STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265469	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levering Regional Health Care Center	1734 Market 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33955 Refer to Event ID QJHT13. Based on interview and record review, the facility failed to notify nine residents' (Residents #1, #3, #12, #22, #30 #34, #35, #102, and #133) guardian or responsible party of allegations of possible abuse or when the residents experienced an emergent event or a change in condition which required intervention, in a review of 48 sampled residents. The facility census was 164. Review of the facility's policy on Contacting Resident's Guardian for Emergent Situations, revised 1/17/18, showed the Administrator or the Director of Nursing are responsible to contact the resident's guardian if an incident arises such as an emergency event, urgent high priority event, or reportable event. These events include, but are not limited to, the following: -High priority events that require investigation; -Unexpected death; -Bruises of unknown origin; -Resident-to-resident altercation; -Resident-to-staff altercation; -Suspicious resident activity; -Ingestion of a harmful substance; -Injury; -Burns; -Any event reportable to the state agency per State and Federal Regulations. 1. Review of Resident #30's face sheet showed the following: (continued on next page)

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 - Some	-admitted [DATE]; -The resident had a guardian; -Diagnoses included traumatic brain injury (sudden trauma that causes damage to the brain), major depressive disorder (mental disorder characterized by a persistently depressed mood and long term loss of pleasure or interest in life), paranoid schizophrenia (the most common form of schizophrenia and included delusions and hallucinations, including paranoid thoughts), and psychoactive substance abuse (abuse of a chemical substance that alters a person's mental state). Review of the resident's nurse's note, dated 6/25/21, at 3:56 P.M., showed Licensed Practical Nurse (LPN) G's documented staff received a report of suspicious behavior from last night. An assessment was completed with no new findings. No abnormal behaviors noted. The resident was calm and cooperative. The resident refused to sign a statement and also refused a urine drug screen. With consent, a room search was completed with no findings. Review of the facility's Registered Nurse Investigation (RNI), dated 6/25/21, showed the following: -Certified Nurse Assistant (CNA) M reported another staff, who wished to stay anonymous, walked into Residents #30, #35, and #102's room the night before. The residents were unaware of the staff member's presence and their eyes appeared reddened; -The anonymous staff reported suspicion these residents were doing something they shouldn't be doing and mentioned another staff member in suspicion of having a vape pen (device used to inhale vapor, typically containing nicotine but may contain other substances); -A room search was completed and no vape pen or drugs were found; -All residents were interviewed and denied any inappropriate activity; -All three residents refused a urine drug screen; -The accused staff member was suspended pending the investigation; -LPN G contacted the residents' legal guardians and made them aware; -Staff reported the incident to the state agency. During an interview on 7/6/21 at 10:45 A.M., the resident's guardian said the facility did not contact him/her about the resident's suspicious behaviors on 6/25/21, or that the resident's room was searched and the resident refused to submit to a urine drug screen. 2. Review of Resident #35's face sheet showed the following: -admitted [DATE]; -The resident had a guardian; (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included paranoid schizophrenia and post-traumatic stress disorder (PTSD, a mental health problem that can occur after a traumatic event). Review of the resident's nurse's note, dated 6/25/21 at 3:53 P.M., showed LPN G documented staff received report of suspicious behavior from last night. An assessment was completed with no new findings. No abnormal behaviors noted. The resident was calm and cooperative. The resident refused to sign a statement and also refused a urine drug screen. With consent, a room search was completed with no findings. Review of the facility's RNI, dated 6/25/21, showed the following documentation: -CNA M reported another staff, who wished to stay anonymous, walked into Residents #30, #35, and #102's room the night before. The residents were unaware of the staff member's presence and their eyes appeared reddened; -The anonymous staff reported suspicion these residents were doing something they shouldn't be doing and mentioned another staff member in suspicion of having a vape pen (device used to inhale vapor, typically containing nicotine); -A room search was completed and no vape pen or drugs were found; -All residents were interviewed and denied any inappropriate activity; -All three residents refused a urine drug screen; -The accused staff member was suspended pending the investigation; -LPN G contacted the residents' legal guardians and made them aware; -Staff reported the incident to the state agency. During an interview on 6/30/21 at 9:45 A.M., the resident's guardian said the facility did not contact him/her regarding the resident's suspicious activity related to a vape pen and possibly illegal drugs on 6/25/21 or of the allegation of a staff member being involved. The guardian was not aware the facility searched the resident's room or that staff asked the resident to submit to a urine drug screen, which the resident refused. The resident's guardian expected the facility to notify him/her of this situation. 3. Review of Resident #102's face sheet showed the following: -admitted [DATE]; -The resident had a guardian; -Diagnoses included major depressive disorder, conduct disorder (a range of antisocial behaviors displayed in childhood or adolescence), and personality disorder (a mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning, and behaving. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurse's note, dated 6/25/21 at 3:55 P.M., showed LPN G documented staff received report of suspicious behavior from last night. An assessment was completed with no new findings. No abnormal behaviors noted. The resident was calm and cooperative. The resident refused to sign a statement and also refused a urine drug screen. With consent, a room search was completed with no findings. Review of the facility's RNI, dated 6/25/21, showed the following: -CNA M reported that another staff, who wished to stay anonymous, walked into Resident #30, #35, and #102's room the night before. The residents were unaware of the staff member's presence and their eyes appeared reddened; -The anonymous staff reported suspicion these residents were doing something they shouldn't be doing and mentioned another staff member in suspicion of having a vape pen (device used to inhale vapor, typically containing nicotine); -A room search was completed and no vape pen or drugs were found; -All residents were interviewed and denied any inappropriate activity; -All three residents refused a urine drug screen; -The accused staff member was suspended pending the investigation; -LPN G contacted the residents' legal guardians and made them aware; -Staff reported the incident to the state agency. During an interview on 6/29/21 at 9:30 A.M., the resident's guardian said the facility did not contact him/her and he/she was not aware of the resident's suspicious activity on 6/25/21 or that the facility received an allegation that a staff member was involved. The facility did not contact him/her in regards to searching the resident's room or requesting a urine drug screen. The resident's guardian expected the facility to notify him/her of this situation. During an interview on 7/6/21 at 2:22 P.M., LPN G said he/she was not certain if he/she actually spoke to Residents' #30, #35, and #102's guardians about the incident on 6/25/21 or if he/she left a message. LPN G said half the time staff have to leave a message with the guardians' offices. LPN G was not always the one to notify the residents' guardians even if he/she was the one to document the guardian was contacted in the residents' records. Other nursing staff may have actually contacted the guardian, and LPN G just helped with the documentation. LPN G may have charted the guardian contact, but another staff actually made the contact. 4. Review of Resident #30's face sheet showed the following: -admitted [DATE]; -The resident had a guardian; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included fetal alcohol syndrome (a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects could include physical problems, and problems with behavior and learning), bipolar disorder (mood disorder characterized by periods of depression and periods of abnormally elevated mood), organic mood disorder (variation of bipolar disorder that is caused by physical trauma or illness), post traumatic stress disorder (PTSD, a mental health condition triggered by a terrifying event causing flashbacks, nightmares, and severe anxiety), mild intellectual deficit, oppositional defiant disorder (pattern of angry/irritable mood), dysthymic disorder (long-term mood disorder), and borderline personality disorder (emotionally unstable personality disorder or borderline pattern personality disorder characterized by long-term pattern of unstable relationships, distorted send of self, and strong emotional reactions, argumentative/defiant behaviors or vindictiveness). Review of the resident's nurse's note, dated 6/22/21 at 4:30 P.M., showed LPN Q documented the resident was exhibiting increased physical aggression towards a peer. Immediate staff intervention from peers and was allowed to vent feelings to nursing staff. Resident was upset over divider curtain. Documentation also showed the guardian was contacted and made aware of the situation, and was asked for permission to move the resident to another hall. Review of the facility's RNI, dated 6/22/21, showed the following: -Code Green (an announcement alerting staff to respond to a behavioral emergency) was called on the resident due to physical aggression towards another resident due to a disagreement over a curtain. The resident was placed on one-on-one observation. The resident continued on one-on-one observation and was moved to another hall. The guardian was made aware of the situation; -Documentation showed the Resident Care Coordinator (RCC) notified the resident's guardian of the incident on 6/22/21. During an interview on 6/28/21 at 10:45 A.M., the resident said he/she had his/her teeth removed in February 2020 and had not been able to get dentures. It was very difficult to eat certain foods and he/she wanted to get dentures. Observation on 6/28/21 at 10:45 A.M. showed the resident was edentulous (without teeth) and did not have dentures. During interview on 6/29/21 at 9:55 A.M., the deputy public administrator (representative for the resident's guardian) said the resident had teeth extracted on 2/18/20. The facility had not told him/her the resident did not have dentures. He/She was upset because this was the first time he/she was made aware of the resident's dental status. The facility held a care plan conference in April 2021 and staff didn't mention the resident needed dentures. During an interview on 6/29/21 at 11:25 A.M., the resident's guardian said the following: -The facility did not contact him/her about the incident involving the resident on 6/22/21; -He/She was unaware the resident had moved halls after the incident; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She was unaware the resident had not received his/her dentures after having his/her teeth removed; -He/She was very angry that he/she did not know the resident had not been fitted for dentures. 5 . Review of Resident #34's face sheet showed the following: -admitted [DATE]; -The resident had a guardian; -Diagnoses included schizoaffective disorder (a combination of symptoms of schizophrenia (disorder that affects a person's ability to think, feel and behave clearly), and mood disorder (disorder which your general emotional state or mood is distorted or inconsistent with your circumstances) that may occur at the same time or at different times), bipolar disorder (disorder associated with mood swings ranging from depressive lows to manic highs), unspecified disorder of psychological development (disorder diagnosed in childhood that is marked by physical or mental impairment which affects the child from achieving age related developmental milestones), borderline personality disorder, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), cannabis abuse (a pattern of using marijuana that causes physical or mental problems), unspecified psychosis (individuals who experience symptoms of schizophrenia or other psychotic symptoms), and PTSD. Review of the resident's nurse's notes, dated 5/7/21 at 6:57 P.M. and 6:58 P.M., showed LPN G documented the resident was reported to have inappropriate behavior with medication. Immediate staff intervention and separation from peers. Primary care provider (PCP) notified with new order to monitor. Legal guardian made aware. Poison control called. Review of the facility's RNI, dated 5/7/21, showed the following: -Room searches were completed on the locked unit where the resident resides; -Certified Nurse Assistant (CNA) C's medication bottle was found in the resident's room; -The resident said he/she took the bottle of pills, but was not sure if he/she took any of them; -PCP contacted with no new orders; -Poison control contacted; -Documentation showed the guardian made aware. During interviews on 6/29/21 at 4:36 P.M. and 6:36 P.M., 6/30/21 at 11:13 A.M. and 7/6/21 at 2:20 P.M., CNA C said he/she fell asleep during his/her night shift on 5/7/21. He/She had a pill bottle with five hydrocodone (opioid pain medication), four gabapentin (nerve pain medication) and six Flexeril (muscle relaxant) in his/her bag. Staff conducted room searches and found the pill bottle in Resident #34's room. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/30/21 at 4:46 P.M., Resident #104 said he/she was in bed and CNA C was sitting outside his/her room asleep on 5/7/21. The resident said he/she observed Resident #34 come up to CNA C, reached into CNA C's bag, took a medicine bottle, and went back to his/her room. During an interview on 6/30/21 at 12:43 P.M., the resident's legal guardian said he/she didn't know anything about the resident taking a staff member's medications. The facility did not notify him/her about the incident. 6 . Review of Resident #457's admission MDS, dated [DATE], showed the following: -admitted [DATE]; -Diagnoses included medically complex conditions, personality disorder, stimulant abuse (overuse of prescription and/or illicit drugs that result in increased activity in the body) and psychoactive substance abuse with psychoactive substance abuse induced dementia (over use of prescription or illicit drugs that change a person's mental state by affecting the way the brain and nervous system work which causes impairment of at least two brain functions such as memory loss and judgement). Review of the resident's Preadmission Screening and Resident Review (PASRR, an assessment tooled use to ensure a resident was not inappropriately placed in a nursing home for long-term care and to ensure the resident was provided appropriate treatment and care for mental health problems), dated 5/17/21, showed the resident had a guardian. Review of the resident's nurse's notes, dated 5/23/21, showed the resident had a Code Green (behavioral emergency). The resident was verbally and physically aggressive towards staff. Immediate staff intervention and separation from peers. Staff was unable to redirect the resident. Requesting an as needed (PRN) prescription; medication given. The resident placed on one-on-one supervision for protective oversight. Documentation showed the legal guardian made aware. Review of the RNI, dated 5/24/21 at 1:14 P.M. (for the incident that occurred on 5/23/21), showed the Assistant Director of Nursing (ADON) documented the following: -The resident displayed increased verbal and physical aggression toward staff; -Staff were unable to redirect the resident; -Approved Crisis Alleviations Lessons and Methods (CALM) hold techniques (specific physical interventions limiting the resident's movements by retaining his/her hands and arms) were required to ensure the resident's safety; -The resident requested an as needed (PRN) medication. Staff administered Zyprexa (a medication used to treat schizophrenia and bipolar disorder) 10 milligrams without difficulty; -RCC notified the resident's guardian on 5/24/21. During an interview on 6/29/21 at 4:15 P.M., the resident's legal guardian said the facility had not called him/her about any incidents involving the resident since the resident arrived at the facility (admitted [DATE]). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident #12's face sheet showed the following: -admitted [DATE]; -Diagnoses included autistic disorder (a serious developmental disorder that impairs the ability to communicate and interact), paranoid schizophrenia, attention-deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity and impulsiveness), and schizoaffective disorder; -The resident had a guardian. Review of the resident's nurse's notes, dated 6/4/21 at 4:31 P.M., showed LPN G documented the following: -The resident voiced concerns about another peer; -Immediate staff intervention and separation from peers. The resident was allowed to vent and verbalize thoughts and feelings to staff; -Staff provided one-on-one attention; -PCP notified and a new order was given to send the resident to the emergency room ; -Documentation also showed, the staff notified the resident's legal guardian. Review of the RNI, dated 6/5/21 at 5:05 P.M. (for the incident that occurred on 6/4/21), showed the following: -Date of incident was 6/4/21; -The resident said Resident #600 touched him/her inappropriately; -RCC notified the resident's guardian on 6/4/21; -PCP contacted with new orders to send the resident to the emergency room . Review of the resident's nurse's notes, dated 6/4/21 at 9:38 P.M., showed the following: -The resident returned to the facility from the hospital; -The resident had a diagnosis of jock itch (a fungal infection in the skin of the genitals, inner thighs and buttocks) with a new order for treatment; -The legal guardian was made aware of the resident's treatment plan. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/21 at 5:25 P.M., the resident's legal guardian said the facility did not notify him/her the resident was sent to the emergency roiagnom on [DATE]. The hospital called to let him/her know the resident was in the emergency room . The facility does not call and give him/her information about the resident. He/She finds out things from the resident when they talk on the phone. 8. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included schizoaffective disorder, bipolar disorder, major depressive disorder and borderline personality disorder; -The resident had a guardian. Review of the residents nurse's notes, dated 5/31/21 at 7:43 P.M., showed the following: -The resident had a Code Green; -The resident voiced increased anxiety and threatened self-harm; -The resident said he/she was just upset; -Staff removed all the resident's belongings from his/her room; -The resident was placed on one-on-one for protective oversight; -Staff made the resident's legal guardian aware. Review of the resident's nurse's notes, dated 6/2/21 at 6:37 P.M., showed the following: -The resident told the nurse he/she heard voices; -The resident requested a PRN (as needed) medication; -Staff educated the resident on coping skills; -Staff provided one-on-one attention; -Staff made the resident's legal guardian aware. Review of the resident's nurse's notes, dated 6/8/21 at 9:13 P.M. and 9:17 P.M., showed the following: -The resident had a Code Green; -The resident was upset at another resident; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff easily redirected the resident without invasive interventions; -Staff educated the resident on coping skills; -Staff continued to monitor the resident for protective oversight; -Staff made the resident's legal guardian aware. Review of the resident's nurse's notes, dated 6/22/21 at 7:47 P.M., showed the following: -The resident had a Code Green; -Staff noted the resident was upset over staff; -Staff easily redirected the resident without invasive interventions; -Staff educated the resident on utilizing coping skills; -Staff continued to monitor the resident for protective oversight; -Staff made the resident's legal guardian aware. During an interview on 6/29/21 at 2:15 P.M., the resident's legal guardian said the following: -The facility did not notify him/her or his/her office of the incidents involving the resident that took place on 5/31/21, 6/2/21, 6/8/21 and 6/22/21; -The legal guardian checked the log for the the resident and there were no notifications from the facility since 5/20/21; -The legal guardian said this was twice he/she found out the facility said they notified him/her and didn't; -The legal guardian checked with all other staff in his/her office and no one received a phone call from the facility regarding the incidents. 9. Review of Resident #22's face sheet showed the following: -admitted [DATE]; -The resident had a guardian; -Diagnosis of schizoaffective disorder. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurses' notes, dated 6/28/21, showed staff documented at 9:15 A.M. the resident was physically aggressive towards another resident. Immediate staff intervention and separation from peers. The resident was allowed to vent and verbalize thoughts and feelings. Staff administered antipsychotic medication by injection. The resident was placed on one-on-one observation for protective oversight. Documentation showed staff notified the resident's legal guardian. Review of the facility's RNI, completed by the ADON, dated 6/28/21, showed the following: -Incident occurred 6/28/21; -The resident was physically aggressive toward another resident. One-on-one monitoring initiated for the resident. New orders received to give the resident Haldol (antipsychotic medication used to treat schizophrenia and psychosis) 5 milligrams (mg) intramuscularly (IM) (injection administered by injection). Medication administered per order. -The resident's guardian was notified on 6/28/21. During interview on 6/30/21 at 3:38 P.M., the resident's guardian said the facility staff called today (6/30/21) and told him/her the resident hit someone and the resident had said something inappropriate to the other resident. (Staff documented contacting the guardian on 6/28/21.) Staff did not specify when the altercation occurred. He/She was unaware the resident hit another resident on 6/28/21. Staff did not call him/her on 6/28/21 regarding a report the resident hit another resident. He/She wanted to know if the resident had any problems. 10. During an interview on 6/29/21 at 3:51 P.M., LPN G said the following: -He/She made calls to management and long-term psych management (LTPM) when an incident occurred with a resident; -The nurses called the residents' physicians and legal guardians; -If the nurses were very busy, he/she documented the legal guardian was contacted. He/She was not sure if the nurses actually contacted the legal guardians. During an interview on 7/6/21 at 6:11 P.M. the Director of Nurses (DON) said the following: -She expected staff to notify a resident's guardian by telephone if a resident was involved in an altercation with another resident, if staff observed any suspicious behavior, if staff conducted a room search, if a urine drug screen was indicated, and when a resident was moved to another hall; -She expected staff to notify guardians of any dental concerns, including needing dentures; -Staff should not document they contacted the resident's guardian if they didn't actually do so; -It should be clear in the documentation who notified the guardian and if the staff left a message or if they actually spoke to someone; (continued on next page)

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Refer to Event ID QJHT13. This deficiency is uncorrected. For previous examples, see Statement of Deficiencies dated 5/20/21. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #22), in a review of 48 sampled residents, was free from mental abuse when staff were aware another resident made up a song about Resident #22 that described the resident as a fool and he/she had a stinky cunt, and sang the song multiple times in front of Resident #22. Staff failed to intervene and prevent Resident #49 from singing the song and teaching the same song to another resident (Resident #86), who also sang the song to Resident #22. Resident #22 said Resident #49 hurt his/her feelings and, he/she also reported, Resident #49 said get your ass up the hall and out of the dining room. Resident #22 became frustrated and hit Resident #86 in the back of the head with his/her wallet resulting in staff administering Resident #22 an antipsychotic medication for behavior management. The facility census was 164. The administrator was notified on 6/30/21 of the Immediate Jeopardy (IJ) which began on 6/28/21. The IJ was removed on 7/2/21, as confirmed by the surveyor onsite verification. Review of the facility Abuse and Neglect Policy, dated 7/8/20, showed the following: -It was the facility's policy that every resident had the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion; -The facility prohibited mistreatment, neglect, or abuse of residents; -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; -Mental abuse included either verbal or nonverbal conduct which caused, or had the potential to cause, the resident to experience humiliation, intimidation, fear, shame, agitation or degradation; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Prevention and identification section included the facility would provide resident, and staff information on how and to whom they could report concerns, incidents and grievances without fear of retribution and provide feedback on the concerns that were expressed. The facility would identify and correct by providing interventions in which abuse, neglect was more likely to occur. Supervisors should identify inappropriate behaviors such as derogatory language and neglectful care. Prevention would also include assessment care planning and monitoring of residents with needs or behaviors which may lead to conflict or neglect. The facility would identify events, patterns, and trends that could constitute abuse and investigate thoroughly, notify the administrator and the proper authorities. The facility desired to prevent abuse by establishing a resident-sensitive and resident-secure environment. Staff would assess the environment for circumstances which might make abuse more likely to occur, assess residents social history and identify residents with increased vulnerability for abuse or who had needs and behaviors that might lead to conflict and monitor the ability of the staff to meet the needs of residents and monitor the staffs understanding of individual resident care needs; -Protection of residents section included the facility would take steps to prevent mistreatment while the investigation as underway. Resident who allegedly mistreated another resident would be removed from contact with the resident during the course of the investigation. The accused resident's condition should be immediately evaluated to determine the most suitable therapy care approaches and placement considering his/her safety as well as the safety of other residents. 1. Review of Resident #22 Preadmission Screening and Resident Review (PASRR, an assessment tool used to ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in a nursing home for long-term care and to ensure residents are provided appropriate treatment and care for their mental and behavioral health), dated 7/6/17, showed the following: -Diagnoses included schizophrenia (a mental disorder characterized by disturbances of thinking, mood, and behavior), schizoaffective disorder (a mental health disorder including schizophrenia and mood disorder symptoms), and anxiety disorder; -No threat to self or others; -Moderate delusions; -Records indicate long history of schizophrenia with multiple hospitalization s. Auditory hallucinations with extreme paranoia; -Difficulty interacting appropriately/communicating effectively with others, history of altercations, evictions, firing, fear of strangers and difficulty concentrating; -Poor impulse control and poor judgement; -Unable to care for self; needs a behavior unit related to safety issues for the resident. Review of the resident's care plan, revised 9/17/20, showed the following: -Diagnosis of bipolar disease (a mental illness of mood swings); (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At the time of PASRR, the resident was deemed safe for admission. Outcome was resident would remain safe in the facility and learn to understand and accept mental illness. Work on positive and effective communication with peers and staff. The resident would be in the lowest restrictive environment while maintaining protective oversight. Mental health issues began in late teens with hospitalization at age 18. The resident was diagnosed with schizophrenia, paranoia, delusions, hearing voices, and combative. The resident was hospitalized numerous times. Non-compliant with medications, poor impulse control, and poor judgement; -The resident had impaired thought process related to schizophrenia. He/She could be verbally aggressive, would yell, slam doors and throw things. History of taking pictures of other residents and calling the police. Outcome was the resident would improve decision making ability by accepting judgement of staff/guardian as appropriate. The resident would be free of behavior related injury. Staff should administer medications as ordered and keep the resident's routine consistent and try to provide consistent caregivers as much as possible. Provide a safe environment. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 5/7/21, showed the following: -Cognitively intact; -No hallucinations or delusions; -No physical, verbal or other behavioral symptoms directed toward others. 2. Review of Resident #86's psychiatric progress note, dated 4/20/21, showed the following: -Diagnoses included hyper-sexuality disorder (a mental disorder of excessive fixation on sexual behaviors), anxiety disorder, paranoid schizophrenia (a mental disorder characterized by disturbances of thinking, mood, and behavior), obsessive-compulsive disorder (a mental disorder of unreasonable thoughts and fears that lead to repetitive behaviors), and mild intellectual disability; -Staff reported the resident had been more sexually inappropriate and aggressive and difficult to redirect. Review of the resident's care plan, revised 4/1/21, showed the following: -The resident had a long history of mental illness. Desired outcome was stabilization of mental illness. Staff should provide long-term psych management and counseling. The resident exhibited constant talking and impulsivity, and being sexually inappropriate; -The resident had intellectual disability and a history of verbal and physical aggression. Staff should engage the resident in simple, structured activities that avoided overly demanding tasks. The resident preferred to sing, dance and talk loudly. Review of the resident's physician's progress note, dated 5/26/21, showed the resident had hypersexual and abnormal as well as inappropriate behavior around females. Staff reported the behaviors usually got worse around noon and he/she was sometimes difficult to redirect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -No delusions or hallucinations. 3. Review of Resident #49's care plan, revised on 4/15/20, showed the following: -Diagnoses of schizophrenia, bipolar disorder (a mental disorder of extreme mood swings), and schizoaffective disorder (a mental health disorder including schizophrenia and mood disorder symptoms); -The resident had a history of behavioral challenges that required protective oversight in a secure setting. Desired outcome was no serious injuries due to behaviors. Educate on communication and coping skills and provide pharmaceutical interventions as needed; -The resident was delusional, believing he/she had a master's degree in many different professions, and had impaired memory and decision making abilities. The desired outcome was minimized episodes of inappropriate behaviors. Staff should educate on utilizing coping skills and effective communication, administer and monitor medications and provide as needed medications when non-pharmacological interventions were ineffective. Assist the resident in addressing root cause of change in behavior or mood. Writing notes, making lists and music were the resident's coping skills. Staff should encourage the resident to slow his/her speaking, give positive feedback for good behavior. If the resident was disturbing others, encourage the resident to go to a more private areas to voice concerns/feelings. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Physical (hitting, kicking, pushing, scratching, grabbing or abusing) and verbal (threatening others, screaming at others, cursing at others) behavioral symptoms directed toward others occurred one to three days of the previous seven days. 4. Review of the facility Administrator/Registered Nurse (RN) Investigation, completed by Assistant Director of Nursing (ADON), dated 6/28/21, showed the following: -Incident occurred 6/28/21; -Investigative narrative note: Resident #22 became physically aggressive toward Resident #86. Staff immediately separated the residents and allowed the residents to verbalize feelings and concerns. One-on-one monitoring initiated for Resident #22. Long-Term Psych Management (LTPM) Psychiatric physician was contacted with new orders for Resident #22 to receive Haldol (antipsychotic medication used to treat schizophrenia and psychosis) 5 milligrams (mg) intramuscularly (IM) (injection administered by injection). Medication administered per order. -Care plan changed and interventions section: Resident #22 was given Haldol 5 mg IM as ordered and placed on one-on-one monitoring. Both residents educated on socially appropriate behavior with understanding voiced. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #22's written statement, dated 6/28/21 at 9:19 A.M., showed he/she was sitting down watching television. He/She looked at Resident #86 and Resident #86 stuck out his/her tongue at Resident #22. He/She said, stop, and then Resident #86 started singing the song that Resident #49 sang, Hello (Resident #22's first name) about his/her (Resident #22's) stinky cunt. So, he/she hit Resident #86 in the head with his/her wallet, but not hard enough to hurt him/her. During interview on 6/29/21 at 10:05 A.M., Resident #22 said the following: -Yesterday (6/28/21), Resident #49 was in the dining room and sang the song he/she made up about Resident #22's cunt. Resident #49 sings that song every day and has been singing it for a long time. The song includes a part about Resident #22's stinky cunt and says Resident #22 stinks. Resident #86 sat in a chair in the dining room and stuck his/her tongue out at Resident #22. It made Resident #22 mad and upset, so he/she tapped Resident #86 with his/her wallet on his/her head; -Resident #49 taught Resident #86 to mock Resident #22, and taught Resident #86 the song; -Staff don't do anything to Resident #49, and Resident #49 does not get into any trouble for singing the song, however he/she did not have specific examples; -Resident #22 said, I'm the one who got the shot. It's my fault. (referencing Resident #22 hitting Resident #86 with his/her wallet and receiving an injection); -Resident #22 cried and said Resident #49 sang a song everyday about how his/her privates stink. During interview on 6/29/21 at 9:40 A.M., Certified Nurse Assistant (CNA) J said the following: -On 6/28/21 at approximately 9:00 A.M., he/she was in the hallway and heard Resident #22 yelling at Resident #86. The residents were in the Safe Harbor hall dining room. Resident #22 yelled, That is enough, or I am going to hit you. Resident #86 was talking loudly. CNA J did not know what Resident #86 said; -Resident #86 got other residents upset and agitated and was hard to redirect. He/She talked all the time, was often sexual in nature, cussed, and was inappropriate to other residents. Resident #86 would often upset Resident #22. During interview on 6/29/21 at 9:50 A.M., Licensed Practical Nurse (LPN) F said the following: -Resident #49 was in the dining room and was antagonizing the situation. The LPN was passing medications and did not observe the altercation or what led up to it; -Resident #86 was not agitated at the time. Resident #86 chanted and had a robotic and loud speech. He/She had inappropriate speech and made sexual references and cussed; -Resident #22 said Resident #86's mumbling got under his/her skin. During interview on 6/29/21 at 9:55 A.M., Resident #93 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 - Few	-Resident #22 hit Resident #86 in the face and pulled his/her hair yesterday (6/28/21) in the dining room. Resident #93 said his/her room was across the hall from the dining room and he/she saw it happen; -Resident #86 was sitting at the table, and Resident #22 got up and hit him/her; -Resident #49 was in the dining room at the time, was talking and singing a song. (Resident #93 smiled and laughed as he/she explained what Resident #49 was doing.) Observation on 6/29/21 at 10:36 A.M. showed Resident #49 left the Safe Harbor hall dining room and walked towards the common area/television room and stopped at the doorway. Resident #22 sat in the common area/ television room. Resident #22 turned his/her head and turned away from the direction of the doorway and Resident #49. Observation on 6/29/21 at 10:38 A.M. showed Resident #49 remained in the hallway near the common area/television room where Resident #22 sat. Resident #49 sang a lengthy song that included Resident #22's first name and ended with his/her stinky cunt. Resident #49 laughed as he/she sang the song. Resident #22 sat with his/her back to the door way and made no change in position, and did not turn his/her head toward the common area/television room doorway. A staff member was monitoring Resident #22 one-on-one, and other CNA staff were nearby and did not intervene or redirect Resident #49. During interviews on 6/29/21 at 10:38 A.M., CNA J said he/she was aware of the song Resident #49 sang about Resident #22; it had been going on for a long time. Resident #49 provoked Resident #22. He/She had informed the charge nurse previously that Resident #49 provoked Resident #22. Resident #22 only responds negatively or becomes agitated when Resident #49 and Resident #86 sang the song about Resident #22 and agitated the resident. It was abusive for Resident #49 and Resident #86 to sing the song about Resident #22. During interview on 6/29/21 at 11:00 A.M., Resident #86 said Resident #22 got very mad when they sang the song about him/her. Resident #86 sang the first part of the same made up song that included Resident #22's first name. Observation on 6/29/21 showed the following: -At 11:05 A.M., Resident #49 and Resident #86 sat in the Safe Harbor dining area. Resident #49 loudly sang an appropriate song. This song was appropriate and not about Resident #22 . Resident #22 sat in the common area/television room across the hall and down two doors. Resident #22 looked out to the hall towards Resident #49 and then turned his/her head away from Resident #49 and towards the television; -At 11:10 A.M., the activity department staff asked Resident #49 if he/she wanted to do music therapy. Resident #49 walked into the dining area and started singing loudly. Resident #49 was singing a different song, not about Resident #22. The Activity staff member said Resident #49 liked music, smiled and encouraged Resident #49 to sing. However, Resident #22 lowered his/her head and cowered away from the common area/television room doorway. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 6/30/21 at 12:20 P.M., LPN F said Resident #49 was intrusive and agitated on 6/28/21. Resident #49 was loud and yelled at Resident #22 and instigated many issues. Resident #49 was mentally abusive towards Resident #22 and it had been happening for a long time. He/She was aware of the song Resident #49 sang about Resident #22, although he/she had never heard the song. He/She had informed the unit supervisor and the ADON of Resident #49's behaviors towards Resident #22. During interview on 6/30/21 at 12:36 P.M., Resident #22 said Resident #49 picked on him/her all the time. Resident #49 sang the song about him/her, Hello (Resident #22's first name) what can I do, Hello (resident's first name) you are a fool, and then the end of the song was awful about his/her private parts (genitalia). Resident #86 also knew the song and called Resident #22 Wacky (Resident #22's first name). During interview on 6/29/21 at 3:40 P.M., the Director of Nursing said the following: -Staff should first inform the charge nurse, and then supervisors, of a resident taunting another resident. Staff should educate residents on dignity and respect and prevent further taunting; -He/She was unaware Resident #49 made up a song about Resident #22, and taught Resident #86 the song that included inappropriate language and references; -Staff should stop Resident #49 and Resident #86 from singing the song about Resident #22, intervene and prevent a reoccurring behavior and should provide behavior management interventions for Resident #49 and Resident #86; -He/She was unaware Resident #22 felt picked on or that residents were taunting Resident #22. During interview on 6/30/21 at 12:50 P.M., the ADON said he/she did the investigation into the altercation between Resident #22 and Resident #49. He/She wished he/she knew about the song, he/she would have stopped it a long time ago. Resident #49 hurt Resident #22's feelings. Mental abuse included name calling. During interview on 6/30/21 at 1:20 P.M., the Administrator said he/she was unaware Resident #49 and Resident #86 sang a song made up about Resident #22 that included the resident's name and referred to the resident's stinky cunt. If staff thought a resident was abusive towards another resident, staff should report that and immediately, implement interventions, and not allow the abuse to continue. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO187295

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Refer to Event ID QJHT13. Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #133 and #47), in a review of 48 sampled residents, received necessary care and services in accordance with professional standard of practice. Nursing staff failed to assess Resident #133's condition when notified of the resident's change (deterioration) of his/her condition. As a result, the resident became unresponsive, without pulse and respirations, a code blue was called, cardio-pulmonary resuscitation (CPR) initiated, and resident was taken to the hospital where he/she expired. Staff failed to address Resident #47's request for assessment/treatment/prevention of his/her skin wounds that were caused as a result of a neurological disorder. Facility's census was 164. The administrator was notified on [DATE], of the Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by the surveyor onsite verification. 1. Review of Resident #133's Preadmission Screening and Resident Review (PASRR, a required screening to ensure individuals are not inappropriately placed in nursing homes for long-term care), dated [DATE], showed the following: -The resident had serious mental illness; -He/She required psychiatric rehabilitative services of a lesser intensity which could be provided by the nursing home; -His/Her diagnoses included fetal alcohol syndrome (group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects could include physical problems, and problems with behavior and learning), bipolar disorder (mood disorder characterized by periods of depression and periods of abnormally elevated mood), organic mood disorder (variation of bipolar disorder that is caused by physical trauma or illness), post traumatic stress disorder (PTSD, a mental health condition triggered by a terrifying event causing flashbacks, nightmares, and severe anxiety), mild intellectual deficit, oppositional defiant disorder (pattern of angry/irritable mood), dysthymic disorder (long-term mood disorder), and borderline personality disorder (emotionally unstable personality disorder or borderline pattern personality disorder characterized by long-term pattern of unstable relationships, distorted sense of self, strong emotional reactions, argumentative/defiant behaviors or vindictiveness); -The resident had mood lability, irritability, depressed mood, intrusiveness, verbal aggression with threats to staff to become physically aggressive, crying spells, and excessive appetite; -He/She displayed symptoms of PTSD including history of physical/sexual abuse, negative affect, difficult experiencing positive affect, irritability, risk taking behaviors, difficulty sleeping, and avoidance of trauma related thoughts/feelings; -He/She required consistent medical and psychiatric follow up to promote stability. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's care plan, dated [DATE], showed the following: -He/She had history of behavioral challenges that required protective oversight in a secure setting; -He/She had marked mood lability, impulsivity, and irritability manifested by banging his/her head, fighting with peers, and angry outbursts; -He/She required daily monitoring of safety in his/her environment, fall risks, medication compliance, weight stability, and vital signs to assure maximum stability; -He/She required ongoing assessment of mood/behaviors; -Staff were to provide non-pharmacological interventions such as providing one-on-one attention as needed for behaviors; -He/She raised his/her voice and didn't always realize he/she was doing it; -Staff were to monitor behavioral episodes and attempt to determine the underlying cause with taking into consideration the location, time of day, persons involved, and situations. Staff were to document behavior and potential causes. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated [DATE], showed the following: -His/Her cognition was moderately impaired; -He/She had no behaviors in the previous seven days; -He/She required supervision with activities of daily living (ADLs), transfers, ambulation, and eating. Review of the resident's progress notes, dated [DATE] at 10:20 A.M. showed the Assistant Director of Nursing (ADON) documented the resident was sitting on the unit. The resident was noted to be upset and requested a sandwich. The ADON and another staff member met with the resident and explained they would call dietary and request a sandwich for him/her. The resident then requested two sandwiches. Staff explained to the resident that staff would request the sandwiches from dietary. The resident was easily redirected and remained calm and cooperative. Staff would continue to monitor to ensure protective oversight. Review of resident's progress notes, dated [DATE] at 10:35 A.M., showed the ADON documented the resident was unresponsive at that time. The resident was without pulse and respirations. CPR started immediately, and 911 was called. Observation on [DATE] at 10:36 A.M. showed the following: -Code Blue (medical emergency) was called on the overhead paging system for staff to respond to first floor unit (where the resident resided); (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Upon arrival to the unit, the resident lay on floor in front of the dining/common area of the unit. The Director of Nursing (DON) performed chest compressions. Review of the facility's investigation of the event, dated [DATE], showed the following: -A Code Blue was called at approximately 10:30 A.M.; -Upon arrival, the resident was lying on the floor in the hallway. Registerd Nurse (RN) H was performing compressions, automated external defibrillator (AED - device used in an emergent event to shock the heart) obtained, and 911 was called; -Hall Monitor A stated the resident was sitting on the floor and had stated he/she was upset about a smoke break. Hall Monitor A called the nurse and he/she was able to smoke. Hall Monitor A then stated the resident became upset again about snacks. Hall Monitor A called the nurse's station, and ADON and LPN G responded to talk to resident about what was going on. The resident stated he/she wanted two sandwiches and they told him/her they would get him/her one. As they left the unit, they told LPN F. LPN F parked and locked the medication cart and walked out to the hallway. At this time, RN H came on to the unit and saw the resident lying on the floor. He/She began an assessment, and had the residential care facility (RCF) assistant manager come help assess as Code Blue was being called. RN H began compressions; -Received call from the resident's legal guardian that the hospital had contacted him/her to notify him/her the resident had expired. During an interview on [DATE] at 12:05 P.M., Hall Monitor A said the following: -He/She worked on first floor unit (where Resident #133 resided) and it was his/her second day; -He/She had one day (yesterday, [DATE]) of orientation on the unit and then was left on his/her own today; -He/She was not familiar with the residents and their behaviors and/or medical conditions, and should not have been left alone on the unit; -The resident came back from physical therapy and wanted his/her sandwich, but another resident ate it; -He/She gave the resident a [NAME] bar (peanut butter wafer) to try and appease him/her, but the resident wanted a sandwich; -The resident went to the hallway and sat down with the [NAME] bar, but only took a few bites out of it because he/she did not want it; -The resident leaned over while sitting on the floor. Hall Monitor A just didn't think the resident acted right; -He/She contacted LPN F to come over to look at the resident; (continued on next page)

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	265469	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levering Regional Health Care Center	1734 Market 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She called LPN F three or four times trying to get him/her to come look at resident because he/she thought resident was not acting right; -LPN F hung up on him/her during one of the calls he/she made and did not come to the unit to check on the resident; -When LPN F came to the unit, he/she told Hall Monitor A the resident was having a behavior and to just watch him/her; -LPN F shined his/her phone light in the resident's eyes, but did not obtain any vital signs, blood sugar, or any other assessment when he/she was called over to the unit; -Hall Monitor A was distraught over the incident and could not provide exact times of when he/she called LPN F. -Hall Monitor A stated multiple times that he/she attempted three or four times to get LPN F to come check on the resident when he/she noted the resident just wasn't acting right, and other residents were telling him/her that something was wrong with the resident; -The resident was responsive and talking, then leaned forward and starting spitting. -He/She was told resident was a spitter, but could not recall who told him/her that. He/She did not know if spitting was part of resident's known behaviors because he/she was unfamiliar with him/her; -ADON and LPN G came onto the unit. The resident was lying on the floor so they turned him/her onto his/her side. The ADON and LPN G were there for approximately ,d+[DATE] minutes and the resident told them he/she wanted two sandwiches. They did not obtain any vital signs or assessment of resident that he/she was aware of. The resident was lying on his/her side when ADON and LPN G left the unit; -He/She thought it was a behavior when resident quit talking (could not recall exactly when this occurred but thought it was after the ADON and LPN left to get the resident a sandwich); -Two or three minutes after ADON and LPN G left the unit, registered nurse (RN) H arrived on the unit and noticed the resident was not acting right; -RN H touched the resident's wrist and hollered for the RCF assistant manager to come look at the resident, determined there was no pulse, and hollered for him/her (Hall Monitor A) to call a Code Blue; -He/She asked how he/she was to call the Code Blue and RCF assistant manager told him/her how to call the code while RN I started CPR; -He/She thought this situation could have been different if LPN F would have stayed with him/her the first time he/she contacted him/her and if he/she would have responded when he/she called for help as he/she was unfamiliar with the resident. Review of Hall Monitor A's written statement, dated [DATE], 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	-The resident was upset that another resident ate his/her sandwich; -He/She provided the resident with a [NAME] bar. The resident took one bite and said he/she did not want it; -The resident then walked around tapping on the wall and expressed that he/she was upset; -The assistant staffing coordinator stopped by the unit and saw the resident was upset. Hall Monitor A explained why the resident was upset, and after explanation the assistant staffing coordinator instructed him/her to call LPN F; -The resident sat on the floor and was still talking. LPN F was contacted and came over because the resident had laid over. LPN F looked at the resident and told him/her that the resident was having a behavior, -The Hall Monitor kept calling over to LPN F because he/she felt as if something was wrong; -The second time he/she contacted LPN F, the LPN came over and attempted to get the resident up, shined a light in the resident's eyes, and told Hall Monitor A that the resident was having a behavior. Hall Monitor A just saw the resident looking straight forward and didn't know if his/her pupils responded to the light in his/her eyes; -The ADON and LPN G came over and told the resident he/she needed to get up if he/she wanted a sandwich and if he/she wanted to smoke. The resident responded by saying he/she did not want a cigarette; -The ADON and LPN G assisted the resident to his/her side because the resident was on his/her back at that time; -Not even five minutes after the ADON and LPN G left, certified occupational therapy assistant (COTA) I, and RN H walked onto the unit; -RN H stopped and felt the resident's wrist and did not palpate a pulse; -RN H instructed him/her to call a code. He/She asked RCF assistant manager how to call the code, and he/she provided him/her with instructions of how to call the code while RN H performed CPR. During an interview on [DATE] at 1:40 P.M., Hall Monitor A said LPN F came over the first time he/she called for him/her. He/She called LPN F three or four times total to come check on the resident because he/she didn't act right. The resident showed weird symptoms. Review of LPN F's written statement, dated [DATE], showed the following: -Around 10:00 A.M., Hall Monitor A called for him/her to come talk to the resident; -He/She went to the unit and found the resident lying on his/her back on the floor. The resident responded when spoken to and stated he/she wanted sandwiches; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She checked the resident's pupil response and found they responded appropriately; -At 10:29 A.M., he/she contacted LPN G to let him/her know he/she (LPN F) was going on break. LPN G and the ADON spoke to the resident who said he/she wanted a sandwich; -At 10:29 A.M., he/she left the hall to make a phone call. His/Her phone call was completed at the same time RN H entered the unit. As he/she entered the doors back onto the unit, he/she was told CPR needed to be started because the resident had no pulse. Staff called a Code Blue, and he/she went to grab the crash cart. During an interview on [DATE] at 12:20 P.M., LPN F said the following: -He/She went over to the unit because Hall Monitor A told him/her the resident was lying on the floor making funny noises and talking about wanting a sandwich; -He/She thought it was unusual that the resident would be lying on the floor so he/she shined a light in the resident's eyes for everyone's peace of mind. The resident was sitting up talking to staff; -He/She denied that Hall Monitor A called him/her three or four times or that he/she hung up the phone without speaking to the hall monitor. During interview on [DATE] at 12:40 P.M., LPN F said the following: -The resident went to therapy that morning and returned approximately ,d+[DATE] minutes later; -The resident smoked when he/she returned from therapy and Hall Monitor A reported that the resident was on the floor because he/she was upset over a sandwich; -He/She went to the unit to check on the resident and sat down next to him/her on the floor. He/She told the resident to let him/her check his/her eyes; -The resident had no complaints and had not received any of his/her morning medications at that time; -He/She told Hall Monitor A the resident was behaving normal; -Hall Monitor A did not mention any behaviors such as spitting or banging hands on the wall to him/her; -He/She did not perform an assessment because he/she thought the resident was acting normal. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 1:51 P.M., LPN F said the first time he/she went to check on the resident, he/she noted the resident was his/her playful/joking self. The resident was waiting for snacks because he/she wanted a sandwich. The resident was lying on the floor, but he/she would do that from time to time. The resident acted like he/she was pouting because he/she wanted a sandwich. LPN F contacted LPN G to come relieve him/her for break. Hall Monitor A did not report the resident was not acting right. Hall Monitor A just called and said the resident was upset about a sandwich that someone else ate. He/She was unaware the resident was spitting or banging his/her hands on the wall. He/She was unsure if staff placed the resident on his/her side because he/she had stepped off of the unit to make a phone call. Before he/she stepped off of the unit, the resident was talking about wanting the sandwich. He/She was gone for four minutes and 32 seconds. He/She was hanging up the phone as he/she returned to the unit and was asked to grab the crash cart because the resident was without a pulse. During interview on [DATE] at 2:00 P.M., LPN G said he/she came to the unit to relieve LPN F for a break. When he/she walked onto the unit, the resident asked about smoking and a sandwich. The resident told him/her that he/she wanted two sandwiches with cheese. He/She did not think the resident acted any different than normal. He/She did not recall assisting the resident onto his/her side. The ADON was also on the unit for another reason and they were both called to go to other side of the unit. As he/she went down the hall, he/she heard the Code Blue called for the unit he/she had just left. Hall Monitor A had told him/her the resident had a behavior, but did not describe what type of behavior. Hall Monitor A did not tell him/her the resident was not acting right. During an interview on [DATE] at 2:30 P.M., the ADON said the following: -The resident's condition/behavior did not appear to be out of the normal to him/her; -He/She was unaware that Hall Monitor A contacted LPN F three or four times because he/she thought the resident was not acting right. -The date of the incident was Hall Monitor A's second day working and his/her first day on the unit alone with residents. LPN F should have been there to support him/her when needed. During interview on [DATE] at 1:25 P.M., RN H said the following: -He/She noted the resident was lying on the floor on his/her back when he/she came on the unit; -The resident did not appear to be acting right. He/She rubbed the resident's chest and hollered the resident's name with no response. He/She checked for a pulse and could not palpate one. He/She hollered for RCF's assistant manager to come check for pulse of which he/she could not palpate one either; -He/She instructed Hall Monitor A to call Code Blue as he/she began CPR; -He/She noted the resident was pale and had vomit on his/her face. Review of written statement from Resident #95, provided by the facility, dated [DATE] 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	-The aide flipped out and tried to contact the nurse; -Resident #133 turned blue and his/her eyes went in the back of his/her head; -Resident #133 hit the floor pretty hard and the aide yelled for them to go to their rooms. During interview on [DATE] at 12:55 P.M., Resident #95 said the following: -He/She had therapy with Resident #133 on the morning of [DATE]; -Resident #133 looked fine, but complained of dizziness and was taken back upstairs; -He/She watched Resident #133 sit down on the floor and his/her eyes rolled back in his/her head; -Staff thought he/she was faking and tried to sit him/her up, but he/she slumped back over and on his/her right side; -He/She watched the resident turn blue. He/She told Hall Monitor A that he/she needed to call the nurse, but was told not to worry about it. After that, he/she heard assistant RCF manager yell call Code Blue. Review of Resident #27's written statement, provided by the facility, dated [DATE] showed the following: -Resident #133 had went to the kitchen and someone had eaten his/her snack; -Resident #133 complained of being real dizzy, went out in the hall, and collapsed; -His/Her face was blue as a berry, eyes were red around the rims, and he/she quit breathing. Review of Resident #501's written statement, provided by the facility, dated [DATE] at 10:26 A.M., showed the following: -He/She was sitting next to Resident #133 on the floor when he/she noticed he/she was acting strange, but still talking to him/her; -While sitting with him/her, he/she quit talking and started to lay on the floor; -Hall monitor A told him/her to get up and walk away when he/she laid down; -He/She heard code blue called after he/she got up. During an interview on [DATE] at 12:55 P.M., Resident #87 said the following: -Hall monitor A said that Resident #133 was faking; -He/She watched resident turn blue. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:10 P.M., Fire and Rescue staff member said the biggest concern he/she had was how long the resident was down because there were different stories whether resident's event was witnessed or unwitnessed. During interview on [DATE] at 11:20 A.M., Resident #145 said the following: -His/Her room was by where Resident #133's emergent situation occurred; -He/She was familiar with Resident #133 as they have been there together for quite some time; -Resident #133 said he/she was hungry and wanted a sandwich and just kept repeating it over and over; -Resident #133 was acting different than normal; -Hall Monitor A kept calling over to the nurse's station to let them know Resident #133 did not look right and he/she overheard other staff say he/she always did that when he/she laid down; -Nursing staff thought Resident #133 was attention seeking. During an interview on [DATE] at 2:30 P.M., certified occupational therapy aide (COTA) I said that Resident #133 worked out better than he/she normally had and had asked to stay longer. During an interview on [DATE] at 6:15 P.M., the DON said the following: -She would have expected licensed staff to acknowledge and assess the resident's condition when hall monitor A called to alert LPN F of the resident's change in condition and/or his/her concerns. Especially since the hall monitor was not familiar with the resident; -Licensed staff should not hang up on hall monitors when they are attempting to contact them; -She would not expect licensed staff to tell a hall monitor a resident was having behaviors and not conduct an assessment. Staff should not assume a resident is having a behavior without a proper assessment; -Staff should conduct assessments, including checking pupils, vital signs, checking blood sugar level, asssessing general appearance including skin color, level of consiciouness, and listening to lungs when applicable when there is a concern that a resident's condition had changed. During interview on [DATE] at 2:46 P.M., the ADON said he/she was on the unit rounding and performing resident focused interviews. The resident was upset over a sandwich and nothing else was wrong. Hall Monitor A did not report anything other than the resident was upset over a sandwich. He/She was not called to the unit to assess the resident. LPN G was on the unit at the same time as him/her to relieve LPN F for a break. 2. Review of Resident #47's care plan, dated [DATE], showed the following: -He/She had a behavioral problem of picking at his/her skin related to depression and anxiety; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She had a large scabbed area to his/her forehead that he/she continuously picked; -Staff were to educate the resident on infection control, and if reasonable, discuss the resident's behavior; -Staff were to reinforce with the resident why the behavior was inappropriate or unacceptable; -Staff were to intervene as necessary; -Staff were to praise the resident when he/she showed improved behavior; -Staff were to administer medications as ordered, and to anticipate his/her needs. Review of the resident's psychiatric physician's progress note, dated [DATE], showed the following: -The resident had some moody days; -Staff reported he/she seemed to experience more anxiety and skin picking continued; -Resident said he/she picked at his/her skin, but had done it for [AGE] years; -The resident had multiple scabbed areas; -Plan: Ativan (medication used to decrease anxiety) 0.25 milligrams (mg) by mouth three times a day. Review of the resident's history and physical, dated [DATE], showed the following: -He/She had a long history of self-mutilation behaviors; -He/She had an open area on his/her forehead and many new other locations that continued to get worse with many of the areas infected; -This is a persistent problem; -Present illness: neurotic excoriations (skin picking disorder) from self-mutilation. Areas were getting larger with multiple areas becoming more severe. Further psychiatric evaluation pending; -Problem continued, but never improved; -Skin assessment: multiple open sores from self-mutilation. Area on left forearm was wrapped with gauze and covered with an ace wrap bandage to prevent him/her from making the area of concern worse, but he/she would remove as he/she had in the past; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included neurotic excoriations, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), attention deficit disorder with hyperactivity (poor concentration, hyperactivity, and impulsivity), mixed obsessional thoughts and ideas, and diabetes (medical condition with elevated blood sugar level). Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated [DATE], showed the following: -His/Her cognition was intact; -He/She had no behaviors; -He/She had no skin concerns documented; -He/She did not receive any skin treatments. Review of the resident's physician's order sheet (POS), dated [DATE] through [DATE], showed the following: -He/She was allergic to tape adherents; -Mupirocin 2% cream (antibiotic cream used to treat superficial skin infections), apply topically to forehead twice a day as needed for irritation (original order dated [DATE]); -Mupirocin 2:% cream, apply topically to left shoulder as needed until abscess is healed (original order dated [DATE]); -Diphenhydramine (medication applied topically to relieve pain and itching) 50 mg, administer two capsules every six hours as needed for itching (original order dated [DATE]); -Ativian (antianxiety medication) 0.5 mg to be administered three times a day. Review of the resident's weekly skin assessment, dated [DATE], showed the resident's skin was intact. Review of the resident's monthly nursing assessment, dated [DATE], showed staff documented the resident picked at his/her skin. There were no skin treatments documented. Review of resident's weekly skin assessments showed the following: -On [DATE], the resident's skin was intact; -On [DATE], the resident's skin was intact; -On [DATE], the resident's skin was intact; -On [DATE], the resident's skin was intact. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:10 P.M., Licensed Practical Nurse (LPN) F said the following: -The resident asked staff to wrap his/her arms and night shift staff wrapped them, but the resident went days without them wrapped; -The resident did not have physician's order to wrap his/her arms; -The resident placed socks on his/her arms, but would dig through the socks; -The resident had an order for duoderm to affected areas, but he/she wasn't sure of order directions. (Review of the resident's physician's orders showed no order for duoderm.) During an interview on [DATE] at 3:30 P.M., the resident said the following: -He/She had to ask staff to put ointment on his/her skin when he/she wanted it on; -LPN O would not put ointment on his/her skin and would not wrap his/her arms because LPN O said the resident did not have physician orders; -The day nurses would not wrap his/her arms either, so he/she placed socks over his/her arms. Observation on [DATE] at 3:30 P.M. showed the following: -The resident's arms were unwrapped; -He/She had five open areas on his/her left arm, hand, and wrist that were beefy red in color; -He/She had eight open areas on his/her right arm/hand area; -There was dried blood on the resident's shirt and bed linens. During an interview on [DATE] at 3:20 P.M., LPN O said the following: -The resident had sores and scabbed areas from head to toe from where he/she had picked at his/her skin; -The resident called state because LPN O refused to wrap the resident's arms without an order; -He/She denied being rude to the resident, just said he/she was not going to do anything without a physician's order; -He/She did not contact the resident's physician regarding the resident's skin condition or the resident's request for staff to wrap his/her arms. During an interview on [DATE] at 4:35 P.M., the Assistant Director of Nursing (ADON) said 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	-This morning, he/she noticed the resident had socks on his/her arms to prevent him/her scratching at them; -Some staff wrapped the resident's arms, but other staff would not because there wasn't a physician's order to wrap them; -He/She added an order to wrap both the resident's arms because he/she thought it would be cleaner than placing socks on the resident's arms; -Wrapping the resident's arms would not necessarily require an order because there were no medications involved; -Staff needed to be proactive to prevent problems. Review of the resident's POS showed an order, dated [DATE], stating staff may wrap the resident's bilateral arms as needed. Review of the resident's Treatment Administration Record (TAR) showed no evidence staff wrapped the resident's arms on [DATE]. Observation on [DATE] at 7:15 P.M. showed the following: -The resident's arms were not wrapped; -He/She had multiple open areas on his/her arms, face, and legs that were irritated and reddened. During interview on [DATE] at 7:15 P.M., the resident said the following: -Staff had not wrapped his/her arms; -He/She asked LPN F to wrap his/her arms (on [DATE]), but was told he/she only had orders for duoderm. He/She is allergic to adhesive tape and could not have duoderm; Review of the resident's TAR showed no evidence staff wrapped the resident's arms on [DATE]. During an interview on [DATE] at 7:50 P.M., Corporate Management P said the following: -He/She observed the resident's skin and was concerned with condition of his/her skin; -Staff should assess the resident's skin. He/She would not expect the resident's skin assessment to state the resident's skin was intact when the resident had multiple areas of concern; -Staff need to address skin concerns. Review of the resident's skin assessment, dated [DATE] at 8:19 P.M., showed the following: -The resident had an area of concern measuring 9.7 centimeters (cm) by 4.6 cm by 2.6 cm. (Staff did not document a description or location of the area of concern.); (continued on next page)

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	265469	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levering Regional Health Care Center	1734 Market 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.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident had an area of concern measuring 3.9 cm by 2.8 cm by 2.3 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 1.1 cm by 1.3 cm by 1.3 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 4.6 cm by 3.6 cm by 1.8 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 11.8 cm by 5.9 cm by 3.3 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 1.1 cm by 1.3 cm by 1.3 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 12.2 cm by 7.4 cm by 3.5 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 4.9 cm by 3.0 cm by 2.2 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 8.2 cm by 6.8 cm by 3.4 cm. (Staff did not document a description or location of the area of concern.); -The resident had an area of concern measuring 1.0 cm by 1.6 cm by 1.1 cm. (Staff did not document a description or location of the area of concern.) Review of the resident's care plan, revised on [DATE], showed the following: -Intervention added on [DATE] showed the resident had an order to have his/her arms wrappped, but he/she removed the dressings; -The resident had multiple areas to his/her face, both arms, and leg that he/she continuously picked; -On [DATE], staff educated the resident on infection control. Review of resident's progress notes, dated [DATE] a [TRUNCATED]

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 33955 Refer to Event ID QJHT13. This deficiency is uncorrected. For previous examples, see Statement of Deficiencies dated 5/20/21. Based on interview and record review, the facility failed to provide protective oversight for 11 residents on a secured behavioral unit when Certified Nurse Assistant (CNA) C left the unit unattended. While the unit was unattended, Resident #76 fell to the floor and experienced a seizure. Resident #167 witnessed the event and called an emergency Code Blue (critical medical emergency) on the facility's overhead paging system to obtain help for the resident. The facility also failed to provide protective oversight when CNA C fell asleep on the same unit, and Resident #34 took medications from CNA C's personal bag. A sample of 48 residents was selected for review. The facility census was 164. The administrator was notified on 6/30/21, of the Immediate Jeopardy (IJ) which began on 6/26/21. The IJ was removed on 7/2/21, as confirmed by the surveyor onsite verification. The Director of Nursing (DON) said the facility does not have a policy for staffing or sleeping when on duty. 1. Record review of the facility census sheet, dated 6/25/21, showed 11 residents resided on Resident #76's unit. Review of the facility staffing sheet, dated 6/25/21 and 6/26/21, showed CNA C was the only staff assigned to the unit from 7:00 P.M. to 7:00 A.M. 2. Review of the Resident #76's care plan, dated 2/17/20, showed the following: -Per the Pre-Admission Screening and Resident Review (PASRR, a tool to assess individuals and ensure they are not inappropriately placed in nursing homes for long-term care), the resident had periods of agitation with a display of violent behaviors such as throwing things and hitting others; -The resident required a structured environment and was unable to care for himself/herself without supervision for behaviors and medication compliance; -Displays physical and verbal aggression towards staff and other residents at times; -Administer anti-seizure medications as ordered and protect from injury during witnessed seizures; -The resident advanced directive for code status was Full Code (requires cardio-pulmonary resuscitation in the event of a code blue); -On 4/2/21, a Code Blue (critical medical emergency) was called when the resident was noted to have seizure-like activity. Witnesses stated the resident experienced two seizures two to three minutes apart; (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/20/21, showed the following: -admitted [DATE]; -Diagnoses included medically complex conditions, diabetes, seizure disorder, and schizophrenia (a mental disorder characterized by disturbances of thinking, mood, and behavior); -The resident's Brief Interview for Mental Status (BIMS, a mandatory interviewing tool to assist with identifying a resident's current cognition) score was 14 on a scale of 0-15, indicating the resident's cognition was intact; -Required supervision and oversight for walking in the hall and locomotion on the unit. Review of the facility's video surveillance, dated 6/26/21, showed the following: -At 10:59 P.M., Certified Nurse Assistant (CNA) C walked through the locked doors on the unit where the resident resided to enter another locked unit. He/She left the unit unattended; -At 11:05 P.M., Resident #76 walked out of room [ROOM NUMBER] and fell on the floor in the hallway. Resident #167 got out of his/her chair in the hallway, bent over Resident #76, and touched him/her. Resident #34 looked out his/her door for a few seconds, went back in his/her room and shut the door. Resident #167 ran to the dining room and while he/she was gone, Resident #76 had seizure-like activity; -At 11:06 P.M., Resident #167 returned to Resident #76. Two staff members came running into the hallway from another locked unit. Review of the resident's nurse's note, dated 6/26/21 at 11:50 P.M., showed the resident had seizure activity and a Code Blue was called. During interviews on 6/29/21 at 3:09 P.M. and on 6/30/21 at 1:50 P.M., Resident #167 said a couple of nights ago, CNA C left the unit unattended for about 20 minutes. Resident #167 was in the hall eating popcorn and saw Resident #76 walk down the hall from the dining room, collapse on the floor and become unresponsive. Resident #167 was tapping and shaking and calling Resident #76's name but he/she wouldn't wake up. Resident #167 then got on the facility phone and overhead paged a Code Blue to their unit. CNA C and Licensed Practical Nurse (LPN) E arrived to the unit. Resident #76 had to be sent to the hospital because he/she hit his/her head. CNA C apologized for leaving the unit unattended for so long. Resident #167 was very scared and upset and had to take medication for nausea because his/her stomach was so upset after the incident. Sometimes CNA C fell asleep on the unit. Other staff who worked on the unit frequently left it unattended to go smoke or go to another unit. During an interview on 6/29/21 at 3:32 P.M., Resident #34 said he/she saw Resident #76 on the floor in the hall and he/she was unresponsive for a little while. There was no staff on the unit at the time the resident fell . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 6/29/21 at 6:36 P.M. and on 7/6/21 at 2:14 P.M. and 2:20 P.M., CNA C said he/she worked on Resident #76's unit the night of the incident and was the only staff member on the unit. He/She left the unit unattended for a couple of minutes to get a drink. He/She called the other unit for the charge nurse, LPN E, to tell him/her he/she needed to leave the unit but no one answered. While CNA C was off the unit, he/she heard a Code Blue called on the overhead paging system. CNA C returned to the unit and saw Resident #76 on the floor, unresponsive and having a seizure. The resident had a pulse but was not verbal. He/She arrived on the unit at the same time LPN E arrived to the unit. The charge nurse was supposed to get someone to cover the unit if staff needed to leave, but someone was not always available. He/She also left the unit later that same shift (about 6:00 A.M.), when all residents were in their rooms sleeping, to go to another unit to get a drink from the vending machine. Sometimes he/she had to walk a resident to another unit in order for them to get their medications from the nurse, leaving the unit unattended. He/She tried not to leave the unit unattended, but sometimes there was no choice because he/she had to go get supplies and other items or take a resident to the nurse. At times, he/she would call the nurse and tell him/her that he/she was going on break, and he/she would then go to the dining room on the unit and sleep without any other staff on the unit. Only rarely was he/she relieved for breaks or meals. He/She worked many hours and was very tired and was unable to stay awake throughout his/her shift. He/She had to have residents call Code Greens (behavioral emergencies) in the past in order to de-escalate a situation or get help dealing with a resident-to-resident altercation (as there were no other staff to assist). During an interview on 7/6/21 at 3:35 P.M., the Director of Nursing (DON) said she expected staff to be present on the units at all time to monitor residents. It was unacceptable for a staff member to leave a unit without coverage. There were more than 2 staff members on the schedule but only female were allowed to supervise the women's locked unit. The DON also said there is no written policy regarding keeping personal items (such as bags and purses) on the unit where residents could have access to them. During an interview on 7/6/21 at 4:08 P.M., the administrator said she expected staff to monitor all units at all times. Licensed staff should check the units hourly to ensure staff are not only present but on task and engaged with the residents. 3. Review of Resident #34's care plan, dated 7/13/20, showed the facility will continue to monitor the resident for protective oversight to ensure his/her highest practicable level of physical, mental and psychosocial well-being is met. Review of the resident's quarterly MDS, dated [DATE], showed the following: -admitted [DATE]; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Diagnoses included medically complex conditions, psychotic disorder (a mental disorder characterized by a disconnection from reality), post traumatic stress disorder (PTSD), (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), schizoaffective disorder (a combination of symptoms of schizophrenia (a mental disorder involving a breakdown in the relation between thought, emotion and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion) and mood disorder (disorder where your general emotional state or mood is distorted or inconsistent with your circumstances and interferes with your ability to function. Symptoms may occur at the same time or at different times), bipolar type, cannabis abuse (over use to the point of addiction of marijuana), mental, behavioral and neurodevelopment disorders (conditions that produce impairment of personal, social, academic, or occupational functioning); -The resident's BIMS score was 15 on a scale of 0-15, indicating the resident's cognition was intact; -Required supervision and oversight for walking in the hall and locomotion on the unit. Review of the Registered Nurse Investigation (RNI) report, dated 5/7/21, showed the following: -CNA C reported to LPN G, on 5/7/21 at approximately 7:30 P.M., that he/she had brought a bottle of medicine into the facility on [DATE] and the bottle was missing; -CNA C said he/she last saw the medication bottle about 1:00 A.M. on 5/7/21; -A room search was completed and the medication bottle was found in Resident #34's room on a locked unit where the resident resides; -The resident said he/she took the medication but was not sure if he/she took the pills; -Poison control was contacted; -The resident's primary care provider was contacted with no new orders given. During interviews on 6/29/21 at 4:36 P.M. and 6:36 P.M., 6/30/21 at 11:13 A.M. and 7/6/21 at 2:20 P.M., CNA C said he/she fell asleep during his/her night shift on 5/7/21. He/She had a pill bottle with five hydrocodone (opioid pain medication), four gabapentin (nerve pain medication) and six Flexeril (muscle relaxant) in his/her bag. He/She did not know the pill bottle was missing until the next day and he/she reported it to LPN G. Staff conducted room searches and found the pill bottle in Resident #34's room. There was rarely anyone to relieve him/her. He/She will call the nurse and tell them he/she is going on break in the dining room and sometimes he/she falls asleep on his/her break without any other staff on the unit. CNA C said there is a place to lock up his/her personal belongings and should have done that. He/She is not supposed to have his/her bag on the unit. During an interview on 6/30/21 at 4:32 P.M., Resident #34 said he/she does not remember anything about taking a bottle of pills from CNA C. He/She said staff found a bottle with some pills in his/her room. Resident #34 said he/she did not take any pills. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/30/21 at 4:46 P.M., Resident #104 said he/she was in bed and CNA C was sitting outside his/her room asleep on 5/7/21. Resident #34 came up to CNA C, looked at Resident #104 and put his/her fingers to his/her lips and said shhhh. Resident #34 reached into CNA C's bag and took a medicine bottle and went back to his/her room. This happened at 2:00 A.M. (on 5/7/21). During an interview on 7/6/21 at 4:28 P.M., LPN G said on 5/7/21, staff found a pill bottle in Resident #34's room with some pills still in the bottle. He/She couldn't remember what kind of pills were in the bottle. He/She didn't know if the resident actually took any of the pills. During an interview on 7/6/21 at 5:41 P.M. and 5:53 P.M., LPN R said the following: -Observation of the pill bottle showed almost the entire number of hydrocodone tablets that had been in the bottle were missing; -Poison control told the LPN to monitor the resident since the facility did not know if or when the resident had taken the pills; -There was no drug screen done on the resident; -The resident slept most of the day on 5/8/21. 4. During an interview on 7/6/21 at 3:35 P.M. and 6:11 P.M., and on 7/23/21 at 9:05 A.M., the DON said she expected the licensed charge nurses to check the units every hour to ensure staff were present and were relieved for breaks. The DON was not aware staff were not being relieved for breaks and were leaving the units unattended. Staff should not leave their personal belongings where residents could access them. During an interview on 7/6/21 at 4:15 P.M.,and on 7/23/21 at 9:18 A.M., the administrator said she expected licensed staff to check the units every hour to ensure the staff were present and engaged with the residents. The licensed nurse should coordinate coverage for break times. Either the licensed nurse or one of the aides should cover for staff during breaks to ensure the units were monitored by staff at all times. The administrator was not aware staff had left units unattended. She expected staff to be present to monitor residents at all times. Residents should not have access to staff member's personal belongings. Staff members should keep personal belongings locked in the employee break room where lockers were available or in the locked nurse's station or the locked snack rooms where they were not accessible to the residents. 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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Refer to Event ID QJHT13. Based on observation, interview, and record review, the facility failed to provide sufficient and competent staffing, for residents with severe mental illness, on a secured behavioral units to assure the resident safety and prevent resident to resident physical altercations, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population. Certified Nurse Aide (CNA) C left an 11 bed secured behavioral unit unattended, during which time Resident #76 experienced a seizure. Resident #167 called an emergency code situation on the facility's overhead paging system to obtain help for the resident. Hall Monitor A worked alone on a 20 bed secured behavioral unit. Hall Monitor D worked alone on a 25 bed secured behavioral unit. Both Hall Monitor A and Hall Monitor D said it was their second day working with residents and both reported they did not know how to call an emergency code situation, if required. A sample of 48 residents was selected for review. The facility census was 164. The administrator was notified on 6/30/21 of the Immediate Jeopardy (IJ) which began on 6/25/21. The IJ was removed on 7/2/21, as confirmed by the surveyor onsite verification. 1. Review of the facility's Assessment Tool, last updated on 6/30/21, showed the following: -The last quarter average number of occupied beds was 98; -The facility had six skilled special care units: First floor women's unit (behavioral health) 20 beds, First floor men's unit (behavioral health) 25 beds, Safe Harbor (behavioral health) 15 beds, Second floor 59 beds, Third floor women's unit (behavioral health) 11 beds, and Third floor men's unit (behavioral health) 43 beds; -Common diagnoses present in the facility included psychosis (hallucinations, delusions), impaired cognition, mental disorders, depression, bipolar disorder, anxiety disorder, behaviors that need interventions, personality disorder, schizoaffective disorder, explosive disorder, seizure disorder, Alzheimer's disease, dementia, and traumatic brain injury; -Over the past year, or in a typical month, the number of residents required or had the following: -Rehabilitation and extensive services was 31; -Special Care was seven; -Clinically Complex was eight; -Behavioral symptoms and cognitive performance was 18; -Reduced physical function was 131; (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The average daily staffing plan for staff providing direct care was two licensed practical nurses (LPNs), 12 hours each shift from 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M., two LPNs Resident Care Coordinators (RCCs), 11 certified nurse aides (CNAs) from 7:00 A.M. to 7:00 P.M. and nine CNAs from 7:00 P.M. to 7:00 A.M., one certified medication technician (CMT), and hall monitors (hall monitors monitored residents on the unit, completed hourly face checks, monitored smoking, and passed ice and snacks) and department heads as needed; -In addition to nursing staff, other staff needed for behavioral healthcare and services were listed as two lead CNAs and one assistant lead CNA 24 hours daily and hall monitors; -Training required for newly hired CNAs was a total of 8.25 hours. 2. Review of the Resident #76's care plan, dated 2/17/20, showed the following: -Per the Pre-Admission Screening and Resident Review (PASRR) tool, the resident had periods of agitation with a display of violent behaviors such as throwing things and hitting others; -The resident required a structured environment and was unable to care for himself/herself without supervision for behaviors and medication compliance; -Displays physical and verbal aggression towards staff and other residents at times; -On 4/2/21, a Code Blue (critical medical emergency) was called when the resident was noted to have seizure like activity. Witnesses said the resident experienced two seizures two to three minutes apart; -On 6/25/21, the resident exhibited seizure like activity and a code blue was called. The physician was contacted and an order was received to send the resident to the emergency room for evaluation; -Upon return, orders to administer anti-seizure medications and protect from injury during witnessed seizures; -The resident advanced directive for code status was Full Code (requires cardio-pulmonary resuscitation in the event of a code blue). Review of the resident's annual Minimum Data Set (a federally mandated assessment instrument required to be completed by facility staff), dated 5/20/21, showed the following: -admitted [DATE]; -Diagnoses included medically complex conditions, diabetes, seizure disorder, and schizophrenia; -Cognition was intact; -Required supervision and oversight for walking in the hall and locomotion on the unit. Review of the resident's nurse's note, dated 6/26/21 at 11:50 P.M. showed the resident had seizure activity and a Code Blue was called. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/29/21 at 6:36 P.M. and on 7/6/21 at 2:14 P.M., CNA C said he/she worked on Resident #76's unit the night of 6/25/21 and was the only staff member on the unit. CNA C said he/she had left the unit to get a drink and left the unit unattended for a couple of minutes. CNA C said he/she had called the other unit for the charge nurse, LPN E, to tell him/her he/she needed to leave the unit but no one answered. While CNA C was off the unit, he/she heard a code blue called on the overhead paging system. CNA C returned to the unit and saw Resident #76 on the floor, unresponsive with seizure activity. The resident had a pulse but was not verbal. CNA C arrived on the unit at the same time LPN E arrived to the unit. CNA C went and grabbed the crash cart in case the resident needed supplemental oxygen and a pillow. CNA C said the charge nurse was supposed to get someone to cover the unit if staff needed to leave, but someone was not always available. CNA C said sometimes he/she had to walk a resident to another unit in order for them to get their medications from the nurse, leaving the unit unattended. CNA C tried not to leave the unit unattended, but sometimes there was no choice because he/she had to go get supplies and other items or take a resident to the nurse. CNA C also said at times he/she would call the nurse and tell them he/she was going on break and CNA C would go to the dining room on the unit and sleep without any other staff on the unit. Only rarely was CNA C relieved for breaks or meals. CNA said he/she worked many hours and was very tired and was unable to stay awake throughout his/her shift. CNA C said he/she had worked four, 16 hour shifts in a row and on one occasion worked from 6:00 P.M. until noon the following day. CNA C said he/she had to have resident's call Code Greens (behavioral emergency) in the past in order to de-escalate a situation or get help dealing with a resident to resident altercation. CNA C felt the facility was extremely short staffed and that residents' needs were not being met because of this. During interviews on 6/29/21 at 3:09 P.M. and on 6/30/21 at 1:50 P.M., Resident #167 said a couple of nights ago CNA C left the unit unattended for about 20 minutes. Resident #167 was in the hall eating popcorn and saw Resident #76 walk down the hall from the dining room, collapse on the floor and become unresponsive. Resident #167 was tapping and shaking and calling Resident #76's name but he/she wouldn't wake up. He/She knew something wasn't right and knew he/she needed help so Resident #167 then got on the facility phone, dialed 21500, and overhead paged a code blue to their unit. CNA C and LPN E arrived to the unit. Resident #76 had to be sent to the hospital because he/she hit his/her head. CNA C told Resident #167 he/she did the right the thing calling the code and apologized for leaving the unit unattended for so long. Resident #167 said sometimes the residents have to call codes on the overhead paging system so staff doesn't have to leave a resident they are helping, however, they are not trained on when and how to call a code. 3. Review of the facility Administrator/Registered Nurse (RN) Investigation, completed by Assistant Director of Nursing (ADON), dated 6/28/21 with no documented time of incident, showed the following: -Incident occurred 6/28/21 with no documented time (on Safe Harbor); -Investigative narrative note: Resident #22 became physically aggressive toward Resident #86. Staff immediately separated the residents and allowed the residents to verbalize feelings and concerns. One-on-one monitoring initiated for Resident #22. A psychiatric physician from Long-Term Psychiatric Management (LTPM) was contacted with a new, one time order, for Resident #22 to receive Haldol (antipsychotic medication used to treat schizophrenia and psychosis) 5 milligrams (mg) intramuscularly (IM) (injection administered by injection). Medication administered per order; (continued on next page)

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

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Care plan changed and interventions section: Resident #22 was given Haldol 5 mg IM as ordered and placed on one-on-one monitoring. Both residents educated on socially appropriate behavior with understanding voiced. Review of the resident's written statement, dated 6/28/21 at 9:19 A.M., showed he/she was just sitting down watching television. He/She looked at Resident #86 and Resident #86 stuck out his/her tongue at Resident #22. He/She said, stop, and then Resident #86 started singing the song that Resident #49 sang, Hello (resident's first name) about his/her stinky (vulgar term for genitalia). So, he/she hit Resident #86 in the head with his/her wallet but not hard enough to hurt him/her. During an interview on 6/29/21 at 9:40 A.M. and 11:05 P.M., CNA J said the aide on the first floor Safe Harbor unit (15 beds) was responsible to assist those residents as well as the residents on the first floor men's unit (25 beds). Today, he/she was the only aide on Safe Harbor with one nurse who covered all three units on the first floor and was in and out. The aide on Safe Harbor also had to pass snacks and monitor and assist residents. There was no CMT or hall monitor on Safe Harbor and it was very difficult to assist and monitor residents as needed along with his/her other duties. Residents' smoke break times had been reduced to five times a day because of this. Weekends were horrible staffing wise and they did not have enough coverage. Department heads rarely came to assist on the units. Today, on the first floor, there was one hall monitor on the men's unit and one hall monitor on the women's unit. It was the second day on the job for both of these hall monitors and they were not able to complete any charting. CNA J had to complete the charting for the hall monitor on the men's unit because he/she did not know how to complete the charting. If CNA J was assisting residents in the smoke room, he/she had to try and monitor the residents who were smoking through the door of the smoke room as well as keep an eye on the other residents on the unit. On 6/28/21 at approximately 9:00 A.M., he/she was in the hallway and heard Resident #22 yelling at Resident #86. The residents were in the Safe Harbor hall dining room. Resident #22 yelled, that is enough, or I am going to hit you. CNA J heard yelling between Resident #22 and #86. CNA J heard cursing but he/she did not observe what occurred between the two residents. Resident #86 got other residents rallied up and was hard to redirect. He/She talked all the time, was often sexual in nature, cussed and was inappropriate to other residents. Resident #86 often riled up Resident #22. There were not enough staff to monitor the residents appropriately and complete other duties. It was difficult to supervise what was occurring on the unit. During interview on 6/29/21 at 9:50 A.M., LPN F said he/she was the charge nurse and was passing residents' medications on the hall at the time of the altercation between Resident #22, Resident #86 and Resident #93. He/She responded to the altercation but was not in the dining room at the time of the altercation. He/She did not witness the altercation. 4. Review of Hall Monitor A's employee file showed the following: -Date of hire 6/24/21; -An orientation checklist was signed, which included abuse and neglect training, codes, and crisis alleviation training, on 6/24/21; -There was no documentation in the record to show Hall Monitor A demonstrated any competencies or had completed his/her training with another staff member. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 6/29/21 at 12:05 P.M. and 4:55 P.M., Hall Monitor A said the following: -He/She was hired on 6/24/21; -He/She spent one day completing paperwork and receiving training from 9:00 A.M. until 3:00 P.M. Hall Monitor A was supposed to watch training videos the day before but instead worked on the first floor women's unit with another staff member; -Today, he/she worked the first floor women's unit by himself/herself; -He/She felt like he/she needed more training before working alone; -He/She was upset because he/she was placed to work on the unit by himself/herself after one day of training; -He/She was not familiar with any of the residents' medical conditions or behaviors; -He/She did not have his/her own computer access and had to complete his/her charting under another staff member's log in; -He/She did not know how to access the residents' care plans; -He/She was responsible for monitoring the residents smoking in the smoke room which was located on the Safe Harbor unit and keep an eye on the other residents on the hall at the same time, which was around the corner from the smoke room. -He/She did not know how to call an emergency code if needed; -He/She was told Resident #133 had a behavior, and then next thing he/she knew, staff told him/her to call a code because they could not find the resident's pulse. He/She had to ask the Assistant Residential Care Facility (RCF) Manager how to call the code because he/she had never done it before. 5. Review of Hall Monitor D's employee file showed the following: -Date of hire 6/21/21; -An orientation checklist was signed, which included abuse and neglect training, codes, and crisis alleviation training, on 6/21/21; -There was no documentation in the record to show Hall Monitor D demonstrated any competencies or had completed his/her training with another staff member. Observation on 6/29/21 at 11:15 A.M. showed Hall Monitor D was the only staff on the first floor men's unit (occupied by 25 residents). No other staff were observed on the unit. Hall Monitor D went from room to room completing visual checks of the residents. Several residents were out in the hallway requesting to smoke and sitting in the dining room on the unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/29/21 at 11:20 A.M., Hall Monitor D said it was his/her second day of work on the floor in the facility. He/She worked with a CNA on the unit the day before. He/She was the only staff on the unit that day. He/She would leave the unit and go to the nurse's station to tell staff residents were ready to smoke, and the aide from the other unit would monitor the residents smoking. Hall Monitor D was responsible for completing hourly face checks (laying eyes on the resident) as well as passing snacks and meals. Hall Monitor D did not have computer access and was unable to complete any charting. Hall Monitor D was still getting to know and learning about the residents. Hall Monitor D said he/she had not been taught how to use the overhead paging system in order to call an emergency code situation. Hall Monitor D would have to leave the unit unattended to find the nurse and report any emergencies, such as a resident to resident physical altercation. 6. During an interview on 6/28/21 at 12:12 P.M., CNA T said if a resident asks for one-on-one supervision, they don't always get it because the facility doesn't have enough staff. CNA T will position himself/herself closer to that resident's room to watch over them more closely. During an interview on 6/29/21 at 11:10 A.M., CNA K said he/she was currently on the Safe Harbor unit returning a resident to the unit from the gym. CNA L said there were not enough staff in the facility to sufficiently monitor the residents as well as get all the other assigned duties completed. During an interview on 6/29/21 at 11:50 A.M., the assistant staffing coordinator said there were new staff on the first floor women's unit and the first floor men's unit that day. Typically new staff got two or three days of training with another staff member but the facility was really short staffed right now and several staff were out on vacation. They were doing what they could to get shifts covered. The smoke times for residents on the first floor had been reduced to five times a day to allow the aides to get other duties completed. The residents still got the same amount of cigarettes, only the smoking times were reduced. The aide from Safe Harbor was responsible for monitoring those residents smoking as well as the residents on first floor men's unit when they smoked. The aide on the first floor women's unit monitored those residents smoking as well as the residents who remained on the unit. The aide had to monitor the women's hall through the open double doors by the smoke room (which was on the Safe Harbor unit and around the corner from the women's hallway) while other residents were smoking in the smoke room. It was a lot for the aide from Safe Harbor to monitor because there was so much for that aide to do. During an interview on 6/29/21 at 4:25 P.M., the administrator said resident smoke break times on the first floor had been reduced to five times a day in order to accommodate resident care needs. No cigarettes were taken away. Residents now received two cigarettes at some smoke breaks. Staff on the units should call transportation and other staff to assist them at smoke times. During an interview on 7/6/21, the staffing coordinator said the following: -The first floor was typically staffed with one nurse, who floated between the three locked units, and then an aide or a hall monitor on each unit; -The second floor was typically staffed with a nurse, a CMT if available, and three aides; -The third floor was typically staffed with one nurse, who floated between the men's and women's units, and two aides on the men's unit and one aide on the women's unit; (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-It was not typical to have new staff work units by themselves. New hires would typically receive two or three days completing paperwork and video training and then spend one day with another staff on each unit of the facility; -It depended on how comfortable the new staff member felt as to whether they could work on their own. If a new staff member was not comfortable or wanted more training, they would have to come to him/her and request it. During an interview on 7/6/21 at 3:35 P.M. and 6:11 P.M., the DON said she expected the licensed charge nurses to check the units every hour to ensure staff were present and were relieved for breaks. The DON was not aware staff were not being relieved for breaks and leaving the units unattended. The DON felt more staff in the facility would help in monitoring residents and possibly preventing some of the verbal altercations before they escalated to physical altercations. The DON felt staffing issues had contributed to other issues in the facility identified through the survey process. During an interview on 7/6/21 at 4:15 P.M. and on 7/23/21 at 9:18 A.M., the administrator said she expected licensed staff to check the units every hour to ensure the staff were present and engaged with the residents. She expected staff to be fully trained and comfortable before working on their own. The administrator was not aware staff had left units unattended. She expected staff to be present to monitor residents at all times. The administrator felt staffing was sufficient to allow staff to be on the floor at all times and be relieved for breaks if staff followed the facility system of the charge nurse coordinating coverage for break times. 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). MO186725 MO186828

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Refer to Event ID QJHT13. Based on observation, interview, and record review, the facility failed to ensure seven residents (Residents #22, #42, #61, #80, #49, #265, and #500), in a review of 48 sampled residents, with mental disorders who lived on secured behavioral units, received individualized treatment and services to meet their needs. The residents displayed newly developed delusions, and verbal and physical behaviors directed towards others on multiple occasions. The facility failed to adequately develop and implement meaningful interventions, including non-pharmacological interventions, alternate strategies, or to ensure the residents received timely and appropriate treatment or services to address the residents' psychosocial well-being. The facility census was 164. Review of the facility's Behavioral Emergency Policy, last revised 4/6/17, showed the following: -Purpose: To provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to correctly care for the resident in a behavioral crisis, and to ensure the resident is not being coerced, punished, or disciplined for staff convenience; -If the resident exhibits extreme behaviors such as suicidal, homicidal, self-mutilation, elopement, or resident to resident altercations the following steps will occur; -The licensed nurse/team leader/Resident Care Coordinator (RCC) will assess the resident who is exhibiting such behaviors, ensuring the safety of the resident and others is the first priority. A one to one monitoring of the resident will be initiated at this time under the direction of the licensed nurse; -The Director of Nursing (DON) or designee and the administrator or designee and management team on call will be notified regarding assessment findings and will decide, given the assessment findings, as to whether the resident's needs can be met safely and whether the resident continues to be appropriate for placement in the facility; -The physician and guardian will be notified; -If the management team on call and administrator or designee decide the resident's needs cannot continue to be safely met, or that the resident is not appropriate for placement at the facility, the physician will be notified by the licensed nurse requesting a psychiatric evaluation; -The licensed nurse will document the behavioral emergency in the medical record with the following: define the behavior, document interventions, document reaction/response of the resident after interventions, and evaluation; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Documentation of the Behavior Emergency in the Registered Nurse (RN) Investigation will include evaluation of the resident's behavior, including consideration of precipitating events or environmental triggers, and other related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible, identifying or attempting to identify the root causes of the behaviors and revising the plan of care with measurable goals and interventions to address the care and treatment for a resident with behavioral and/or mental or psychosocial symptoms. 1. Review of Resident #42's Pre-Admission Screening and Resident Review (PASRR) evaluation, dated 4/9/18, showed the following: -Diagnoses included chronic paranoid schizophrenia (the most common form of schizophrenia that includes delusions and hallucinations, including paranoid thoughts), attention deficit disorder (marked by a pattern of inattention and/or hyperactivity or impulsivity that interferes with functioning and development), post traumatic stress disorder (PTSD, a mental health problem that can occur after someone experiences a traumatic event), mood disorder (a disorder characterized by the elevation or lowering of a person's mood), and combination drug dependency (a substance abuse disorder in which an individual abuses more than one class of substances); -The resident had two psychiatric admissions since 2015 due to violent and combative behaviors with staff and peers; -The resident's behavior is described as defiant; -Poor insight and judgement, continued mood instability, and violation of rules and law; -The resident may benefit from regular psychiatric appointments to evaluate medication and mental status, group counseling/psychotherapy, and adjustment counseling/emotional support. Review of the resident's care plan, revised 3/23/21, showed the following: -The resident had a history of behavioral challenges that require protective oversight in a secure setting; -Provide one-on-one interventions as needed; -Pharmaceutical interventions as needed; -Diagnoses of paranoid schizophrenia, bipolar disorder (a mental disorder marked by alternating periods of elation and depression), antisocial personality (a disorder characterized by persistent, irresponsible, or criminal behavior, often impulsive or aggressive without regard for harm caused to others), PTSD, and combination drug dependency; -History of being verbally and physically aggressive, poor insight and judgement with poor decision-making skills; -Administer medications as ordered; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist in verbalization of source of agitation, set goals for more pleasant behavior, and encourage seeking out a staff member when agitated; -Coping skills were watching television, smoking, listening to music, and sleeping; -The resident was independent with activities of daily living and continent of bowel and bladder. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 5/18/21, showed the following: -Diagnoses included manic depression (a mental disorder marked by alternating periods of elation and depression, also referred to as bipolar disorder), schizophrenia, and PTSD; -Cognition was intact; -No delusions or hallucinations; -No behaviors exhibited; -Received antipsychotic and antianxiety medications daily. Review of the resident's psychiatric telemedicine note, dated 5/19/21, showed the following: -Staff reported no current behavioral concerns; -The resident was compliant with medications and sleep was fair and restful; -No active psychosis; -No delusional thinking elicited; -No sedation from medications reported. Review of the resident's nurse's note, dated 6/15/21 at 11:02 A.M., showed the resident said a peer which he/she shared a bathroom with, came in the room in the middle of the night and was sexually inappropriate with him/her. The resident was brought to the administrator's office and interviewed. The resident said now he/she was not certain who came in his/her room and the unknown person used his/her hand to touch themselves. Review of the facility's Registered Nurse Investigation (RNI) showed the following: -On 6/15/21, the resident reported Resident #37, who he/she shared a bathroom with, came into the room in the middle of the night and was sexually inappropriate with him/her; -The administrator interviewed the resident. The resident then said he/she wasn't sure who came into his/her room. The resident said he/she was lying on his/her stomach, and someone came in the room, pulled his/her hand and touched their (the other person's) private area with his/her hand; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #42 was assessed and no abnormalities found and was placed one-on-one with staff. Review of the resident's nurse's notes showed the following: -On 6/20/21 at 4:15 A.M., the resident exhibited increased verbal and physical aggression towards staff. Staff verbally redirected the resident without incident. The resident was placed one-on-one with staff for protective oversight; -On 6/20/21 at 6:45 A.M., the resident voiced concerns related to a staff member. Staff completed a head-to-toe assessment with no findings. Staff contacted the physician and received orders to send the resident to the emergency room . The resident refused to go to the emergency room . The resident continued one-on-one with staff for protective oversight. Review of the facility's RNI, dated 6/20/21, showed the following: -Resident #42 said Certified Nurse Aide (CNA) M entered his/her room and raped him/her; -CNA M denied the allegation; -Immediate assessment of the resident showed no signs of trauma or assault; -Staff contacted the physician and received new orders to send the resident to the emergency room for evaluation; -The resident refused to go to the emergency room for evaluation; -The resident was placed one-on-one with staff; -Interviews were completed with staff and residents. All residents, including Resident #42, denied seeing staff or residents being sexually inappropriate; -Conclusion: There was no evidence to support the resident's statement. Review of the resident's nurse's note, dated 6/30/21 at 3:34 P.M., showed the resident's legal guardian returned a call from the administrator and said approximately three years prior, the resident had some delusional thought processes related to his/her prescribed medications. The guardian requested the facility review the resident's medications with the physician. The Resident Care Coordinator/Licensed Practical Nurse (LPN) G was notified. Review of the resident's medical record showed no documentation the facility requested or the physician completed, a medication review for the resident after 6/30/21 as requested by the guardian. Observation on 6/28/21 at 11:45 A.M. showed the resident lay in bed in his/her room with a blanket pulled over his/her head. The window curtains were drawn and the room was dark. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/21 at 11:46 A.M., the resident said everybody thought he/she was crazy, but when he/she gets up in the mornings, his/her rectum was larger than normal. He/She did not remember seeing anyone doing anything so he/she guessed he/she was crazy. CNA M opened his/her room door at night and he/she thought that was suspicious. The resident felt like he/she had tears in his/her rectum. The discomfort may be from hemorrhoids. The Director of Nursing (DON) assessed him/her and didn't see anything wrong. Another resident came into his/her room and laid on top of him/her and put his/her hands on their privates. He/She never saw anyone assault him/her, but only had the discomfort in his/her rectum so he/she must be crazy. Staff asked him/her if he/she wanted to go to the hospital but he/she refused. He/She could not say for sure who it was raping him/her and he/she only had suspicions. He/She tried to stay awake at night so he/she would be ready if anyone tried anything again. He/She had been sleeping during the day. During an interview on 6/28/21 at 5:25 P.M., CNA M said on two occasions the resident had accused someone of sexually assaulting him/her. One time, he/she accused another resident, and the second time, the resident accused him/her (CNA M). Staff investigated the allegations and the resident recanted his/her statements. CNA M said he/she had never been inappropriate sexually or physically with any resident. CNA M opened the resident's door at night, as he/she did with all other residents, in order to complete the hourly face checks and ensure the residents were okay. The resident had been drinking a lot of caffeine and was having trouble sleeping at night. CNA M encouraged the resident to walk in the halls at night if he/she couldn't sleep and maybe he/she would get tired and fall asleep. Observation on 6/30/21 at 1:25 P.M. showed the resident lay in bed in his/her room. The window curtains were pulled and the room was dark. During an interview on 6/30/21 at 1:26 P.M., the resident said he/she did not having problems through the night. He/She stayed awake and nothing happened. He/She was very sleepy. Review of the resident's nurse's note, dated 7/3/21 at 6:28 P.M., showed the resident had increased delusional thoughts. The resident requested an as needed (PRN) medication and a new one time order for Haldol (antipsychotic medication) 5 milligrams (mg) and Ativan (antianxiety medication) 2 mg were given by mouth. The resident was noted to make a general accusation as he/she walked away after receiving the medication. Staff contacted the long-term psychiatric management and received a new order to send the resident to the acute psychiatric hospital for evaluation. Review of the facility's RNI, dated 7/3/21, showed the following: -The resident requested PRN medication from the nurse on the unit; -The nurse administered Ativan 2 mg and Haldol 5 mg by mouth as ordered; -The resident then told the nurse that everything was a conspiracy and everyone was raping him/her; -The resident returned to his/her room; -Staff attempted to obtain a statement from the resident but he/she refused; -The resident refused the nurse's attempted assessment; (continued on next page)

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	265469	A. Building B. Wing	07/06/2021

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff contacted the physician and received new orders to send the resident to the acute psychiatric hospital for evaluation. During an interview on 7/6/21 at 2:22 P.M., Licensed Practical Nurse (LPN) G said the resident stayed in his/her room most of the time. LPN G had not noticed any changes in the resident's sleeping or eating patterns. The resident made sexual accusations against others on 6/15/21, 6/20/21, and again on 7/3/21. The sexual delusions the resident had were not constant and came and went. LPN G was not sure if staff contacted the physician regarding a medication review. If the physician had reviewed the resident's medications, it would have been documented in the progress notes. LPN G had not considered sending the resident out for a psychiatric evaluation prior to 7/3/21. During an interview on 7/6/21 at 6:11 P.M., the DON said the resident's sexual accusations were not usual for him/her; it was a new occurrence. At first, the staff were not sure what to make of it and investigated and could not substantiate the allegation. After the second time the resident made the allegation of sexual abuse (on 6/20/21), the DON would have expected staff to notify the psychiatric physician and request a medication review or a psychiatric evaluation prior to the guardian asking for this to take place on 6/30/21. During an interview on 7/13/21 at 1:00 P.M., the resident's primary physician said he/she would expect staff to obtain a psychiatric medication evaluation or treatment for the resident prior to 7/3/21 due to the resident's sexual delusions. 2. Review of Resident #265's PASRR evaluation, dated 6/15/20, showed the following: -Diagnoses included schizoaffective disorder (a chronic mental health condition characterized by symptoms of schizophrenia such as hallucinations or delusions, mania, and depression), intermittent explosive disorder (involves repeated, sudden, episodes of impulsive aggressive, violent behavior, or angry verbal outbursts), major depressive disorder (a mental disorder characterized by a persistently depressed mood and long term loss of pleasure or interest in life), bipolar disorder (a mental disorder marked by alternating periods of elation and depression), borderline personality disorder (a personality disorder characterized by severe mood swings, impulsive behavior, and difficulty forming stable relationships), polysubstance dependence (a substance use disorder in which an individual uses at least three different classes of substances indiscriminately), adjustment disorder (an emotional or behavioral reaction to a stressful event or a change in a person's life, considered unhealthy if it extends beyond three months of the event), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, and people interpret reality abnormally); -Can become very isolated and paranoid, active responses to auditory and visual hallucinations; -Legal issues related to substance abuse and most recently a restraining order filed by his/her neighbors for throwing rocks at their house. The resident believes they were stealing from him/her, making his/her feet hurt, and watching him/her; -Current psychiatric support services required were inpatient psychiatric treatment and a secured behavioral unit. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 2/6/21, showed the resident had manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These include paranoia, property destruction, and isolation. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Diagnoses included depression and schizophrenia; -Cognition was intact; -Required supervision from staff for activities of daily living; -No behaviors, hallucinations, or delusions present. Review of the resident's nurse's note, dated 6/18/21 at 7:10 P.M., showed another resident was physically aggressive with this resident. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thought and feelings to staff. Assessment completed with multiple bruises noted to different areas of the resident's body and a small laceration to the resident's lower lip. The physician was notified and ordered the resident be sent to the emergency room for evaluation and treatment. The resident complained of pain to his/her facial area and forehead. Review of the facility's Registered Nurse Investigation (RNI), dated 6/18/21, showed the following: -On 6/18/21, Residents #80 and #485 became physically aggressive with Resident #265. The residents were immediately separated and allowed to verbalize feelings and concerns. Immediate assessment of Resident #265 showed bruising throughout his/her body. The physician was contacted and orders received to send Resident #265 to the emergency room for evaluation; -CNA N's undated written statement showed staff were in the hallway talking with one another when they heard a commotion down the hallway. Staff asked the nurse to call a code (behavioral emergency). It appeared Resident #80 and #265 were having a tussle in the hallway. Review of the resident's care plan showed on 6/18/21 another resident was physically aggressive towards this resident. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thoughts and feelings to staff. Multiple bruises noted to different areas of the resident's body and a small laceration to the lower lip. The physician was contacted and an order received to send the resident to the emergency room for evaluation and treatment. The resident voiced complains of pain to the facial area and forehead. The resident returned from the emergency with one suture to the lower lip. Observation on 6/28/21 at 10:36 A.M. showed the resident had fading bruising to his/her left foot which was slightly swollen and fading bruising to his/her right upper arm. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/21 at 10:37 A.M., the resident said said he/she used to live on another floor where Resident #80 and #485 got into a fight with him/her. Resident #80 stepped on his/her foot so he/she pushed Resident #80 away and made contact with his/her face. Then Resident #80 started wailing on him/her and Resident #485 jumped in and also started hitting him/her (Resident #265). The resident said it started because Resident #80 asked him/her what he/she said about another resident (Resident #265's roommate at the time). Resident #80 thought he/she (Resident #265) was picking on this other resident, but that wasn't true. Resident #265 said he/she had to go to the emergency room and get a stitch in his/her lip and said his/her neck was still sore from the fight. The fight went on for about one minute before staff arrived and broke it up. 3. Review of Resident #80's PASRR evaluation, dated 10/10/20, showed the following: -Diagnoses of schizoaffective disorder (onset age 15), generalized anxiety disorder, major depressive disorder, conduct disorder (a range of antisocial behaviors displayed in childhood or adolescence), oppositional defiance disorder (a behavior disorder in which a child displays a pattern of angry, defiant, or combative behaviors), mood disorder, bipolar disorder, and antisocial personality disorder (a disorder characterized by persistent, irresponsible, or criminal behavior, often impulsive without regard for harm caused to others); -Records indicate a long standing history of behavioral issues inclusive of medication noncompliance, sleep disturbance, auditory and visual hallucinations, periods of depression and liable mood swings, impaired insight and judgement, and bizarre behavior with response to internal stimuli; -History of threatening family with a knife in the past. Can become agitated and aggressive with others. Displays violent behavior; -Records indicate multiple psychiatric admissions in the past, presentation is often clouded by substance use; -Staff reports intrusive displays and manipulative behaviors and acts out when not getting his/her way; -Current psychiatric support services required were outpatient psychiatric follow up, and behavior checks every hour. Requires a safe environment in a locked high level behavior unit. Review of the resident's admission MDS, dated [DATE], showed the following: -admitted [DATE]; -Diagnoses included anxiety, depression, and schizophrenia; -Cognition was intact; -Independent with activities of daily living; -No behaviors, delusions, or hallucinations present. Review of the resident's care plan, dated 12/17/20, showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had manifestations of behaviors related to his/her mental illness that may create a disturbance for others. These include bizarre behaviors with response to internal stimuli; -Non-pharmacological interventions include listening to music and talking with family; -Psychiatric consult for medication adjustments as needed; -On 1/1/21, the resident had signs and symptoms of physical aggression towards another resident. Immediate staff intervention and separation from peers. Assessment completed and no injuries found. Allowed to verbalize and vent feelings to staff. Medication review to be completed with psychiatry in the morning. The resident was placed one-on-one with staff. Education provided on utilizing coping skills and appropriate behaviors. The resident requested as needed (PRN) medication. Long-term psychiatric management was contacted and an order was received for Zyprexa (antipsychotic medication) 10 milligrams (mg) intramuscularly (IM) every eight hours as needed. The resident tolerated well. -The resident was independent for meeting emotional, intellectual, physical, and social needs; -On 3/5/21, the resident had increased anxiety. Immediate staff intervention and separation from peers. Long-term psychiatric management was contacted and a new order was received for Zyprexa 10 mg every eight hours PRN, medication given and tolerated well. Education provided on coping skills. -On 4/12/21, another resident was verbally aggressive with this resident. Immediate staff intervention and separation from peers. Easily redirected with no invasive interventions. The other resident was moved to a different floor to separate the residents. Education provided on appropriate behaviors and using coping skills. Interventions effective at this time. -On 5/12/21, the resident showed physical aggression towards facility property. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thoughts and feelings to staff. Swelling to left hand with superficial laceration noted. The resident requested PRN. A new order for Zyprexa 10 mg IM one time given and tolerated well. Education provided on appropriate behaviors and utilizing coping skills. Interventions effective at this time. Review of the resident's nurse's notes showed the following: -On 6/17/21 at 9:14 P.M. (late entry), the resident exhibited increased anxiety. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thoughts and feelings to staff. The resident requested a PRN. Long-term psychiatric management contacted and order for Ativan (antianxiety medication) 2 mg and Haldol (antipsychotic medication) 5 mg IM given and tolerated well. Education provided on appropriate behaviors. -On 6/18/21 at 7:43 P.M., the resident was physically aggressive with another resident. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thought and feelings to staff. Long-term psychiatric management notified and new order received to send the resident to the acute psychiatric hospital for evaluation and treatment. PRN order for Haldol 5 mg and Ativan 2 mg IM given and tolerated well. Review of the facility's RNI, dated 6/18/21, showed the following: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/18/21, Resident #80 and #485 became physically aggressive with Resident #265. The resident were immediately separated and allowed to verbalize feelings and concerns. Immediate assessment of Resident #265 showed bruising throughout his/her body. Long-term psychiatric management was contacted and orders received to give Resident #80 Ativan 2 mg and Haldol 5 mg IM and Resident #485 Zyprexa 10 mg. Resident #80 was sent to the acute psychiatric hospital for evaluation; -CNA N's undated written statement showed staff were in the hallway talking with one another when they heard a commotion down the hallway. Staff asked the nurse to call a code (behavioral emergency). It appeared Resident #80 and #265 were having a tussle in the hallway. During an interview on 6/28/21 at 11:38 A.M., Resident #80 said Resident #265's roommate was looking sad and said Resident #265 was bullying him/her. Resident #80 went to Resident #265 and asked him/her why he/she was bullying his/her roommate. Resident #265 hit Resident #80 so Resident #80 fought back. That's when Resident #80's roommate (Resident #485) jumped in and to help Resident #80 in the fight. CNA N and other staff broke up the fight. During an interview on 6/28/21 at 11:42 A.M., Resident #485 said he/she jumped into help Resident #80 when he/she was in a fight with #265 because Resident #80 was his/her roommate. Resident #485 didn't know what the two residents were fighting about and only jumped in to back up Resident #80. Review of the resident's care plan showed on 6/18/21, the resident was physically aggressive with another resident. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thoughts and feelings to staff. Order received to send to the acute psychiatric hospital and Zyprexa 10 mg IM PRN, medication given and tolerated well. Interventions effective. Review of the resident's nurse's notes showed he/she was readmitted to the facility from the psychiatric hospital on 6/25/21. Review showed no updates to the resident's care plan following his/her psychiatric hospitalization . Review of the resident's nurse's note, dated 6/30/21 at 10:04 A.M., showed another resident was verbally aggressive with this resident. In return, this resident pushed the other resident. Immediate staff intervention and separation from peers. Allowed to vent and verbalize thoughts and feelings to staff. Assessment completed and no injury found. The resident requested a PRN medication. Long-term psychiatric management contacted and order given for Haldol 5 mg and Ativan 2 mg IM given and tolerated well. Education provided on appropriate behaviors. This resident is a recent readmit from the acute psychiatric hospital. Resident placed one-on-one with staff. Review of the facility's RNI, dated 6/30/21, showed the following: -Resident #500 was verbally aggressive towards Resident #80; -Resident #80 then pushed Resident #500; -Staff immediately separated the residents and completed assessments with no injuries found; (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #80 said Resident #500 accidentally elbowed him/her while walking down the hallway. Resident #80 became upset and yelled at and pushed Resident #500; -Resident #500 said Resident #80 bumped into him/her while walking down the hallway; -The physician was contacted and long-term psychiatric management gave orders for Resident #500 to receive Zyprexa 10 mg IM and Resident #80 to receive Ativan 2 mg and Haldol 5 mg IM. Medications administered to both residents without difficulty; -One-on-one staff monitoring initiated for Resident #80. Review of the resident's undated written statement showed as Resident #80 walked to the smoke room, Resident #500 elbowed him/her in the chest by accident. Resident #80 told Resident #500 to watch what he/she was doing. Resident #500 said, I'm sorry, just go on. Resident #80 told Resident #500, do not tell me what to do. Resident #80 got into Resident #500's face and they started yelling. As they were yelling, Resident #80 felt like he/she hit a pressure point and that's when Resident #80 pushed Resident #500. Review of Resident #500's undated written statement showed Resident #80 bumped into him/her in the hallway and told Resident #500 to shut the fuck up and called Resident #500 the N word. Resident #500 told Resident #80 to get away from him/her. Resident #80 took both hands and pushed Resident #500. Staff called a code. During an interview on 7/6/21 at 11:20 A.M., Resident #500 said Resident #80 called him/her a nigger and a racist mother fucker several times over the past few days prior to the altercation on 6/30/21. Resident #500 said he/she had finally had enough, and when Resident #80 bumped into him/her in the hallway, Resident #500 started yelling at Resident #80. Resident #80 took both of his/her hands and placed them on Resident #500's face and pushed. Resident #500 screamed, and LPN G came and took Resident #500 to the office and gave him/her a shot. Resident #500 was very upset. When Resident #80 came back to the facility, Resident #500 planned to just stay in his/her room. He/She did not like to fight and did not want it to happen again. It made Resident #500 mad and upset when Resident #80 called him/her those names. Resident #500 thought LPN G had heard Resident #80 call him/her those bad names in the past. During an interview on 7/6/21 at 2:22 P.M., LPN G said Resident #500 bumped into Resident #80 on 6/30/21. Resident #500 apologized and Resident #80 mouthed off. Resident #500 yelled and LPN G came out of the nurse's station. Resident #500 and Resident #80 had already separated on their own at that point. Both residents received PRN medications. LPN G had not heard any arguing, name calling, or fighting between these two residents prior to this altercation. LPN G did not know why Resident #80 and Resident #485 got into a fight with Resident #265. It was reported to LPN G that Resident #265 said something that Resident #80 did not like so he/she hit Resident #265 and then Resident #485 jumped in. LPN G had not heard anything about the fight happening because Resident #80 thought Resident #265 was bullying another resident. During an interview on 7/6/21 at 12:22 P.M., CNA N said he/she was not aware of any issues or name calling between Resident #80 and Resident #500. CNA N was not aware of what Resident #500 and Resident #80 were fighting about. CNA N was one of the staff who responded to the fight between Resident #80 and Resident #265 but he/she did not know why they got into the fight either. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/6/21 at 6:11 P.M. the DON said staff should be identifying the root cause of resident to resident behaviors and altercations. Identifying the root cause could prevent situations from escalating or recurring. Staff should be aware of resident's name calling and having verbal altercations with other residents and should intervene and engage with the residents to prevent the situation from continuing. 4. Review of Resident #61's Pre-Admission Screening and Resident Review (PASRR) evaluation, dated 3/3/17, showed the following: -Diagnoses included schizoaffective disorder (a chronic mental health condition characterized by symptoms of schizophrenia such as hallucinations or delusions, mania, and depression), bipolar disorder (a mental disorder marked by alternating periods of elation and depression), borderline personality disorder (a personality disorder characterized by severe

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Refer to Event ID QJHT13. Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #133 and #109), in a review of 48 sampled residents, received dental services including fitting for dentures after having teeth extracted and experiencing tooth pain, inability to eat and follow up with recommendations for further dental intervention. The facility census was 164. 1. Review of Resident #133's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility staff, dated 4/7/21, showed the following: -Cognition was intact; -Oral status was not documented; -Resident had no difficulty with chewing; -He/She weighed 171 pounds (16 pound weight loss from previous assessment on 1/12/21). Review of resident's care plan dated 5/12/21 showed the resident was on a regular diet with mechanical soft texture after having all of his/her teeth pulled in February. (There were no interventions documented to address him/her being edentulous (without teeth).) Review of the resident's face sheet showed there was no dentist documented. During interview on 6/28/21 at 10:45 A.M., the resident said he/she had teeth pulled in February 2020 and had not been fitted for dentures. He/She had asked the transportation coordinator if he/she could get fitted for dentures and was told no. He/She could not eat most foods due to his/her inability to chew. He/She said it sucked when asked how it made him/her feel by not having teeth. Observation on 6/28/21 at 10:45 A.M. showed the resident was edentulous and did not have dentures. During interview on 6/29/21 at 9:55 A.M., the deputy public administrator (representative for the resident's guardian) said the resident had teeth extracted on 2/18/20. The facility had not told him/her the resident did not have dentures. He/She was upset because this was the first time he/she was made aware of the resident's dental status. The facility held a care plan conference in April 2021 and staff didn't mention the resident needed dentures. He/She thought the facility would have made a follow-up appointment for the resident to be fitted for dentures. He/She had sent beef jerky sticks to the resident and the resident said he/she could not eat them, but the resident did not mention he/she could not eat them due to his/her inability to chew them. During interview on 6/29/21 at 11:25 A.M., the resident's guardian said he/she was unaware the resident did not have any teeth, and the resident had lost weight. He/She was very angry that he/she did not know. (continued on next page)

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F 0790 Level of Harm - Actual harm Residents Affected - Few	Review of resident's electronic health record (EHR) showed no progress notes regarding the resident's dental status. The record did show the resident had a weight loss (16 pounds in three months per the MDS), but there is no documentation the registered dietician had evaluated the resident for weight loss. During an interview on 6/29/21 at 9:30 A.M., Transportation Coordinator said he/she was responsible for making follow-up dental appointments. The resident had his/her teeth removed before COVID-19 (Coronovirus 2019; an infectious disease caused by severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) pandemic, and then the dental office shut down due to the pandemic. He/She thought the resident had to also wait six months to ensure swelling was gone, but it had been more than six months. He/She had not made the resident a follow-up appointment as of yet and had not been reminded to do so. During an interview on 6/29/21 at 9:49 A.M., a representative from the resident's dental office said the dental office had been open for full service, including dentures, since the summer of 2020. During an interview on 7/6/21 at 6:15 P.M., the director of nursing (DON) said he/she was not aware the resident was not fitted for dentures after his/her teeth were removed. He/She was not sure of how follow up appointments were made after residents had their teeth pulled. 2. Review of Resident #109's face sheet showed the following: -admitted [DATE]; -Diagnosis of traumatic brain injury, seizures, chronic kidney disease, and depression. Review of the resident's Physician's Order Sheet, dated 12/15/20, showed the following: -May see dentist; -Clindamycin (antibiotic medication) 150 milligrams (mg), two capsules every eight hours for tooth infection for five days. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Required extensive assistance from one staff for personal hygiene; -The resident had no broken or loose fitting teeth, no tooth fragments, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth; -The resident had mouth or facial pain, discomfort or difficulty with chewing. Review of the resident's care plan, revised 12/30/20, showed staff should assist the resident to provide good oral hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265469	A. Building B. Wing	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levering Regional Health Care Center	1734 Market 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 0790 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's nurses' note, dated 2/1/21, showed the resident complained of pain on the lower right side of his/her mouth due to a toothache. There was a small amount of swelling. Staff notified the physician and received new orders for antibiotics. Tylenol offered for pain. Review of the resident's Physician's Order Sheet, dated 2/1/21, showed Clindamycin (an antibiotic) 300 mg twice daily for seven days for toothache. Review of the resident's dental clinic note, obtained from the resident's dental office, dated 2/12/21, showed the following: -The resident presented with chief complaint of jagged teeth and said all his/her teeth were going to hell. The resident also said his/her lower right tooth was cutting his/her tongue and lip making it hard to swallow. The resident said he/she had lost weight due to this because he/she could not eat as well. The resident reported taking over the counter Tylenol for pain. The area has been a problem for three months; -Exam findings of root tip below the gum line and lesion of one lower tooth that was non-restorable due to root tip and another lower tooth with three-fourths of a crown remaining that was sharp to the resident's tongue with no lesion also non-restorable due to missing tooth structure; -Limited oral evaluation was completed with x-ray taken. Treatment options given were extraction of both lower teeth. The resident choose extraction of both teeth. The resident could not transfer out of the wheelchair alone and the wheelchair would recline but there was no neck support. The driver helped the resident transfer to the dental chair. The jagged tooth was smoothed for a temporary fix. The resident wanted dentures but needed comprehensive care first. Would attempt extraction of both teeth at next visit. Review of the resident's care plan showed no update regarding the resident's infection or interventions to address the dental infection. Review of the dental clinic note, obtained from the resident's dental office, dated 3/19/21, showed the resident was checked in and while waiting in the waiting room he/she was leaning on the driver. Dental staff asked if the resident was okay, and the driver said the resident was trying to adjust his/her position in the wheelchair but started to fall over. Dental staff asked the driver if there was an aide available to help assist the resident to get in and out of the dental chair. The driver said there was no aide with them, but if he/she had help, he/she could move the resident. Dental staff asked if the driver was legally certified to move the resident and the driver said no. Dental staff told the driver the dentist office did not have anyone who could help and they would need to have an aide come with them. Since there was no one who could legally help the resident get into the dental chair, the dental staff were unable to treat the resident. Dental staff was trying to reach out to the facility to reschedule the appointment. Review of the dental clinic note, obtained from the resident's dental office, dated 4/30/21, showed the resident's dental appointment was canceled without 24-hour notice. The facility did not have a licensed practical nurse to send with the resident today. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0790 Level of Harm - Actual harm Residents Affected - Few	Observation on 6/28/21 at 11:43 A.M. showed the resident had few teeth remaining in his/her mouth. A tooth located on the bottom right side of his/her mouth was broken off at the gum line. The resident's gums were swollen and reddened. There was debris and white matter on the resident's remaining teeth. During interviews on 6/28/21 at 11:44 A.M. and on 7/6/21 at 11:00 A.M., the resident said the facility took him/her to dentist a couple of times about six months ago. He/She was supposed to see the dentist again to have all his/her teeth pulled and get dentures. He/She would like to have that done soon. His/Her teeth hurt and it was difficult and painful to eat. It hurt to brush his/her teeth. He/She told the staff about his/her tooth pain and difficulty eating, but it did no good. During interview on 6/28/21 at 11:57 A.M., LPN Q said he/she was a charge nurse on the resident's floor. He/She did not know if the resident had any dental issues. The resident had not been to the dentist since April 2021. The transportation coordinator arranged dental appointments. Observation on 6/28/21 at 1:18 P.M. showed the resident sat in the dining room eating lunch. Staff served him chicken nuggets, corn, carrots and yogurt. The resident said the food was difficult to chew and his/her teeth hurt when he/she ate. The resident ate very little of the chicken nuggets and the corn. He/She ate the yogurt. During interview on 6/28/21 at 4:10 P.M., the transportation coordinator said he/she took the resident to the dentist three or four times. The resident had dental appointments on 2/12/21, 3/19/21 and 4/30/21. Record review showed no documentation of a follow up dental appointment following the resident's last dental visit. During interview on 6/29/21 at 12:20 P.M., the medical records staff said the resident's record contained no dentist appointment documentation or dental follow up recommendations. During interview on 7/6/21 at 12:40 P.M., the Social Services Director said the following: -He/She did not set dental appointments at the offsite dental office in the community; the transportation coordinator set up those appointments; -The floor nurse manager or charge nurse should ask either social services or transportation coordinator for a dental appointment if needed; -If the facility missed a resident's dental appointment, staff should follow up and reschedule. 3. During interview on 7/6/21 at 6:00 P.M., the Director of Nursing said staff should follow up and ensure residents' dental appointments were completed and any treatment provided. Staff should provide oral care daily and as needed for dependent residents. The transportation coordinator and social services director made residents dental appointments. Staff should not miss residents' dental appointments and should follow up and ensure dental problems were taken care of. A resident with known dental infections needed follow up care. MO186828