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	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of nine sampled residents, was free from verbal abuse when Licensed Practical Nurse (LPN) A, after denying to get the resident a cup of coffee when he/she requested one, proceeded to pursue the resident to another wing of the facility, yelled loudly he/she already told the resident the resident could not have a cup of coffee, and LPN A meant it in a demeaning manner at the resident while pointing his/her finger at the resident's face. Witnesses reported the resident had a surprised look on his/her face and asked what he/she had done wrong. The facility investigation showed when interviewed, Resident #1 confirmed LPN A had treated him/her very nasty, pointed his/her finger in the resident's face, and felt like LPN A dismissed him/her like a dog over a cup of coffee. The facility census was 64. The administrator was notified of the past noncompliance on 06/05/25, which occurred on 05/28/25. On 05/28/25, the Director of Nursing (DON) suspended the alleged perpetrator (AP) for the allegation of staff to resident abuse. In-servicing of staff on abuse began and the facility began their investigation into the allegation. In-servicing was completed on 06/01/25. As a result of the facility investigation, the facility determined the AP's actions did constitute staff to resident abuse and the AP was terminated on 06/02/25. This deficiency was corrected on 06/01/25. Review of the facility policy, dated 2001, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, showed the following: -Residents have the right to be free from abuse. This includes but is not limited to freedom from verbal abuse; -Protect residents from abuse by anyone, including, but not necessarily limited to facility staff; -Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems; -The policy did not include a definition of verbal abuse. 1. Review of Resident #1's undated medical diagnosis sheet, showed his/her diagnoses included nonrheumatic aortic valve stenosis (a heart condition, involving the valve between the lower left heart chamber and the body's main artery) , muscle weakness, and falls. (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
	265108	A. Building B. Wing	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 05/02/25, showed the following: -Hearing: minimal difficulty; -No hearing aids; -Makes self understood; -Understands, clear comprehension; -Adequate vision; -Cognitively intact; -No behaviors or rejection of cares; -It was very important to the resident to make choices regarding snacks/food; -Independent for mobility. Review of the resident's care plan, dated 05/13/25, showed the following: -Assist the resident when he/she asked for help with activities of daily living (ADL's); -Ensure the resident's needs were met such as hunger, thirst, and socialization. During an interview on 06/04/25 at 11:15 A.M., the resident said the following: -He/She enjoyed a cup of coffee throughout the day and in the evenings; -He/She asked LPN A for a cup of coffee, and LPN A said he/she would not make a cup of coffee just for the resident; -He/She went to another area of the facility to get a cup of coffee; -Another nurse came over and asked him/her why he/she was there (on the west wing), and he/she said he/she had friends there who would make him/her some coffee; -LPN A came over and told him/her to not ever do that again; there was a coffee station on the resident's wing; -He/She was a very obedient person and LPN A spoke very loudly. 2. Review of an undated facility investigation, Summary of Investigation, showed the Director of Nurses (DON) documented the following: (continued on next page)

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	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 05/30/25 (DON clarified that this date was typed in error, actual date was 05/28/25) at 07:44 P.M., it was reported by telephone to her by night shift staff that LPN A yelled at Resident #1 in the facility's core area; -She arrived at the facility and suspended LPN A pending an investigation; -She interviewed Resident #1, and the resident confirmed LPN A had treated him/her very nasty, pointed his/her finger in the resident's face, and dismissed the resident like a dog over a cup of coffee; -An investigation was started; -An in-service was started on verbal abuse for all facility staff; -LPN A was terminated on 06/02/25. 3. Review of a facility statement, dated 05/28/25, showed CNA B wrote the following: -He/She stood at the desk on the west side; -LPN A came over from the east side yelling, Where is Resident #1 at?; -LPN A walked over to the resident and was within inches of the resident's face; -LPN A, with his/her finger pointed at the resident's face, yelled at the resident and told the resident he/she could not have coffee and the resident was going to listen to LPN A; -LPN A returned to the east side of the building. During an interview on 06/03/25 at 05:20 P.M., CNA B said the following: -He/She worked on the west wing of the facility on the evening of 05/28/25; -The resident resided on the east wing of the facility but came over to the west wing to get a cup of coffee; -Graduate Practical Nurse (GPN) D gave the resident a cup of coffee and the resident sat down at a table across from the west wing nurses station; -CNA B heard LPN A's voice before he/she saw LPN A; -LPN A said, Where is Resident #1 at? multiple times, in a loud voice, and LNP A sounded angry; -LPN A saw the resident at the table and LPN A put his/her face very close to the resident's face, within 12 inches; -LPN A pointed his/her finger at the resident's face; (continued on next page)

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	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A told the resident he/she could not have coffee, and that LPN A meant it; -The resident looked surprised and just sat there; -LPN A left the west wing and went back to the east wing; -The resident said he/she did not know what he/she had done wrong; -CNA B and CNA C went outside of the facility and called the DON; -LPN A should not have spoken to the resident that way; and he/she considered it verbal abuse of the resident. 4. Review of a facility statement, dated 05/28/25, showed CNA C wrote the following: -LPN A stomped over to the west side and screamed, Where is Resident #1 at?; -LPN A marched over to where the resident sat, and got in the resident's face; -LPN A pointed his/her finger at the resident and yelled that the resident was going to listen to LPN A when he/she said no; -LPN A said he/she meant it, and that did not mean the resident could go and ask other people, and he/she was sick of it; -LPN A turned around and marched back to the other side. During an interview on 06/10/25 at 10:54 A.M., CNA C said the following: -He/She worked on the west wing on the evening of 05/28/25; -The resident sat at a table across from the west wing nurses station; -He/She heard LPN A screaming Where is Resident #1, where is Resident #1!? before CNA C saw LPN A; -LPN A marched over to the resident, pointed his/her finger within inches of the resident's face, and yelled at the resident. LPN A said he/she told the resident no, and the resident should not go and ask other people when LPN A told the resident no; -LPN A returned to the east wing; -The resident had a surprised look on his/her face and asked what he/she had done wrong; -CNA C had never heard a staff person yell at a resident like that; that was probably the worst he/she had ever seen; -Yelling at a resident, or refusing a need, was a form of abuse. (continued on next page)

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	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of a facility statement, dated 05/28/25, showed GPN D said the following: -He/She asked LPN A why he/she did not give Resident #1 a cup of coffee when the resident asked for one; -LPN A told GPN D the resident could not have any coffee and he/she had already told the resident no; -GPN D got the resident a cup of coffee. During an interview on 06/10/25 at 03:00 P.M., GPN D said the following: -He/She worked on the west wing of the facility on the evening of 05/28/25; -Resident #1 resided on the east wing of the facility; -The resident came over to the west wing nurses station and begged the staff for a cup of coffee; -The resident said the other nurse would not make him/her a cup of coffee when the resident asked for one; -GPN D went to the east wing to ask the staff why the resident could not have a cup of coffee; -LPN A immediately turned from the medication cart and said, no, the resident was not going to get a fucking cup of coffee, the resident had already asked and been told no, and the resident had already caused a commotion; -GPN D asked again why the resident could not have a cup of coffee, but LPN A did not respond and only said he/she had already told the resident no; -GPN D left the east wing and got a cup of coffee for the resident from another area in the facility; -When GPN D returned to the west wing nurses station, CNA B and CNA C reported LPN A came over from the east wing, found the resident at the table, and yelled at the resident and told him/her that he/she (LPN A) had already told the resident he/she could not have coffee; -Yelling at a resident, or refusing a request or need, would be considered abuse. 6. During an interview on 06/03/25 at 03:55 P.M., the DON said the following: -She received a phone call on 05/28/25 around 07:44 P.M. from CNA C who said that LPN A had yelled at Resident #1 while the resident sat at a table across from the west wing nurses station; -The resident walked to the west wing to get a cup of coffee and told the west wing staff that LPN A had refused to get a cup of coffee when the resident asked for one; -CNA C said LPN A stomped over to the west wing and said, Where is Resident #1 at? multiple times; (continued on next page)

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	06/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C said LPN A saw the resident at the table and laid into him/her (the resident); -CNA C said LPN A had his/her finger in the resident's face and said, LPN A told the resident no!; -CNA C said he/she had never heard a staff person yell at a resident like that; -LPN A went back to the east wing; -GPN D asked LPN A why he/she did not get the resident a cup of coffee when the resident asked for one; -LPN A said he/she had already told the resident no, but did not give any other explanation; -The resident told her that LPN A was very, very nasty to him/her when he/she asked for a cup of coffee; -The resident said LPN A would not make a cup of coffee just for him/her; -The resident walked to the other wing and asked the staff there to make him/her a cup of coffee and they did; -The resident said he/she really got a lashing from LPN A, LPN A did not like it when the resident asked the other staff to get the cup of coffee; -The resident said it hurt his/her feelings when LPN A spoke that way to him/her; -LPN A should have accommodated the resident's request for a cup of coffee and should not have spoken to the resident in that way; -She would consider how LPN A spoke to the resident as verbal abuse. During an interview on 06/04/25 at 2:50 P.M., the administrator said the following: -She was made aware that LPN A yelled at Resident #1 on 05/28/25 and she came into the facility; -LPN A was suspended during the investigation, then terminated on 06/02/25; -Yelling at a resident was a form of abuse. MO00254942