke his/her nose. Sometime later, Hall Monitor NN came down to Resident #140's room and per Resident #140, while he/she was asleep, Hall Monitor NN hit him/her in the eye. Certified Nurse Assistant (CNA) OO stated he/she saw Resident #140 come out of his/her room after Hall Monitor NN left the unit with his/her head down. CNA OO asked the resident what was wrong and the resident said Hall Monitor NN hit him/her. Hall Monitor NN was suspended pending the investigation. Resident Care Coordinator (RCC), administrator, legal guardian, management on call made aware. 5/19/21 at 00:30 A.M., after LPN/RCC G came in and while continuing to monitor resident, area to face continued to swell and resident was sent to the hospital for evaluation. The resident returned with a contusion to his/her face. The resident continues to be calm and cooperative with one-on-one monitoring. The police and the state agency were made aware for self report.<br><br>Review of the self-report submitted to the state agency showed the incident occurred on 5/18/21 at 11:55 A. M. (actually occurred at 11:55 P.M.). The facility reported the allegation of abuse to the state agency on 5/19/21 at 8:30 A.M. (The facility did not report an allegation of abuse that resulted in injury to the state agency no later than two hours after the allegation of abuse was made.)<br><br>During interview on 5/19/21 at 12:30 P.M., the Director of Nursing (DON) said the incident (involving Resident #140 and Hall Monitor NN) occurred five minutes before midnight (on 5/18/21). The abuse hotline closed at midnight so she notified the administrator and they decided they would call and report the incident to state agency the next morning. She would consider the incident abuse.<br><br>During interview on 5/19/21 at 12:35 P.M., the Administrator said she thought they could just call in the morning since the hotline was closed. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813<br><br>Refer to Event ID QJHT12.<br><br>Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #33 and #130), who resided on a secured behavioral unit, did not obtain illegal drugs, including methamphetamine (a powerful, highly addictive, stimulant, that affects the central nervous system) and cannabis (marijuana; a psychoactive drug from the cannabis plant), while in the facility, in a review of 33 sampled residents. The residents had histories of substance abuse problems and psychiatric diagnoses, which were treated with psychotropic (any medication that affects behavior, mood, thoughts, or perception) medications. The facility also failed to ensure the residents could not obtain contaminated needles from the facility's sharps container to inject illegal drugs. Resident #33 reported he/she obtained methamphetamine from Resident #130 every couple weeks, and injected the illegal drug with contaminated syringes five or six times on separate occasions, in the last couple of months. Resident #33 was treated for symptoms of withdrawal on 5/12/21 after testing positive for methamphetamine on 5/4/21. The facility census was 167.<br><br>The administrator was notified on 5/17/21 of an Immediate Jeopardy (IJ) which began on 5/4/21. The IJ was removed on 5/17/21, as confirmed by surveyor onsite verification.<br><br>Review of the facility's policy, Sharp Container, dated 4/6/17, showed the following:<br><br>-Purpose: To ensure that sharps containers are disposed of safely and in compliance with current regulations;<br><br>-All sharps containers will be placed in proper wall [NAME] or in the designated boxes on the medication carts while being used;<br><br>-All sharps containers will be sealed and stored in designated area when 3/4 full;<br><br>-The housekeeping supervisor or designee will monitor all sharps containers and change the containers out when they are 3/4 full;<br><br>-The sharps containers will be checked three times a week but not limited to this;<br><br>-The containers will be stored in the designated site until the biohazard company picks up the containers;<br><br>-In the event that a spill occurs with a sharps container and needles are exposed in any way, they will be returned to the container by using tongs.<br><br>1. Review of Resident #33's medical record showed the following:<br><br>-admitted [DATE];<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -The resident lived on a secured behavioral unit;<br><br>-No documentation the resident had left the facility since admission.<br><br>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 8/27/20, showed the following:<br><br>-Diagnoses included high blood pressure, post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), bipolar depression (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and anxiety;<br><br>-Cognition was intact;<br><br>-Independent with activities of daily living;<br><br>-Received antipsychotic, antianxiety, and antidepressant medications daily.<br><br>Review of the resident's nurse's note, dated 9/24/20 at 5:20 P.M., showed the nurse noticed the resident was with his/her peers having suspicious behaviors. The legal guardian gave consent for urine drug screen and room search. Contraband was found.<br><br>Review of the resident's urine drug screen results, dated 9/24/20, showed the resident was positive for methamphetamine.<br><br>Review of the resident's Physician Order Sheet (POS) for September 2020 showed he/she did not have orders for any medications that contained methamphetamine.<br><br>Review of the resident's statement form, dated 9/25/20, showed the resident received methamphetamine from another resident.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-Diagnoses included high blood pressure, manic depression, anxiety, and post-traumatic stress disorder;<br><br>-Cognition was intact;<br><br>-Received antipsychotic, antianxiety, and antidepressant medications daily.<br><br>Review of the resident's care plan, dated 2/16/21, showed the resident had a history of substance abuse, including alcohol, methamphetamine, and cannabis. On 9/24/20, staff noted the resident having suspicious behaviors with peers. The guardian was contacted and consent was given for a urine drug screen and a room search. Contraband was found.<br><br>(continued on next page) |

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| | 265469 | A. Building<br>B. Wing | 05/20/2021 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the resident's nurse's note, dated 5/4/21 at 12:14 P.M., showed staff received report in regards to this resident. Immediate staff intervention and separation from peers. The resident states inappropriate behavior with medications. The resident states he/she got from another resident. A room search was completed with a needle found. A head to toe assessment was completed with pin point marks found to bilateral inner arms. The primary physician was notified and consent given for a urine drug screen. The sample was obtained and sent to the lab.<br><br>Review of the resident's urine drug screen results, dated 5/4/21, showed the resident was positive for methamphetamine and cannabis.<br><br>Review of the resident's written statement, dated 5/4/21 at 12:45 P.M., showed around a month ago, the resident obtained a small bag with a crystalline (having the structure or form of a crystal) substance he/she was told was methamphetamine from another resident. Around that same time, the resident stole a syringe from the sharps container.<br><br>Review of the facility's investigation, dated 5/4/21, showed the following:<br><br>-Resident Care Coordinator (RCC) A received a report regarding the resident. Consent was received from the legal guardian for a room search and a needle was found in the laundry basket;<br><br>-A head to toe assessment was completed with pin point marks found to the resident's bilateral inner arms;<br><br>-The resident stated he/she got drugs from Resident #130;<br><br>-Received report the resident had a positive drug screen;<br><br>-The resident said he/she obtained an insulin syringe out of the sharps container after another resident didn't push it into the container all the way. The resident said he/she got the methamphetamine from Resident #130.<br><br>Review of the resident's written statement, dated 5/5/21, showed he/she had been taking needles out of the sharps container after Resident #31 because Resident #31 did not stick the needles in the container very far.<br><br>Review of the interview summary between the resident and the facility's consultant security officer, confirmed by RCC A and the Director of Nursing (DON), dated 5/5/21 at 10:00 A.M., showed the following:<br><br>-The resident obtained drugs from Resident #130 in exchange for money;<br><br>-The resident said he/she obtained syringes from the sharps container when a certain resident self-administered insulin and didn't push the syringe all the way inside the sharps container;<br><br>-The resident said he/she purchased methamphetamine and occasionally weed (cannibis) from Resident #130;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -The resident had been doing drugs off and on for 10 or [AGE] years and reported getting high two days ago;<br><br>-The resident said methamphetamine was in the facility two days ago, but he/she used it all right away;<br><br>-Two weeks ago, the resident got methamphetamine from Resident #130.<br><br>During an interview on 5/13/21 at 9:15 A.M., the resident said the following:<br><br>-A couple of months ago he/she watched Resident #31 self-administer insulin;<br><br>-Resident #31 couldn't get the insulin syringe to go all the way into the sharps container because the container was full;<br><br>-There were three syringes sticking out of the sharps container;<br><br>-He/She waited for the Certified Medication Technician (CMT) to go into another resident's room to administer medications, and then he/she removed two insulin syringes from the sharps container;<br><br>-One of the syringes belonged to Resident #31, but he/she didn't know who had used the other syringe;<br><br>-He/She purchased methamphetamine from Resident #130 every couple of weeks and had also purchased marijuana from Resident #130 a couple of times;<br><br>-He/She mixed the methamphetamine with water and injected it into his/her arm five or six times on separate occasions, in the last couple of months;<br><br>-He/She injected all of the methamphetamine he/she obtained at once;<br><br>-The last time he/she injected methamphetamine and smoked marijuana was about a week and half ago;<br><br>-He/She smoked the marijuana, which was rolled in a joint, in his/her bathroom, with a lighter he/she obtained from another resident.<br><br>Review of the resident's nurse's note, dated 5/12/21 at 4:29 P.M., showed the following:<br><br>-The resident told the nurse he/she was shaky and had tremors from drug withdrawal;<br><br>-Shaking was noted in both the resident's hands;<br><br>-The physician was contacted and orders were received for Ativan (antianxiety medication) 2 milligrams (mg) by mouth every 12 hours as needed for three days.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 5/13/21 at 3:45 P.M., the resident's guardian said the facility notified him/her about a week ago they had suspicions about drugs getting into the facility and the guardian gave consent for a urine drug screen and a room move. The resident had a history of breaking into medication rooms and taking used syringes out of sharps containers at previous facilities.<br><br>2. Review of Resident #130's medical record showed the following:<br><br>-admitted [DATE];<br><br>-The resident lived on a secured behavioral unit;<br><br>-No documentation the resident had left the facility since admission.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included schizophrenia (a long-term mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions, and a feeling of withdrawal from reality);<br><br>-Cognition was intact;<br><br>-Independent with activities of daily living;<br><br>-Received antipsychotic, antianxiety, antidepressant, and opioid medications daily.<br><br>Review of the resident's nurse's note, dated 9/24/20 at 5:07 P.M., showed the nurse noted the resident was with his/her peers having suspicious behaviors. The resident's legal guardian gave consent for a urine drug screen and room search. Contraband was found.<br><br>Review of the resident's urine drug screen results, dated 9/24/20, showed the resident was positive for methamphetamine and amphetamine (a synthetic mood altering drug, used illegally as a stimulant).<br><br>Review of the resident's POS for September 2020 showed he/she did not have orders for any medications that contained amphetamine or methamphetamine.<br><br>Review of the resident's care plan, dated 1/11/21, showed the resident had a history of extensive drug and alcohol abuse.<br><br>Review of the resident's nurse's note, dated 5/4/21 at 2:45 P.M., showed the following:<br><br>-There was a report by a peer regarding this resident;<br><br>-The resident stated inappropriate behavior with medications;<br><br>-The resident refused to say where the medications came from;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -The physician gave orders for a urine drug screen which was obtained and sent to the lab;<br><br>-Consent was obtained to conduct a room search.<br><br>Review of the resident's written statement, dated 5/4/21 at 2:35 P.M., showed the following:<br><br>-He/She did Boost Bar (Buspar) in his/her arm;<br><br>-The resident didn't' lie when he/she was dirty and could take a urine test when asked.<br><br>Review of the results of the resident's urine drug screen, dated 5/4/21, showed the resident was positive for methamphetamine.<br><br>Review of the resident's POS for May 2021 showed he/she did not have orders for any medications that contained methamphetamine or Buspar (antianxiety medication)<br><br>Review of the facility's investigation, dated 5/4/21, showed the following:<br><br>-RCC A received a report regarding Resident #33;<br><br>-Resident #33 said he/she got drugs from the resident (Resident #130);<br><br>-The resident said he/she had been inappropriate with medications;<br><br>-Received report the resident had a positive drug screen;<br><br>-Resident #33 stated he/she got the methamphetamine from the resident.<br><br>During an interview on 5/13/21 at 1:28 P.M., the resident said the following:<br><br>-He/She got methamphetamine from Resident #33;<br><br>-He/She received methamphetamine once through the mail but would not say who it was from;<br><br>-He/She had never given or sold drugs to any other residents in the facility;<br><br>-He/She injected Buspar into his/her arm a couple of months ago with a new needle that was wrapped in plastic he/she got from Resident #130;<br><br>-He/She found the Buspar tablet on the floor of another resident's room but would not say which room;<br><br>-He/She knew the tablet was Buspar because he/she had been on that medication in the past and recognized the pill;<br><br>-RCC A noticed the mark on his/her arm while he/she was in the smoke room and Resident #130 told RCCA he/she had injected the Buspar.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 5/13/21 at 1:40 P.M., RCC A said a couple of months ago he/she noticed a mark on the resident's inner arm and asked the resident about it. RCC A did not remember what the resident said about the mark on his/her arm, but it wasn't anything alarming. RCC A said the resident wasn't acting strange so he/she didn't think anything else about it.<br><br>During an interview on 5/13/21 at 4:08 P.M., Resident #130's guardian said the resident had a history of drug use and was very drug seeking. The resident was not a reliable source of information as he/she was very delusional. The guardian was not sure how the resident obtained drugs in the facility.<br><br>3. During an interview on 5/13/21 at 10:02 A.M., CMT J said the following:<br><br>-He/She thought transportation staff emptied the sharps containers once a week;<br><br>-The sharps containers sat inside a metal box attached to the medication cart;<br><br>-The CMTs and nurses on the floor did not have a key to open the metal box to remove or replace the sharps containers.<br><br>During an interview on 5/13/21 at 2:22 P.M., Transportation Staff II said the following:<br><br>-Transportation staff were to check all the sharps boxes in the facility daily through the week and the nurse manager was to check them on the weekends;<br><br>-Usually every two to three days they need to be replaced;<br><br>-There was a fill line on the sharps containers that showed when they needed to be changed out;<br><br>-Occasionally he/she saw the sharps containers over full, usually if the nurse forgot to check them over the weekend, but not very often.<br><br>During interviews on 5/12/21 at 6:25 P.M. and on 5/13/21 at 8:35 A.M., the DON said the following:<br><br>-Someone reported to staff that someone gave Resident #33 a needle. There were several rumors going around about it;<br><br>-RCC A talked to Resident #33 about it and he/she gave RCC A the needle;<br><br>-There were three residents on the unit who self-administered insulin;<br><br>-Staff was expected to monitor the residents administer insulin and then ensure residents disposed of their syringes correctly in the sharps container;<br><br>-The sharps container fit inside a metal box on the outside of the medication cart. There was a narrow spout that prevented anyone from reaching into the sharps container;<br><br>-Resident #33 told RCC A he/she got the methamphetamine from Resident #130 which is what prompted the urine drug screens;<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | -Resident #130 said he/she got the methamphetamine through the mail from a discharged resident and said he/she was doing it to help people.<br><br>During interviews on 5/12/21 at 5:55 P.M., and on 6/3/21 at 10:35 A.M., the administrator said the following:<br><br>-Both Resident #33 and Resident #130 tested positive for methamphetamine on urine drug screens on 5/4/21;<br><br>-The residents reported the drugs were coming into the facility through the mail.<br><br>-All residents were interviewed and they denied any knowledge of staff bringing drugs into the facility;<br><br>-She expected that residents would not be able to obtain, have access to, or use illegal drugs while in the facility.<br><br>During an interview on 6/3/21 at 11:15 A.M., the psychiatric physician for Residents #33 and #130 said the following:<br><br>-He/She does not prescribe methamphetamine to any resident in long-term care;<br><br>-Methamphetamine use could increase psychosis in anyone, especially residents with a psychiatric diagnosis;<br><br>-Methamphetamine use could interfere with the effectiveness of prescribed psychotropic medications;<br><br>-Methamphetamine use could increase the frequency and severity of negative behaviors from residents;<br><br>-It was absolutely his/her expectation that residents did not have access to illegal drugs while residing in the facility.<br><br>NOTE: At the time of the survey, the violation was determined to be at the immediate and serious 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 address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.<br><br>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 be taken to address Class I violations(s). |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813<br><br>Refer to Event ID QJHT12.<br><br>Based on interview and record review, the facility failed to provide the necessary behavioral health care services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for three residents (Residents #33, #130, and #162) with a history of substance use disorders, who had tested positive for methamphetamines (a powerful, highly addictive stimulant that affects the central nervous system) twice while residing on the secured behavioral unit of the facility, in a review of 33 sampled residents. The facility census was 167.<br><br>During interview on 5/19/21 at 12:32 P.M., the administrator said the facility did not have a policy to address care and services provided to residents with a history of substance abuse.<br><br>1. Review of Resident #33's Pre-Admission Screening and Resident Review (PASSR), dated 8/7/12, showed the following:<br><br>-Diagnoses included bipolar disorder (a mental disorder marked by alternating periods of elation and depression) with psychosis, post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), depression, and polysubstance abuse (a pattern of harmful use of more than one substance for mood altering purposes);<br><br>-History of alcohol, cannabis (marijuana; a psychoactive drug from the cannabis plant), methamphetamine, prescription drugs, opiates, K2 (synthetic cannabis), and bath salts abuse (a synthetic drug with mood altering and stimulant properties);<br><br>-Had been in drug rehab several times, the most recent 4/18/12 through 4/27/12;<br><br>-Individual weaknesses included lack of self-direction and insight as well as legal problems;<br><br>-Level of service needs included continued drug and alcohol rehabilitation, as well as follow up with a psychiatrist.<br><br>Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument, required to be completed by facility staff, dated 8/27/20, showed the following:<br><br>-Diagnoses included high blood pressure, post-traumatic stress disorder, bipolar depression, and anxiety;<br><br>-Cognition was intact;<br><br>-Independent with activities of daily living;<br><br>-Received antipsychotic, antianxiety, and antidepressant medications daily.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Diagnoses included high blood pressure (generally defined as a blood pressure reading greater than 130/80), manic depression (a mental disorder marked by alternating periods of elation and depression), anxiety, and PTSD;<br><br>-Cognition was intact;<br><br>-Received antipsychotic, antianxiety, and antidepressant medications daily.<br><br>Review of the resident's nurse's note, dated 9/24/20 at 5:20 P.M., showed the nurse noticed the resident was with his/her peers having suspicious behaviors. The legal guardian gave consent for urine drug screen and room search. Contraband was found.<br><br>Review of the resident's urine drug screen results, dated 9/24/20, showed the resident was positive for methamphetamine.<br><br>Review of the resident's POS for September 2020 showed he/she did not have orders for any medications that contained methamphetamine.<br><br>Review of the resident's statement form, dated 9/25/20, showed the resident received methamphetamine from another resident.<br><br>Review of the resident's care plan, dated 2/16/21, showed the following:<br><br>-History of substance abuse including alcohol, methamphetamine, and cannabis;<br><br>-Will accept judgement of staff/guardian as appropriate;<br><br>-Required another person to point him/her in the right direction;<br><br>-On 9/24/20, staff noted the resident having suspicious behaviors with peers. The guardian was contacted and consent was given for a urine drug screen and a room search. Contraband was found.<br><br>Review of the resident's nurse's note, dated 5/4/21 at 12:14 P.M., showed staff received report in regards to this resident. Immediate staff intervention and separation from peers. Resident states inappropriate behavior with medications. The resident states he/she got from another resident. A room search was completed with a needle found. A head to toe assessment was completed with pin point marks found to bilateral inner arms. The primary physician was notified and consent given for a urine drug screen. The sample was obtained and sent to the lab.<br><br>Review of the resident's urine drug screen results, dated 5/4/21, showed the resident tested positive for methamphetamine and cannabis (indicating the resident had consumed these substances, verified through laboratory testing of the resident's urine).<br><br>Review of the resident's written statement, dated 5/4/21 at 12:45 P.M., showed around a month ago, the resident obtained a small bag with a crystalline (having the form or structure of a crystal) substance he/she was told was methamphetamine from another resident. Around that same time, the resident stole a syringe from the sharps box.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interviews on 5/13/21 at 9:15 A.M. and on 5/20/21 at 11:06 A.M., the resident said the following:<br><br>-A couple of months ago, there were three syringes sticking out of the sharps container;<br><br>-He/She waited for the certified medication technician (CMT) to go into another resident's room to administer medications, and then he/she removed two insulin syringes from the sharps container;<br><br>-He/She purchased methamphetamine from Resident #130 every couple of weeks and had also purchased marijuana from Resident #130 a couple of times;<br><br>-He/She mixed the methamphetamine with water and injected it into his/her arm five or six times, on separate occasions, in the last couple of months;<br><br>-He/She injected all of the methamphetamine he/she obtained at once;<br><br>-The last time he/she injected methamphetamine and smoked marijuana was about a week and half ago;<br><br>-He/She used methamphetamine on and off for the last 10 or [AGE] years;<br><br>-He/She had been in this facility since 2018;<br><br>-He/She had attended alcoholics' anonymous meetings, but these were stopped over a year ago due to COVID-19<br><br>(Coronavirus Disease 2019, an infectious disease caused by severe acute respiratory syndrome);<br><br>-He/She used to talk to a counselor via telemedicine, but this had been quite a while ago and he/she thought he/she would benefit from doing so again;<br><br>-He/She was anxious about his/her roommate being discharged , because he/she relied on the roommate as a source of support and someone to talk to;<br><br>-He/She did not participate in therapeutic groups, which were now just packets handed out by staff. The resident was not sure where to get the packets, what information they included, or who they were supposed to be turned into;<br><br>-He/She did not want to use methamphetamine anymore and was going to try to stay away from it, but still had cravings for the drug.<br><br>Review of the resident's medical record showed no evidence the resident ever received any counseling services or treatment related to drug abuse or addiction while a resident in the facility.<br><br>During an interview on 5/21/21 at 8:51 A.M., the resident's guardian said the resident had an extensive history of drug abuse. The facility had not spoken to the guardian about any substance abuse treatment programs offered by the facility. The guardian thought the resident would benefit from counseling, specifically related to drug addiction, if the resident would be willing to participate.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of Resident #130's PASSR, dated 2/21/17, showed the following:<br><br>-Diagnoses included schizophrenia (a long-term mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions, and a feeling of withdrawal from reality), psychotic disorder, delusional disorder, and polysubstance dependence (substance use disorder in which an individual is dependent at least three different classes of substances);<br><br>-Long history of schizophrenia with paranoid and religious delusions. History of seeing demons, angels, and spirits. History of aggressive and disorganized behavior;<br><br>-Poor insight and judgement;<br><br>-Feels he/she can obtain power from walls and electricity and can heal others;<br><br>-Would benefit from both individual and group counseling for mental health education, support, and coping skills;<br><br>-Needs a structured environment where he/she can be monitored for mental status changes and remain substance abuse free.<br><br>Review of the resident's care plan, dated 2/18/20, showed the following:<br><br>-The resident had a history of extensive drug and alcohol abuse, including cocaine, alcohol, and methamphetamine;<br><br>-The resident will be in the lowest restrictive environment while maintaining protective oversight.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included schizophrenia;<br><br>-Cognition was intact;<br><br>-Independent with activities of daily living;<br><br>-Received antipsychotic, antianxiety, antidepressant, and opioid medications daily.<br><br>Review of the resident's nurse's note, dated 9/24/20 at 5:07 P.M., showed the nurse noted the resident was with his/her peers having suspicious behaviors. The resident's legal guardian gave consent for a urine drug screen and room search. Contraband was found.<br><br>Review of the resident's urine drug screen results, dated 9/24/20, showed the resident was positive for methamphetamine and amphetamine (a synthetic mood altering drug, used illegally as a stimulant).<br><br>(continued on next page) |

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|---|---|---|---|
| | 265469 | A. Building<br>B. Wing | 05/20/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Levering Regional Health Care Center | 1734 Market Street<br>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.

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's POS for September 2020 showed he/she did not have orders for any medications that contained amphetamine or methamphetamine.<br><br>Review of the resident's nurse's note, dated 5/4/21 at 2:45 P.M., showed the following:<br><br>-There was a report by a peer regarding this resident;<br><br>-The resident stated inappropriate behavior with medications;<br><br>-The resident refused to say where the medications came from;<br><br>-The physician gave orders for a urine drug screen which was obtained and sent to the lab;<br><br>-Consent was obtained to conduct a room search.<br><br>Review of the results of the resident's urine drug screen, dated 5/4/21, showed the resident was positive for methamphetamine.<br><br>Review of the resident's written statement, dated 5/4/21 at 2:35 P.M., showed the following:<br><br>-He/She did Boost Bar (Buspar) in his/her arm;<br><br>-The resident didn't' lie when he/she was dirty and could take a urine test when asked.<br><br>Review of the resident's POS for May 2021 showed he/she did not have orders for any medications that contained methamphetamine or Buspar (antianxiety medication)<br><br>During an interview on 5/13/21 at 1:28 P.M., the resident said the following:<br><br>-He/She found a Buspar tablet on the floor of another resident's room;<br><br>-He/She knew the tablet was Buspar because he/she had been on that medication in the past and recognized the pill;<br><br>-He/She injected Buspar into his/her arm a couple of months ago with a new needle that was wrapped in plastic he/she got from Resident #33.<br><br>Review of the resident's medical record showed no evidence the resident had ever received any counseling services or treatment related to drug abuse or addiction while a resident in the facility.<br><br>During an interview on 5/21/21 at 9:04 A.M., the resident's guardian said the resident had an extensive history of substance abuse. The guardian was not aware of any addiction programs offered by the facility. The guardian was not aware of the resident receiving any counseling services while living in the facility.<br><br>3. Review of Resident #162's PASSR, dated 4/4/17, showed the following:<br><br>-Diagnoses included schizoaffective disorder, major depression, and polysubstance dependence;<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Functional limitations noted appear to be related to mental illness and substance abuse issues;<br><br>-Poor coping skills and substance use to deal with symptoms of anxiety;<br><br>-Abuse of alcohol and drugs, previous drug related charges with incarceration. Referral indicates dependence of stimulations and smoking methamphetamine;<br><br>-Family reports other residents encourage the resident's maladaptive behaviors such as alcohol use;<br><br>-Impaired decision making, puts self in unsafe situations, and lack of self-control;<br><br>-The resident would benefit from individual, group, and family psychotherapy, community based substance abuse treatment, and a 12-step substance abuse program, for the individual to live successfully in a less restrictive environment.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included traumatic brain injury, seizure disorder, bipolar depression, and schizophrenia;<br><br>-Cognition was intact;<br><br>-Independent with activities of daily living;<br><br>-Received antianxiety, antidepressant, hypnotic, and opioid medications daily.<br><br>Review of the resident's nurse's note, dated 9/24/20 at 5:03 P.M., showed the nurse noted the resident was with his/her peers having suspicious behaviors. The resident's legal guardian gave consent for a urine drug screen and a room search. Contraband was found.<br><br>Review of the resident's urine drug screen results, dated 9/24/20, showed the resident was positive for methamphetamine and amphetamine.<br><br>Review of the resident's POS for September 2020 showed he/she did not have orders for any medications that contained amphetamine or methamphetamine.<br><br>Review of the resident nurse's note, dated 11/13/20 at 1:34 P.M., showed the resident became delusional and was physically aggressive towards staff after the resident's family delivered and the resident received food. Staff provided immediate intervention and separation from peers. The resident was allowed to verbalize thoughts and feelings but was not easily redirected. A five man CALM technique was utilized. The resident requested and received as needed (PRN) medication without adverse reaction. Staff provided education on appropriate behaviors and the resident was placed on one-on-one supervision. The resident continued with aggressive behaviors towards staff. The physician was contacted and orders received to send the resident to an acute psychiatric hospital for evaluation and treatment.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's urine drug screen from the acute psychiatric hospital, dated 11/14/20, showed the resident was positive for amphetamines.<br><br>Review of the resident's care plan, dated 1/21/21, showed the resident had a history of polysubstance abuse. The resident was oriented but forgetful and had poor insight and judgement.<br><br>Review of the resident's medical record showed no evidence the resident had ever received any counseling services or treatment related to drug abuse or addiction while a resident in the facility.<br><br>During an interview on 5/21/21 at 9:45 A.M., the resident's guardian said the resident had a history of drug abuse. The facility had never spoken to him/her about counseling services or drug addiction treatment plans. The resident would benefit from drug addiction counseling and it would be a good idea for the resident to participate it if was offered.<br><br>4. During an interview on 5/20/21 at 12:42 P.M., the activity director said staff pass out therapeutic group packets to the residents daily, Monday through Friday, except on Thursdays. The packets include information on a variety of topics, including chemical dependency, understanding self and others, respecting boundaries, and human sexuality. The activity director included questions related to the topic in the packet the resident had to fill out. Once the residents read and filled out the packet, an activity aide went back to see if anyone had any questions. There had not been much resident participation in the packets lately. Residents #33, #130 and #162 did not consistently participate with the therapeutic groups. Alcoholics Anonymous (AA) used to come into the facility on ce a week and a sponsor tried to get residents connected with resources after discharge from the facility. The AA group had not been in the facility since last year due to COVID-19.<br><br>During an interview on 5/20/21 at 1:00 P.M., the Social Service Director (SSD) said he/she set up counseling services for residents in the facility who needed them. Sometimes a resident or their guardian would request counseling services. The SSD never had any issue with getting a resident seen by the counseling group when requested. The counseling sessions were typically conducted via laptops or over the phone. Most residents involved with the program were seen once or twice a week and some are seen once a month. Resident #33 was involved in the counseling service and was seen twice a month when he/she did not decline the visits. The SSD had no documentation to show when a resident refused the counseling session. Residents #130 and #162 had not been seen by the counseling service.<br><br>During an interview on 5/20/21 at 1:20 P.M., a staff member from the counseling service said their counseling program did not provide counseling related to substance abuse. They focused on adjustment disorders and chronic mental illness. The facility would need to make arrangements with another resource for drug addiction counseling. Resident #33 participated in their counseling services in the past and had always been willing to participate. It had been at least two months since Resident #33 had been seen by the service. The counselor had no records showing Resident #130 and Resident #162 had ever been seen by the counseling service.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interviews on 5/20/21 at 12:30 P.M. and 3:52 P.M., the administrator said he/she reviewed a resident's PASSR prior to admission to the facility. There used to be Alcoholics and Narcotics Anonymous groups that came into the facility prior to the COVID-19 restrictions. The facility also used a counseling service as a resource for residents. The residents were responsible to complete the therapeutic group packets that were provided by facility staff and to turn them into activities staff once they were completed. These covered a variety of topics and not all residents participated. The therapeutic group packets and the counseling services were the only services the facility provided. |