STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	06/14/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46506

Based on interview and record review, the facility failed to document the administration of a controlled medication removed from the Nexus (locked emergency medication dispense machine) and individual resident controlled medication count sheets, removed future doses of controlled medication from the Nexus machine, and individual resident controlled medication count sheets prior to the ordered administration times. Nursing staff who removed the controlled medication was not the same nursing staff member who administered and documented the medication was administered for two sampled residents (Resident #11 and #13), of 13 sampled residents and one closed record (Resident #15). Facility staff removed a controlled medication from the Nexus machine without a physician's order for one closed record (Resident #16) of three closed record residents. The facility census was 73.

Review of the facility's Documentation of Medication Administration policy, dated April 2007, showed the following:

-A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR):

-Administration of medication must be documented immediately after (never before) it is given;

-Documentation must include the date and time of administration, reason(s) why a medication was not administered, and signature and title of the person administering the medication.

1. Review of Resident #13's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 5/31/24, showed the following:

-The resident readmitted on [DATE];

-He/She had severe cognitive impairment;

-He/She received antianxiety and opioid medications.

Review of the resident's physician orders, dated April 2024, showed the following:

-Hydrocodone/acetaminophen (opioid pain medication) 5/325 milligrams (mg) give 1 1/2 tablets by mouth every six hours as needed (PRN) for pain (started 10/18/23);

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Beth Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Pleasant Street Hannibal, MO 63401	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hydrocodone/acetaminophen 7.5 mg/325 mg give one tablet by mouth four times a day related to low back pain (started 6/11/23); -Lorazepam (antianxiety) 0.5 mg give one tablet by mouth three times a day related to anxiety disorder (started on 6/11/23). Review of the resident's controlled medication record, dated 4/4/24, showed the following: -Certified Medication Technician (CMT) F signed out one tablet of hydrocodone/acetaminophen 7.5/325 mg at 12:00 P.M.; -Licensed Practical Nurse (LPN) I signed out one tablet of hydrocodone/acetaminophen 7.5/325 mg at 12:30 P.M.; -CMT F signed out one tablet of lorazepam 0.5 mg at 12:00 P.M.; -LPN I signed out one tablet of lorazepam 0.5 mg at 12:30 P.M. Review of the resident's Medication Administration Record (MAR), dated 4/4/24, showed no documentation staff administered hydrocodone/acetaminophen 7.5/325 mg or lorazepam 0.5 mg at 12:00 P.M. or the administration or destruction of the second doses removed at 12:30 P.M. Review of the Nexus (locked emergency medication machine) activity transaction report, dated 4/10/24, showed LPN J and LPN O removed four tablets of hydrocodone/acetaminophen 7.5/325 mg at 8:41 A.M. and four tablets of lorazepam 0.5 mg at 8:42 A.M. Review of the resident's MAR, dated 4/10/24, showed the following: -Staff documented administration of hydrocodone/acetaminophen 7.5/325 mg in the morning, midday, evening, but not at bedtime; -Staff did not document administration or destruction of the bedtime dose of hydrocodone/acetaminophen 7.5/325 mg; -Staff documented administration of lorazepam 0.5 mg in the morning, midday, and evening; -LPN J and LPN O did not document administration or destruction of the fourth tablet of lorazepam, removed from the Nexus machine. Review of the resident's controlled medication record, dated 4/13/24, showed the following: -LPN I signed out one tablet of hydrocodone/acetaminophen 7.5/325 mg at 7:30 A.M., 11:30 A.M., 3:30 P.M., and 7:00 P.M.; -LPN I signed out one tablet of lorazepam 0.5 mg at 7:30 A.M., 11:30 A.M., and 3:30 P.M. Review of the resident's MAR, dated 4/13/24, showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No documentation staff administered hydrocodone/acetaminophen 7.5/325 mg in the morning, midday, or evening; -No documentation staff administered lorazepam 0.5 mg in the morning, midday, or evening. Review of the resident's controlled medication record, dated 4/14/24, showed LPN I signed out one tablet of hydrocodone/acetaminophen 7.5/325 mg at 7:00 P.M. Review of the resident's MAR, dated 4/14/24, showed a different LPN signed out the hydrocodone/acetaminophen and documented, administered by day shift nurse. Review of the resident's controlled medication record, dated 4/17/24, showed the following: -LPN I signed out one tablet of hydrocodone/acetaminophen 7.5/325 mg at 7:30 A.M.; -LPN I signed out one tablet of lorazepam 0.5 mg at 7:30 A.M. Review of the resident's MAR, dated 4/17/24, showed no documentation staff administered one tablet of hydrocodone/acetaminophen 7.5/325 mg or one tablet of lorazepam 0.5 mg at 7:30 A.M. Review of the resident's controlled medication record, dated 5/27/24, showed CMT F signed out one tablet of lorazepam 0.5 mg at 5:00 P.M. Review of the resident's MAR, dated 5/27/24, showed no documentation staff administered lorazepam 0.5 mg at 5:00 P.M. During an interview on 6/14/24 at 8:10 A.M., LPN I said the following: -He/She did not remember why he/she removed a second tablet of the resident's hydrocodone/acetaminophen on 4/3/24; -He/She did not know if something happened to the first tablet, but he/she had to get a second one; -If he/she signed out a tablet on the controlled substance log, then he/she or a CMT administered it and forgot to sign it as administered on the MAR. 2. Review of Resident #15's admission MDS, dated [DATE], showed the following: -The resident admitted on [DATE]; -He/She was cognitively intact; -He/She received antianxiety and antidepressant medication. Review of the resident's physician orders, dated April 2024, showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ativan (antianxiety) 1 mg give one tablet by mouth as needed for anxiety (mental condition characterized by excessive apprehensiveness about real or perceived threats, typically leading to avoidance behaviors and often to physical symptoms such as increased heart rate and muscle tension), may have one table as needed throughout the day or evening (started 4/2/24); -Ativan 1 mg give one tablet by mouth two times a day for anxiety (started 4/2/24). Review of the Nexus activity transaction report, dated 4/4/24, showed LPN H and LPN I removed two tablets of Ativan 0.5 mg from the machine at 7:19 P.M. for the resident. Review of the resident's MAR, dated 4/4/24, showed staff did not document administration of the scheduled Ativan for the evening dose. Review of the Nexus activity transaction report, dated 4/5/24, showed the following: -LPN M and LPN N removed two tablets of Ativan 0.5 mg from the machine at 3:26 P.M. for the resident; -LPN M and LPN N removed one tablet of Ativan 0.5 mg from the machine at 3:28 P.M. for the resident. Review of the resident's MAR, dated 4/5/24, showed staff documented administration of the first two Ativan tablets, but no documentation staff administered or destroyed the third tablet. Review of the Nexus activity transaction report, dated 4/6/24, showed no medication was removed for the resident. Review of the resident's MAR, dated 4/6/24, showed staff documented administration of the resident's scheduled Ativan on 4/6/24 for both the morning and evening dose. Review of the Nexus activity transaction report, dated 4/7/24, showed LPN J and LPN M removed six tablets of Ativan 0.5 mg from the machine at 11:57 A.M. for the resident. Review of the resident's MAR, dated 4/7/24, showed staff documented administering the scheduled Ativan in the morning (two tablets) and evening (two tablets). There was no documentation whether staff administered or destroyed the remaining two tablets. Review of the Nexus activity transaction report, dated 4/10/24, showed LPN J and LPN M removed three tablets of Ativan 0.5 mg from the machine at 4:37 P.M. for the resident. Review of the resident's MAR, dated 4/10/24, showed the following: -Staff documented administering the scheduled Ativan for the morning dose, but no medication was removed from the Nexus machine; -Staff documented administering the scheduled Ativan for the evening dose, but the third tablet was not documented as administrated or destroyed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's controlled medication record, dated 4/13/24, showed LPN I removed the medication from the individual resident's Ativan medication card at 7:00 P.M. Review of the resident's MAR, dated 4/13/24, showed no documentation staff administered the resident's evening scheduled Ativan. Review of the resident's controlled medication record, dated 4/17/24, showed LPN I removed the medication from the individual resident's Ativan medication card at 7:00 P.M. Review of the resident's MAR, dated 4/17/24, showed no documentation staff administered the evening scheduled dose of Ativan. During an interview on 6/14/24 at 8:10 A.M., LPN I said if he/she took medication out of the Nexus for the resident, and it was not documented as administered, then he/she missed signing it off on the MAR. 3. Review of Resident #11's quarterly MDS, dated [DATE], showed the following: -The resident was readmitted on [DATE]; -He/She had severe cognitive impairment; -He/She received opioid medication. Review of the resident's physician orders, dated April 2024, showed tramadol (opioid pain medication) 50 mg give one tablet by mouth every six hours for unexplained agitation (started 3/8/24). Review of the Nexus activity transaction report, dated 4/9/24, showed LPN H and LPN I removed four tablets of tramadol 50 mg at 10:28 A.M. for the resident. Review of the resident's MAR, dated 4/9/24, showed no documentation staff administered the scheduled tramadol 50 mg at 12:00 P.M. or 6:00 P.M. Review of the Nexus activity transaction report, dated 4/18/24, showed LPN H and LPN R removed four tablets of tramadol 50 mg at 7:56 A.M. and one tablet at 7:25 P.M. Review of the resident's MAR, dated 4/18/24, showed no documentation staff administered the resident's scheduled tramadol 50 mg for the 6:00 P.M. dose. During an interview on 6/13/24 at 4:18 PM, LPN H said the following: -He/She had to get tramadol for the resident from the Nexus machine, especially if the resident was out of medication and the pharmacy did not deliver it prior to running out; -If the medication was not documented as administered, then he/she accidentally missed signing it off on the MAR or it was put in the locked cabinet in the locked cart for another CMT or licensed nurse to administer and they missed signing it off. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/24 at 8:10 A.M., LPN I said the following: -He/She did not remember taking tramadol out of the Nexus machine for the resident; -He/She did not know what happened to the medication or why it was taken from the Nexus machine; -Previously the Nexus required two licensed nurses to take out controlled meds, now one can be a CMT; -He/She would take extra medication out of Nexus and lock it up in the controlled medication box in the medication cart. 4. Review of Resident #16's admission MDS, dated [DATE], showed the following: -The resident admitted on [DATE]; -He/She had severe cognitive impairment; -He/She received antianxiety and opioid medication. Review of the resident's physician orders, dated April 2024, showed the resident did not have an order for tramadol 50 mg. Review of the Nexus activity transaction report, dated 4/4/24, showed LPN H and LPN I removed one tablet of tramadol 50 mg for the resident. Review of the resident's MAR, dated April 2024, showed no documentation staff administered the tramadol. During an interview on 6/13/24 at 10:30 A.M., CMT F said the following: -LPN I pulled three residents' medication early for the 12:00 P.M. scheduled medication pass and put them in separate medication cups, labeled with each resident's name in the medication cart; -LPN I quit and left the facility leaving the medication cups in the medication cart; -CMT F destroyed the medications and pulled more medications to cover the 12:00 P.M. schedule. During an interview on 6/13/24 at 4:18 PM, LPN H said the following: -He/She usually obtained medications out of the Nexus machine for the East Hall; -Several of the CMTs did not have access to Nexus machine to get their own medications; -He/She helped be second witness for [NAME] Hall when asked. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/24 at 8:10 A.M., LPN I said the following: -Licensed nurses and CMTs were the only staff who could administer medication including controlled medications; -Two staff were required to sign out a controlled medication in the Nexus machine, one could be a CMT; -The controlled medications were dispensed from the Nexus machine in individual labeled packages; -The nursing staff only pulled medications from the Nexus machine if it was a new medication order, and the pharmacy did not send it yet; -The pharmacy sent the medication when there was a prescription at the pharmacy; -He/She did not remember Resident #16 and did not know why tramadol was pulled from the Nexus machine when the resident did not have an order for the medication; -He/She denied pulling a resident's medications early and putting it in a cup to administer later. During an interview on 6/14/24 at 9:25 A.M., the Assistant Director of Nursing (ADON) said the following: -The expectation was the nursing staff who removed the medication from the Nexus machine or signed it out on the the resident's controlled medication record be the person who administered the medication; -The nursing staff should not open a resident's medication package and store it in a cup until time of administration; -If a resident refused to take medication, the expectation was it be destroyed and not left in the medication cart; -No controlled medications could be left in a cup in the medication cart, it was required to be double locked. During an interview on 6/14/24 at 1:05 P.M., the LPN/Clinical Care Coordinator said the following: -He/She audited LPN I's medication cart on 4/17/24 and found three medication cups with residents' medication in the cups; -He/She was not able to identify the medication in the cups, so he/she instructed CMT F to destroy the medication and take the next days dose to cover today and he/she notified the pharmacy of the issue. During an interview on 6/14/24 at 9:25 A.M., the Assistant Director of Nursing (ADON) said the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing staff who removed medication from the Nexus machine or signed it out on the the resident's controlled medication record should be the person who administered the medication; -The nursing staff should not open a resident's medication package and store it in a cup until time of administration; -If a resident refused to take medication, the expectation was it be destroyed and not left in the medication cart; -No controlled medications could be left in a cup in the medication cart, it was required to be double locked. MO236509

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46506 Based on observation, interview, and record review, the facility failed to provide safe transfers and prevent bruising and skin tears for one resident (Resident #9), in a review of 12 residents who staff identified at risk for bruising and skin tears. Staff transferred the resident by lifting the resident under the arms with a gait belt (canvas belt placed around the resident's waist to assist with ambulation, transfer, and positioning in a chair) and pulled on the resident's arms while dressing and undressing the resident. The facility census was 73. Review of the facility policy, Safe Lifting and Movement of Residents, dated July 2017, showed the following: -In order to protect the safety and well-being of staff and residents and to promote quality care the facility used appropriate techniques and devices to lift and move residents; -Resident safety, dignity, comfort and medical condition would be incorporated into goals and decisions regarding the safe lifting and moving of residents; -Manual lifting of residents should be eliminated when feasible; -Staff should assess the individual resident's needs for transfer assistance on an ongoing basis. 1. Review of Resident #9's physician orders, dated 8/24/23, showed the following: -Diagnoses of arthritis, muscle weakness, Alzheimer's disease, difficulty in walking, abnormal gait and mobility, and need for assistance with personal care; -Apply tubigrip (protective sleeves) to extremities. Two staff assistance with gait belt transfers to prevent further injuries. Review of the resident's care plan, revised 3/5/24, showed the following: -High risk for alteration in skin integrity, had fragile skin with potential for skin tears. Staff should use sheep's wool (thick, soft protective covering) applied to the wheelchair for padding the arms/legs. Apply tubigrip to extremities daily, provide two staff assistance with transfers to help prevent skin injury, monitor skin twice daily and report any abnormal findings to the charge nurse. Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface; -Issues with pain at times and the resident would moan or cry out during care. Staff should be gentle and move slowly when providing care to decrease discomfort. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 5/24/24 showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Severe cognitive impairment; -Dependent on staff (staff provided all the effort) with dressing upper and lower body, bathing and personal hygiene; -Substantial/maximal (staff provided more than half the effort, lifted or held the trunk or limbs) staff assistance with transfers; -Did not walk and was,dependent on staff with wheelchair mobility; -Skin tears present. Review of the resident's nurses' notes showed the following: -On 6/8/24 at 10:48 A.M., a large dark purple bruise was noted to the resident's right upper arm measuring 12 centimeters (cm) by 13 cm; -On 6/10/24 at 5:00 A.M., two skin tears occurred during care. One skin tear to the left lower leg measured 2.5 cm by 2.5 cm and one skin tear to the left arm measured 0.5 cm by 0.5 cm. Observation on 6/14/24 at 7:45 A.M. showed the following: -Certified Nurse Assistant (CNA) C and CNA D removed the resident's tight-fitting shirt with difficulty removing the sleeves. CNA C and CNA D pulled on the resident's arms while stretching the shirt and removed the tubigrip sleeves from each arm. The resident's skin appeared thin and fragile with multiple small bruises, discolored areas to both arms and hands. Skin tears were noted on both lower arms. A bruise was noted on the right arm from just above the elbow to approximately three inches below the shoulder and extended around towards the back of the arm. A new skin tear was noted to the back of the resident's left arm, was C shaped and approximately 1.0 cm in length with bleeding present. CNA C and CNA D notified the charge nurse, who cleaned and applied a dressing on the new skin tear; -CNA C and CNA D applied the tubigrip sleeve on the resident's right arm and attempted to redress the resident in a tight-fitting long sleeve t-shirt with difficulty as they pulled on the resident's arms, stretching the shirt. CNA C and CNA D did not place a tubigrip sleeve to the resident's left arm. The resident moaned several times and said people were rough and hurt his/her arms. During an interview on 6/14/24 at 8:00 A.M. CNA D said the resident did not stand and was a total lift with the gait belt by lifting under the resident's arms. The resident should be a mechanical lift. Staff had to pull on the resident's arms while dressing him/her, it was difficult to dress the resident. His/Her skin was fragile and pulling on the resident's arms during dressing and transfers was causing skin tears and bruising. The resident had multiple bruises and skin tears. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/14/24 at 10:00 A.M., showed CNA B and CNA E applied a gait belt around the resident's waist and lifted the resident under both arms out of the wheelchair while holding only the back of the gait belt. The resident moaned and his/her shoulders raised during the transfer. The resident's toes touched the floor without bearing weight, and with ankles crossed as CNA B and CNA E pivoted the resident from the wheelchair to the recliner chair. The resident's feet drug across the floor during the transfer. During interview on 6/14/24 at 10:05 A.M. CNA E said staff always transferred the resident the way he/she and CNA B had just done, with the gait belt and lifting the resident under both arms. The resident did not bear weight during the transfer and staff had to lift the resident. Staff should not lift the resident under the arms. During an interview on 6/14/24 at 3:45 P.M. the Assistant Director of Nursing said staff should not perform a total body lift with a gait belt and by lifting under the resident's arms. A mechanical lift was required for a total body lift. Lifting the resident with a gait belt and under the arms could cause bruising, skin tears and injuries. The resident's skin was fragile, he/she bruised easily and had many skin tears. Dressing the resident in tighter clothing could cause skin tears and bruising while pulling on the resident's arms. During an interview on 6/14/24 at 2:20 P.M. the Administrator said staff should not transfer a resident's full body weight with a gait belt and should not lift a resident under the arms. This could cause injuries, skin tears and bruising. Staff should always provide the safest transfer and avoid injuries. MO237136

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 46506 Based on observation, interview, and record review, the facility failed to provide special eating equipment and utensils for one resident (Resident #9), in a review of 12 sampled residents, who the facility identified needed specialized equipment to assist with eating and drinking. The facility census was 73. Review of the facility Assessment and Care Planning policy, Assisting the Nurse in Examining and Assessing the Resident, dated September 2010, showed the following: -The purpose was to assist the nurse in gathering information about the overall condition of the resident and his/her performance of Activities of Daily Living (ADLs); -The assessment process was continuous. It began upon admission and continued until the resident was discharged ; -ADLs included the resident's physical, psychological, social and spiritual activities; -As meals were served, note assistance needed with eating (opening milk cartons, cutting foods, special devices), the amount and types of food eaten and any changes in the resident's eating habits. 1. Review of Resident #9's physician orders, dated 6/15/23, showed the following: -Diagnoses of arthritis, muscle weakness, Alzheimer's disease, and need for assistance with personal care; -Regular diet, minced texture, soft and bite sized foods. Review of the resident's care plan revised 3/7/24 showed the following: -The resident was at nutritional risk related to confusion and decreased ability to feed self and communicate with appetite less than 76 percent of most meals. Dietary staff should provide a divided plate (a plate with divided sections and raised edges and dividers to facility scooping food onto a fork or spoon) and curved utensils (large handled curved eating utensils to promote gripping and management of food into the mouth) at all meals. Certified Nurse Assistant (CNA) staff should provide Kennedy cups (a cup with a handle and lid that contained a straw) at all meals. Provide yogurt and small, fresh fruit cup at lunch and dinner each day, provide milk with breakfast and tea and water throughout the day. Monitor and report difficulty swallowing, pocketing food, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat or if appeared concerned during all meals. Staff should provide encouragement and assistance with eating if needed; -The resident had alteration in thought processes. Staff should adjust diet to accommodate chewing, swallowing or eating issues in order to maximize independence and nutritional intake; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident required extensive assistance with Activities of Daily Living (ADLs) and extensive assistance with meals. This was often one-on-one encouragement and actually feeding the resident at times. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 5/24/24 showed the following: -Severe cognitive impairment; -Required partial to moderate staff assistance with eating and oral hygiene. Staff provided less than one-half of the effort; -Required a mechanically altered, therapeutic diet. Review of the resident's dietary card on 6/14/24 at 8:25 A.M. showed the following: -Regular diet with soft bite sized pieces; -Divided plate and built up, curved utensils; -Two Kennedy cups; -Yogurt and fresh fruit with every meal. Observation on 6/14/24 at 8:25 A.M. showed the following: -Staff served the resident scrambled eggs, an unopened single serve container of yogurt, an unopened cereal container, an opened carton of milk, a single serving juice container with the sealed foil pulled slightly open, a whole slice of toast and a sausage patty cut into approximately two-inch pieces. Fresh fruit was not provided. The food sat on a regular sized plate with no divided sections. The silver ware was flat without built up and curved handles. No Kennedy cup was provided; -The resident held the toast in his/her hand and attempted to eat. The toast wadded up in the resident's fist as he/she tried to eat. The yogurt and cereal containers remained sealed closed; -The resident picked up one piece of sausage with his/her fingers and placed the entire piece in his/her mouth, attempted to chew and spit out part of the sausage. He/She placed a spoon in the open carton of milk and tried to spoon a drink of milk from the carton. CNA B opened the yogurt container and the resident ate the yogurt with a spoon, holding the flat handled spoon in his/her fist; -The resident ate another bite of sausage and scrambled eggs with his/her fingers, poured milk from the milk carton into the yogurt container and attempted to drink milk from the yogurt container, drank three cartons of juice with a straw and then spit out the unchewed sausage and scrambled eggs; -CNA B removed the resident's tray, the resident asked for water. CNA B did not provide any water or additional food or drinks to the resident. During an interview on 6/14/24 at 9:20 A.M. CNA B said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Beth Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Pleasant Street Hannibal, MO 63401	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She supervised breakfast and the resident required supervision with eating; -He/She had never seen large handled curved utensils provided for the resident. Staff should provide the divided plate, large handled curved utensils and Kennedy cups as the resident's dietary card indicated. The resident could probably eat and drink better with the assistive devices. He/She did not know where the adaptive utensils were kept, there were not any in the dining room. The Kennedy cups come from the kitchen and none were provided for the resident. He/She placed straws in the resident's juice containers to keep the resident from spilling the juice. Observation on 6/14/24 at 12:10 P.M. showed staff served the resident a whole chicken breast, not cut into bite size pieces, on a divided plate with regular flat silver ware. The resident picked the chicken up with his/her fingers and tried to bite the chicken without success. The resident's family member cut the chicken up for the resident. During an interview on 6/14/24 at 12:45 P.M. the Dietary Supervisor said adaptive eating equipment and utensils came from the kitchen. Dietary staff should ensure all meals were served according to the dietary cards and adaptive equipment was provided. All resident meals should be served in the required consistency. Dietary staff were not following the residents dietary cards at every meal and not always providing residents the needed adaptive equipment and consistency of food. During an interview on 6/14/24 at 3:45 P.M. the Assistant Director of Nursing said if the resident's dietary cards instructed staff to provide assistive devices at meals, staff should ensure those devices were provided to prevent choking and facilitate eating. If a resident had change in ability, staff should notify the charge nurse. During an interview on 6/14/24 at 2:20 P.M. the Administrator said staff should ensure residents dietary requirements were followed and provide adaptive eating equipment as each dietary card indicated. If a resident had a change in ability to eat and chew food, CNA staff should inform the charge nurse for evaluation and changes to prevent choking and promote adequate nutritional intake. Dietary staff should serve the resident's food on a divided plate and provide large handled curved utensils for every meal. His/Her drinks should be served in a Kennedy cup at every meal. The resident was assessed previously and found to need these items to promote eating and drinking fluids.