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	07/18/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on interview and record review, the facility failed to ensure two residents (Resident #1 and #3), in a review of seven residents, were free from misappropriation of property, when a Licensed Practical Nurse (LPN) D misappropriated narcotics from the residents. The facility census was 68. Review of the facility policy, Identifying Exploitation, Theft and Misappropriation of Resident Property, dated April 2021, showed the following: -Exploitation, theft and misappropriation of resident property are strictly prohibited; -Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent; -Examples of misappropriation of resident property includes drug diversion (taking the resident's medication). 1. Review of the facility online report, dated 7/7/24 at 4:36 P.M., showed the following: -Resident #1's PRN (as needed) hydrocodone/APAP (opioid pain medication) 5/325 milligrams (mg) was signed out on 7/7/24 by LPN D at 12:58 P.M. The resident said he/she had not reported any pain to the nurse and had not received a pain pill. Upon review of the resident's medical record, it showed staff administered the pill at 1:16 P.M. The resident was adamant he/she had not received this medication and only received his/her morning medications from Certified Medication Technician (CMT) E. The resident said he/she had not received a pain pill since 7/1/24. The Director of Nursing (DON) was notified by House Supervisor/Registered Nurse (RN) F. The resident was cognitively intact when interviewed by the Director of Nursing (DON); -Resident #3 was questioned about receiving his/her pain medication. The resident said he/she thought he/she had received it. The DON noted the resident's pain medication was signed out at 1:18 P.M. (by LPN D). The resident resided on a different hall than LPN D was assigned. LPN D was not to get in the narcotic box on the cart without another staff member due to being on probation for a previous complaint related to missing pain medication that was investigated; -LPN D was suspended pending investigation. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility) staff dated 4/5/24 showed the following: -Makes self understood and understands others; -Cognitively intact; -Opioid use; -The resident used as needed (PRN) pain medication in the last five days and had pain frequently; -Diagnoses included low back pain, pain in right knee, sacrococcygeal disorders (changes in the tailbone) and osteoarthritis (a degenerative joint disease that causes pain, swelling, and stiffness). Review of the resident's care plan, revised on 7/2/24, showed the following: -The resident had arthritis, give medications as ordered, monitor/document side effects and effectiveness; -The resident had pain related to multiple disease processes, respond immediately to any complaint of pain, monitor the resident for any behaviors of inadequate pain control; -Monitor for inadequate pain control such as agitation, restlessness,confusion or hallucinations, nausea, vomiting, dizziness or falls. Review of the resident's physician order sheets (POS), dated July 2024, showed an order for hydrocodone/APAP 5/325 mg, one tablet by mouth every six hours as needed (PRN) for breakthrough pain. Review of the resident's narcotic count sheet for hydrocodone/APAP 5/325 mg showed LPN D removed one tablet on 7/7/24 at 12:58 P.M. Review of the resident's Medication Administration Record (MAR), dated July 2024, showed LPN D documented he/she administered hydrocodone/APAP one tablet to the resident on 7/7/24 at 1:16 P.M. Review of the resident's progress notes showed no evidence on 7/7/24 the resident complained of pain or requested pain medication. During an interview on 7/16/24 at 10:12 A.M. the resident said he/she did not ask for a pain pill on 7/7/24 or that weekend, he/she did not like taking pain pills. He/She had not taken anything for pain in a while. 3. Review of Resident #3's care plan, revised, 1/17/24, showed the following: -The resident had chronic pain in his/her back, left knee and right wrist; -He/She used Percocet for pain management, if pain management regimen was unsuccessful or if complaint of pain increased in frequency notify the physician, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly MDS, dated [DATE] showed the following: -Makes self understood and understands others; -Moderate cognitive impairment; -Opioid use; -The resident used as PRN pain medication in the last five days and had pain frequently; -Diagnoses included pain in left knee, low back pain, pain in right hand, pain in right arm, and pain in left hip. Review of the resident's POS, dated July 2024, showed an order for oxycodone/APAP (Percocet) 7.5/325 mg, one tablet by mouth three times a day related to pain in right hand, pain in left knee and left hip, pain in right arm and low back pain. Review of the resident's narcotic count sheet for oxycodone/APAP 7.5/325 mg showed LPN D removed one tablet on 7/7/24 at 1:00 P.M. Review of the resident's Medication Administration Record (MAR), dated 7/7/24, showed no documentation LPN D administered the resident's scheduled 2:00 P.M. dose of oxycodone/APAP 7.5/325 mg. 4. During an interview on 7/16/24 at 4:30 P.M. CMT E said the following: -He/She worked with LPN D on 7/7/24 and took over the medication cart for him/her because LPN D became ill and had to leave around 1:30 P.M.; -House Supervisor/RN F and CMT E looked over the narcotic count sheets and noted on Resident #1's narcotic count sheet for hydrocodone/APAP 5/325 mg, LPN D had removed one tablet and documented it was administered on the MAR. Resident #1 was not a resident that routinely took anything for pain; -He/She and House Supervisor/RN F went to the Resident #1's room and questioned him/her about the medication, the resident said he/she did not receive anything for pain and had only received his/her morning medications; - LPN D removed one oxycodone/APAP 7.5/325 mg for Resident #3 at 1:00 P.M., but had not documented he/she administered the medication on the MAR. During an interview on 7/16/24 at 1:55 P.M., House Supervisor/RN F said the following: -He/She worked at the facility on 7/7/24 (day shift); -LPN D was the charge nurse on the east hall and was assigned a medication cart and was responsible for passing most of the narcotics; -Around 1:20 P.M., LPN D said he/she was not feeling well and was diaphoretic (excessive sweating), as though under the influence of a drug/medication. House Supervisor/RN F sent LPN D home; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was concerned because of LPN D's behavior and symptoms so he/she checked the narcotic count sheets; -LPN D documented removing one tablet of hydrocodone/APAP 5/325 mg. on the narcotic sheet; and documented administration of the medication on the resident's MAR; -He/She questioned Resident #1 and he/she denied receiving anything for pain. Resident #1 is alert and oriented and seldom took any pain medication; -Resident #3 complained of pain at 1:30 P.M., he/she felt the resident didn't receive his/her scheduled oxycodone/APAP at 2:00 P.M., because he/she was in so much pain. Normally the resident's pain was relieved if he/she had received his/her routine pain medication; -He/She reported his/her concerns to the DON. During an interview on 7/16/24 at 3:15 P.M. the DON said the following: -On 7/7/24 Resident #1 denied requesting his/her PRN oxycodone/APAP 5/325 mg or receiving it from LPN D. Upon review of documentation of the resident's narcotic count sheet, LPN D removed one oxycodone/APAP 5/325 mg at 12:58 P.M. and documented administering the medication on the MAR; -On 7/7/24, Resident #3 rated his/her pain a 14 on a 0 to 10 scale (ten being the worse pain possible) and denied receiving his/her scheduled 2:00 P.M. dose of oxycodone/APAP 7.5/325 mg. Upon review of documentation of the resident's narcotic count sheet, LPN D removed one oxycodone/APAP 7.5/325 mg at 1:00 P.M., but had not documented the medication as being administered on the MAR; -LPN D was terminated because he/she had signed out narcotics for Resident #1 and the resident was alert and oriented and denied receiving the medication. Also Resident #3 denied getting his/her scheduled oxycodone/APAP 7.5/325 mg on 7/7/24; -LPN D refused to provide a statement. LPN D was currently on probation and had received a verbal warning following a previous report regarding removing narcotics from the narcotic log book and not signing that the medications were administered on the residents' MAR; -LPN D was to have a second staff member sign out any PRN narcotics with him/her; -On 7/7/24 LPN D took the medication cart with the most narcotics and there was no need for that, the CMT could have passed all of the medications as there were only 17 residents or the medication pass. During an interview on 7/17/24 at 1:45 P.M. the Administrator said the following: -This was the second incident regarding LPN D and narcotic administration. Previous issues were in April of 2024. LPN D signed out narcotics and documented the narcotic was administered to an alert and oriented resident (Resident #1) who said he/she did not receive the medication; -There were concerns with misappropriation of resident medications by LPN D. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO238641

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on interview and record review, the facility failed to provide evidence an investigation was completed after a one resident (Resident #2), reported staff repeatedly slapped him/her on the hand, and failed to provide evidence a thorough investigation was completed following an allegation of staff misappropriation of narcotics for two residents (Resident #1 and #3) of seven sampled residents. The facility failed to report the results of the investigation regarding Resident #1 and #3 to the state agency within five working days of the incident. The facility census was 68. Review of the facility's policy Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, undated, showed the following: -All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported; -All allegations are thoroughly investigated. The administer initiates investigations according to designating responsibilities to other departments involved; -The individual conducting the investigation will: Review the documentation and evidence; -Reviews the resident's medical record to determine the resident's physical and cognitive statues at the time of the incident; -Observes the alleged victim, including his or her interactions with staff and other residents; -Interviews the person reporting the incident; -Interviews the resident (as medically appropriate) or the resident's representative; -Interviews the resident's attending physician as needed to determine the resident's condition; -Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; -Interview the resident's roommate, family members, and visitors; -Interview other residents to whom the accused employee provides care or services; -Reviews all events leading up to the alleged incident and documents the investigation completely and thoroughly; -Utilizes the facility abuse, neglect and misappropriation packet; -Each interview is conducted separately and in a private location; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process; -Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigation may obtain the statement; -The investigator consults daily with the administrator concerning the progress/findings of the investigation; -Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator; -Within five days of the incident, the administrator will provide a follow-up investigation report; -The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified; -The follow-up investigation report will provide as much information as possible at the time of submission of the report; -If the investigation reveals that the allegation(s) of abuse are founded the employee is terminated. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff dated, 6/14/24, showed the following: -Makes self understood and understands others; -Cognitively intact; During an interview on 7/16/24 at 1:15 P. M, the resident said the following: -A tall staff member (only first name provided), slapped him/her on the hand three or four times, it happened recently; -He/She tried to help the staff member turn off the call light in the bathroom, and the staff member got upset with him/her; -He/She felt the staff and this facility should be a Safe Haven for him/her, but it was not. The staff member made him/her angry and he/she cried; -When the resident was questioned if he/she reported this to anyone, the resident said he/she called his/her family member to tell them, because it upset him/her so much. During an interview on 7/16/24 at 3:50 P.M. Certified Nurse Assistant (CNA) C said the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/15/24 around 4:00 P.M., Resident #2 reported to him/her that the night before (7/14/24) the CNA working got upset with him/her. The resident had made a mess (incontinent of stool/urine) in the bathroom and the CNA couldn't figure out how to turn off the call light; -The resident got out of bed to show the aide how to turn off the call light and the CNA slapped his/her (Resident #2's) hand repeatedly and told the resident to stay in bed and not use his/her call light; -CNA C reported the incident to the DON, as it was an allegation of abuse. The resident was alert and had never reported that a staff member had hit him/her before. There was no documentation the facility completed an investigation regarding the allegation of abuse. 2. Review of Resident #1's admission MDS, dated [DATE], showed the following: -Makes self understood and understands others; -Cognitively intact. Review of the facility online report, dated 7/7/24 at 4:36 P.M., showed the following: -Resident #1's PRN (as needed) hydrocodone/APAP (opioid pain medication) 5/325 milligrams (mg) was signed out on 7/7/24 by Licensed Practical Nurse (LPN) D at 12:58 P.M. The resident said he/she had not reported any pain to the nurse and had not received a pain pill. Upon review of the resident's medical record, it showed LPN D administered the medication at 1:16 P.M. The resident was adamant he/she had not received this medication and only received his/her morning medications from Certified Medication Technician (CMT) E. The resident said he/she had not received a pain pill since 7/1/24. The Director of Nursing (DON) was notified by House Supervisor/Registered Nurse (RN) F. The resident was cognitively intact when interviewed by the DON; -Resident #3 was questioned about receiving his/her pain medication. The resident said he/she thought he/she had received it. The DON noted the resident's pain medication was signed out at 1:18 P.M. (by LPN D). The resident resided on a different hall than LPN D was assigned. LPN D was not to get in the narcotic box on the cart without another staff member due to being on probation for a previous complaint related to missing pain medication that was investigated; -LPN D was suspended pending investigation. Review of the resident's narcotic count sheet for hydrocodone/APAP 5/325 mg showed LPN D removed one tablet on 7/7/24 at 12:58 P.M. Review of the resident's Medication Administration Record (MAR), dated July 2024, showed LPN D documented he/she administered hydrocodone/APAP one tablet to the resident on 7/7/24 at 1:16 P.M. During an interview on 7/16/24 at 10:12 A.M., the resident said he/she did not ask for a pain pill on 7/7/24 or that weekend, he/she did not like taking pain pills. He/She had not taken anything for pain in a while. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation showed there were no written statements from staff or residents to show a complete and thorough investigation was completed. 3. Review of Resident #3's quarterly MDS, dated [DATE], showed the following: -Makes self understood and understands others; -Moderate cognitive impairment. Review of the resident's narcotic count sheet for oxycodone/APAP 7.5/325 mg showed LPN D removed one tablet on 7/7/24 at 1:00 P.M. Review of the resident's MAR, dated 7/7/24, showed there was no evidence LPN D documented he/she administered the resident's scheduled 2:00 P.M. dose of oxycodone/APAP 7.5/325 mg. Review of the facility's investigation showed there were no written statements from staff or residents to show a complete and thorough investigation was completed. 4. During an interview on 7/16/24 at 3:15 P.M. the Director of Nurses (DON) said the following: -The facility did not obtain statements from the residents or staff involved in the incident regarding LPN D and the alleged misappropriation of narcotics; -On 7/7/24, Resident #3 rated his/her pain a 14 on a 0 to 10 scale (ten being the worse pain possible) and denied receiving his/her scheduled 2:00 P.M. dose of oxycodone/APAP 7.5/325 mg. Upon review of documentation of the resident's narcotic count sheet, LPN D removed one oxycodone/APAP 7.5/325 mg at 1:00 P.M., but had not documented the medication as being administered on the MAR; -CNA C reported to him/her that Resident #2 said a staff member had hit him/her on the hand and the resident had a bruise on his/her hand; -The DON asked the resident how he/she received the bruise and if someone had hit him/her. The resident said he/she bumped his/her hand. The DON did not feel anything else needed to be done (no further investigation) because the resident denied being hit; -She was new with completing investigations involving allegations of misappropriation and abuse and was not aware that the facility needed to obtain any written statements or documentation of interviews. During an interview on 7/17/24 at 1:45 P.M. the Administrator said the following: -She expected the staff completing the investigation on Resident #1 and Resident #3 to obtain written statements from residents and staff that were involved in the incident and to complete a thorough investigation; -She felt an investigation should have been completed on Resident #2 since he/she had reported it to a staff member and there was a bruise. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO238641

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 36185 Based on observation and interview, the facility failed to maintain effective pest control measures to prevent mice and roaches in the facility including the east dining room and facility kitchen. The facility census was 68. Review of the facility's policy, Pest Control, undated showed the following: -Our facility shall maintain an effective pest control program; -This facility maintains an ongoing pest control program to ensure that the building was kept free of insects and rodents; -Garbage and trash are not permitted to accumulate and are removed from the facility daily; -Maintain services, assist when appropriate and necessary, in providing pest control services. 1. Observation on 7/16/24 at 10:25 A.M., showed a resident sat at the table in the east dining room eating his/her breakfast. Inside the resident refrigerator in the east dining room (which contained snacks, juice, and small milk cartons to be served to residents) were eight to ten small insects (resembling roaches) that crawled inside of the refrigerator. During an interview on 7/16/24 at 10:30 A.M., Certified Nurse Assistant (CNA) C said the east dining room was treated for roaches yesterday. He/She did not know roaches were inside the resident refrigerator. Some of the residents complained about the roaches in the facility. 2. Observation on 7/16/24 at 11:50 A.M., showed in the dry storage room of the kitchen, mouse droppings were noted on the floor under a metal shelving unit. The floor was dirty with brown debris, loose dry pasta, and crackers. A bag of corn bread mix was on the floor beside the mouse droppings. 3. Observation on 7/17/24 at 1:30 P.M., showed in the dry storage room of the kitchen, mouse droppings on the floor under a metal shelving unit. The floor was dirty with brown debris, dry loose pasta, and crackers. A bag of corn bread mix was on the floor by the mouse droppings. During an interview on 7/17/24 at 1:35 P.M., Dietary [NAME] A said he/she had seen a couple mice recently in the kitchen. He/She was not aware of the mouse droppings in the dry storage room. He/She was not sure who was responsible for cleaning the room. During an interview on 7/17/24 at 3:50 P.M., Dietary Aide B said he/she did know the dry storage area floor was so dirty or had mouse droppings on the floor. In the past, the facility had put dry food items in tubs because of issue with pests. During an interview on 7/18/24 at 3:00 P.M. the Operation Manager of the Pest Control Company said any food on the floor was a food source for pests. He/She typically recommended a facility with a commercial kitchen and an issue with pests store dry foods in tubs. (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/19/24 at 8:48 A.M. the Maintenance Director said the following: -He/She started working at the facility three weeks ago; -He/She was not aware of mice being in the kitchen or mice droppings in the dry storage room; -The East dining room was supposed to be closed to the residents because of the area being treated for roaches. During an interview on 7/17/24 at 1:45 P.M. and on 7/18/24 at 5:35 P.M., the Administrator said she did not know there were mice in the kitchen. At one time, there were mice in the kitchen and all of the dry storage items were to be stored in plastic bins. She was not sure why they quit using the bins. The kitchen floor should be cleaned daily. Food on the floor could cause an issue with roaches and mice. The residents were not supposed to be eating in the East dining room because the area had recently been treated for roaches The facility had an outside pest company that treated the facility routinely. MO238760