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	02/29/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36185 Based on interview and record review, the facility failed to report an allegation of misappropriation of property to the state agency for one resident (Resident #6) in a review of 26 sampled residents. The facility census was 167. Review of the facility's policy, Abuse and Neglect, last revised 1/5/23, showed the following: -The purpose of the policy is to outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of funds and property; -Misuse of funds/property is the misappropriation or conversion of a resident's funds or property for another person's benefit. This includes theft of money from a resident; -Employees and vendors are required to immediately report any occurrences of misappropriation of property they observe, hear about, or suspect to a supervisor or the administrator; -The facility must ensure that all alleged violations involving misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the State Survey Agency. 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 2/10/24, showed the resident had moderate cognitive impairment. During an interview on 2/21/24 at 4:35 P.M., the resident said the following: -A few weeks ago, in the middle of the night, Certified Nurse Assistant (CNA) D was in his/her room emptying the trash; the resident was using his/her bathroom; -When the resident came out of the bathroom, the pockets on his/her purse were open. The resident checked his/her purse, and twenty dollars was missing; (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident immediately reported what happened to Licensed Practical Nurse (LPN) C and that he/she thought CNA D had taken his/her money; -On 2/25/24 the facility replaced his/her money. During an interview on 2/21/24 at 7:15 P.M., LPN C said the following: -The resident reported missing money to him/her a couple weeks ago; -The resident did not mention who he/she thought had taken the money; -LPN C spoke to Registered Nurse (RN) B the next morning, RN B said he/she thought administration was aware of the resident's missing money; -LPN C was not aware of the investigation/reporting process involving misappropriation or what to do if a resident reported missing or stolen money. During an interview on 2/28/24 at 3:25 P.M., RN B said the following: -Approximately two to three weeks ago the resident reported that while he/she was in his/her bathroom, CNA D was talking to him/her from outside of the resident's bathroom; -When the resident came out of the bathroom his/her purse was open and the resident thought CNA D had taken money out of his/her purse; -RN B texted the administrator and the Director of Nursing (DON) about the accusation and assumed they would take over and investigate; -RN B was not sure of time frames for reporting misappropriation to the state agency; -RN B told LPN C to not allow CNA D to go on the resident's hall for a while because of the accusation made by the resident against CNA D. During an interview on 2/28/24, the administrator said the following: -On 2/25/24, the resident reported that he/she had twenty or twenty-two dollars missing. The resident said he/she came out of the bathroom and his/her purse was open and money was missing; -The administrator did not report the incident to the state agency because the resident's story was inconsistent; -Staff should have reported the missing money immediately to administration when the resident reported it to them; -If the resident accused a staff member of taking his/her money, the allegation should have been reported to the state agency. MO232032

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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 - Few	Respond appropriately to all alleged violations. 36185 Based on interview and record review, the facility failed to thoroughly investigate an allegation of misappropriation made by one resident (Resident #6) in a review of 26 sampled residents. The facility census was 167. Review of the facility's policy, Abuse and Neglect, last revised 1/5/23, showed the following: -The purpose of the policy is to outline procedures for reporting and investigating complaints of misuse of funds/property, and to define terms of funds and property; -To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -Misuse of funds/property is the misappropriation or conversion of a resident's funds or property for another person's benefit. This includes theft of money from a resident; -Upon learning of the report of abuse or neglect, the Administrator shall initiate an incident investigation. Once the administrator or designee determines that there is a reasonable possibility that mistreatment occurred, the Administrator or designee will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident. The investigation will include assessment of all residents involved and interventions to ensure protective oversight of all residents and involved residents in the facility/interventions; -A final report of the investigation will be sent to the state agency no later than 5 days following the initial complaint or incident; -Employees of the facility who have been accused of mistreatment will be immediately removed from contact with residents and must leave the facility pending the results of the investigation and review by the administrator. 1. Review of Resident #27's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 2/10/24, showed the resident had moderate cognitive impairment. During an interview on 2/21/24 at 4:35 P.M., the resident said the following: -A few weeks ago, in the middle of the night, Certified Nurse Assistant (CNA) D was in his/her room emptying the trash; the resident was using his/her bathroom; -When he/she came out of the bathroom, the pockets on his/her purse were open, the resident checked his/her purse, and twenty dollars was missing; -He/She immediately reported what happened to Licensed Practical Nurse (LPN) C and that he/she thought CNA D had taken the money. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/24 at 7:15 P.M., LPN C said the following: -The resident reported missing money to him/her a couple weeks ago; -The resident did not mention who he/she thought had taken the money; -LPN C spoke to Registered Nurse (RN) B the next morning. RN B said administration was aware of the resident's missing money; -LPN C was not aware of the investigation process involving misappropriation or what to do if a resident reported missing or stolen money. During an interview on 2/28/24 at 3:25 P.M., RN B said the following: -Approximately two to three weeks ago the resident reported that while he/she was in his/her bathroom, CNA D was talking to him/her from outside of the resident's bathroom; -When the resident came out of the bathroom his/her purse was open and the resident thought CNA D had taken money out of his/her purse; -RN B did not recall the amount of money the resident said was missing; -RN B texted the administrator and the Director of Nursing (DON) about the accusation and assumed they would would take over and investigate; -RN B told LPN C to not allow CNA D to go on the resident's hall for a while because of the accusation made against CNA D. During an interview on 2/28/24, the administrator said the following: -On 2/25/24, the resident reported that he/she had twenty or twenty-two dollars missing. The resident said he/she came out of the bathroom and his/her purse was open and money was missing; -He/She did not complete an investigation because the resident's story was inconsistent; -If the resident accused a staff member of taking his/her money, the employee should have been immediately suspended pending the facility's investigation; -Looking back, he/she should have probably completed an investigation when the resident reported missing money on 2/25/24. MO232032

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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** 35615 Based on interview and record review, the facility failed to ensure one resident (Resident #1) in a review of 26 residents was provided care and treatment in accordance with professional standards of practice to meet the resident's highest practicable physical, mental and psychosocial well-being, when staff failed to assess the resident following a fall, failed to assess the resident's pain and change in condition, and failed to provide pain management for six days following the fall that resulted in four pelvic fractures (broken bones at four different sections of the pelvis), and a compression fracture (weakened and crumpled back bone in the thoracic spine, the portion of the back bone just above the buttocks). The resident became unable to get out of bed, incontinent of urine and had suicidal ideations due to the pain. The resident was hospitalized and required surgical intervention to stabilize the fractures. The facility census was 167. The administrator was notified on 2/21/24 at 5:09 P.M., of the Immediate Jeopardy (IJ) which began on 2/11/24. The IJ was removed on 2/23/24, as confirmed by the surveyor onsite verification. Review of the facility policy, Post Fall Protocol, dated 6/30/23, showed the following: -The purpose of the policy was to ensure all residents who had a fall had accurate assessment and follow through to prevent further injury and recurrence of falls; -The nurse on duty would perform full head to toe assessment of the resident immediately when informed of the fall; -Immediate vital signs were to be taken and a neurological assessment (assessment of change in level of consciousness and for changes in neurological status) if the fall was unobserved, if the resident hit any part of the head, or if cognitively impaired; -Stabilize and give first aide of any injuries. Call 911 if needed; -Notify the physician of the incident and any injuries immediately; -Document in the resident's record the incident details of time, location, equipment involved if any, and the resident's activity at the time of the incident. Document the actions taken, the resident's condition at the time of the incident, details of the incident; -Implement any orders received from the physician; -Document follow up within 24 hours including vital signs, neurological checks, any complaints of pain or discomfort, an identified injury with specific appearance, functional status such as gait pattern (walking ability) compared to prior to the incident. Review of the facility policy, Notifying Clinicians, dated 8/23/22, showed the following: -The purpose was to outline indications of when to notify the physician; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The physician was to be called on medical emergencies like falls, incidents and injuries and change in condition; -The nurse would implement 911 for immediate transfer for physician evaluation when there was an accident involving the resident which resulted in an injury and had the potential for requiring physician interventions. A significant change or deterioration in resident physical, mental or psychosocial status; -The nurse would initiate verbal communication with the physician, nurse practitioner when a condition or incident arose with the resident that would warrant an immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that caused worsening in condition. Review of the facility policy, Pain Management, dated 7/5/22, showed the following: -The purpose was to ensure all residents who were receiving routine scheduled pain medication or as needed pain medication on a frequent basis had their pain evaluated and assessed prior to pain medication administration within one hour after the medication was given to determine if the current pain medication regimen was effective to adequately manage the resident's acceptable pain level; -The nurse administering pain mediation must assess the resident, determine the location and intensity of the pain. Pain should be rated on a 0 - 10 scale. Zero being no pain and 10 being the worst pain imaginable. Mild pain was 1-5. Moderate pain was 6-8. Severe pain was 9-10; -If the resident 's pain was evaluated to be greater than 5, the licensed nurse would ensure the administration of the pain mediation and complete the follow through and re-evaluation of the resident's pain. 1. Review of Resident #1's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 11/20/23, showed the following: -Cognitively intact; -No hallucinations or delusions; -No physical or verbal behavioral symptoms directed at others; -No functional limitation in the upper and lower extremities range of motion; -Independent in Activities of Daily Living (ADLs) including showers, dressing, toileting and personal hygiene; -Independent in mobility, transfers and ambulation without an assistive device or wheelchair; -Frequently had pain at level 3 on a 0 - 10 pain scale (zero being no pain and ten as the worst pain you can imagine); -Received scheduled pain medication in the previous five days and no as needed pain medication. (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 Physician's Order Sheet (POS) dated 1/1/24 showed the following: -Diagnoses of severe morbid obesity, obsessive-compulsive disorder (characterized by unreasonable thoughts and fears that lead to repetitive behaviors), bipolar disorder (excessive mood swings ranging from depressive lows to manic highs), major depressive disorder, anxiety disorder, and pain; -Tylenol (non-narcotic pain medication) Extra Strength 500 milligrams (mg) give two tablets by mouth every eight hours for dental pain; -Naproxen (non-steroidal anti-inflammatory medication used for pain) 440 mg every six hours as needed for pain. Review of the resident's nurses' note, dated 1/26/24 at 10:09 A.M., showed Registered Nurse (RN) A documented a code blue was called (medical emergency alert paged over the loud speaker to alert staff assistance was needed immediately for an event such as an injury, fall, loss of consciousness, etc.) the resident slipped on the stairs. The resident said he/she was going too fast and missed one of the stairs, fell back on his/her bottom then went onto his/her knees. The resident said he/she was not hurting anywhere. RN A assessed the resident to have no injuries and no redness, bruising, or swelling. The resident was educated on making sure to hold onto the railing when using the stairs, to watch placement of his/her feet, and not go too fast. The resident's physician was notified. Review of the resident's care plan, updated with new interventions following a fall on 1/26/24, showed the following: -Risk for falls. Resident slipped on the stairs, fell back on his/her bottom and then down onto his/her knees. Staff educated the resident to use the handrailing when walking the stairs, watch feet placement and not go too fast. Staff should maintain a safe environment, free of potential fall hazards, ensure call light was available, ensure proper footwear and evaluate the environment to identify factors known to increase the risk of falls. If a fall occurred, staff should notify the physician, initiate fall risk precautions, and inform the caregivers of the increased fall risk; -Independent in ADLs, required reminders and supervision for safety. Staff should provide protective oversight and assist where needed; -Chronic pain aggravated by physical activity relieved by rest and medication. Staff should administer analgesia (pain medication) as physician ordered, anticipate the resident's need for pain relief and respond immediately to complaints of pain, evaluate the effectiveness of pain interventions, alleviation of symptoms, resident satisfaction with results and impact on functional ability and cognition. Identify, record and treat the resident's existing conditions which may increase pain and or discomfort. Monitor/document for probable cause of each pain episode and remove/limit causes where possible. Review of the resident's care plan showed no documentation the hall monitors would assess the resident for pain. (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 nurses note, dated 2/10/24 at 2:08 P.M., showed RN A documented the resident had been complaining of hip pain that prevented the resident from walking around. RN A called the physician and placed the resident on the physician's rounding list (list of residents scheduled for physician assessment). Review of the resident's record showed no documentation RN A assessed the resident's complaints of hip pain preventing the resident from walking around on 2/10/24. Review of the resident's Medication Administration Record (MAR) for February 2024 showed staff documented the following: -On 2/11/24 at 6:16 A.M., naproxen 440 mg administered for pain. The medication was effective; -On 2/14/24 at 6:05 A.M., naproxen 440 mg administered for pain. The medication was effective. Review of the resident's record showed no documentation staff assessed the resident's pain level prior to administration of naproxen 440 mg on 2/11/24 or 2/14/24. Review of the resident's nurses' note, dated 2/14/24 at 1:47 P.M., showed the Director of Nursing (DON) documented he/she was called to the resident's room due to the resident's complaints of pain. The resident reported he/she fell in the shower room a few days ago. The floor was wet and slick and the resident slipped. The resident denied striking his/her head. The resident said he/she was having trouble walking due to right hip pain, groin pain, buttock pain and could not walk because he/she was sore. Noted the resident walking at a slow pace, gait unsteady. Denied feeling dizzy or lightheaded. Rated his/her pain at 10/10. Skin assessment showed no redness or bruising. The DON called the physician and obtained new orders for hip and back x-rays. Review of the resident's record showed no documentation of the resident's fall in the shower on 2/9/24 and no documentation staff assessed the resident following the fall, or notified the physician until 2/14/24. Review of the resident's POS dated 2/14/24 showed a physician order for x-ray of low back/sacrum (low back, tailbone area) and right hip due to unwitnessed fall and complaints of pain. Review of the resident's nurses' note dated 2/15/24 at 4:19 P.M., showed Transporter/Administrative Assistant documented he/she took the resident to the dentist on 2/14/24 for a dental exam. When they arrived, the resident had to get in a wheelchair because the resident said his/her hip hurt and he/she could not walk. The Transporter/Administrative Assistant asked the resident if he/she reported this to anyone and the resident said to the staff and it happened two weeks ago. When it was the resident's turn to go back and see the dentist, the resident refused because he/she would not get up out of the wheelchair. The Transporter/Administrative Assistant told the resident if he/she wanted to get the dental work done, he/she had to get out of the wheelchair and get in the dentist chair. The resident finally got up, but he/she refused the dental cleaning and checkup and was cussing and yelling. The Transporter/Administrative Assistant came back to the facility and tried to call the resident's guardian, left a message for the guardian to call back for further dental care consent. Review of the resident's Nurse Practitioner's note dated 2/15/24 and signed on 2/17/24 at 4:14 P.M., showed the Nurse Practitioner documented 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	-Chief complaint on 2/14/24 was the resident's pain level was 10/10. The resident reported he/she fell in the shower a few days ago and was having pain in the groin area, lower back and right hip. The resident was very shaky and had trouble standing and walking which was not like him/her. No bruising or discoloration, but this just was not normal for the resident. Staff requested x-ray of right hip and lower back, orders given for x-rays; -The resident had not had x-rays yet. The resident complained of trouble getting out of bed due to tailbone pain. The resident said he/she took Tylenol and naproxen without relief; -Diagnoses of hip and back pain. Review of the resident's nurses' note dated 2/15/24 at 7:01 P.M. showed RN A documented the resident complained of intense pain in the right hip and back. The resident said he/she could not move his/her leg without it shaking, could not get out of bed and had been urinating on himself/herself. The pain was making him/her have suicidal ideations and the resident was crying. Vital signs checked with blood pressure 124/88 (normal of 120/80) pulse 109 (normal 60-80 beats per minute) and pain level of 9/10. The physician was notified and order received to send the resident to the hospital emergency room by ambulance. The resident was sent to the emergency room . Review of the resident's nurses' note dated 2/16/24 at 12:00 P.M., showed the DON documented the resident's guardian was called and provided an overview of the resident's complaints voiced on 2/14/24 and physician orders received. Discussed the resident's inability to appropriately position for x-rays and physician orders to send to the emergency room for further treatment. Review of the resident's regional hospital records dated 2/16/24 showed the following: -Adult who fell in the shower several days ago (6-7) with pelvic pain and right leg pain; -Plan hospital admission, orthopedic surgery consultation and probable surgical fixation (surgical repair); -Acute traumatic bilateral sacral fractures (broken bones in the pelvis on both sides of the body near the tailbone caused by a single traumatic event such as a fall); -Acute traumatic L5 transverse process fractures (broken lower back bone at the attachment to the pelvis indicating unstable pelvic injury); -Right parasymphyseal fracture (broken bone in the lowest part of the pelvis); -T11 compression fracture (weakened and crumpled back bone in the thoracic spine, the portion of the back bone just above the buttocks); -Fixation (surgical repair with screws) of the bilateral sacral fractures. During an interview on 2/21/24 at 9:50 A.M., Resident #24 said the following: -He/She was Resident #1's roommate at the time of the resident's fall and complaints of pain; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 fell in the shower about two weeks ago. Resident #1 told people he/she fell including staff and other residents. The resident was in pain and urinated in the bed because he/she could not get out of bed; -Several days went by following the fall and Resident #1 got worse and worse. The resident could not walk and cried with the pain. It got to where Resident #1 could not move in the bed, was incontinent, and could not get to the bathroom; -Resident # 24 told staff the resident needed help. Staff would not help the resident to the bathroom. For three or four days no staff checked on the resident until 2/14/24 following a dentist appointment when Resident #1 returned crying and in pain, unable to walk; -Finally the next day, RN A got the physician and they sent Resident #1 out of the facility by ambulance. During an interview on 2/21/24 at 10:00 A.M., Nursing Assistant (NA) H said the following: -The resident fell on Friday 2/9/24 while in the shower. The following Monday (2/12/14) and Tuesday (2/13/24) after the fall the resident was in pain; -NA H worked overnight on 2/12/24 (7:00 P.M. to 7:00 A.M.). He/She knew the resident was in pain and brought the resident's food to the room so the resident did not have to go downstairs to eat. NA H asked Certified Medication Technician (CMT) G for the resident's pain medication which was never administered that night. The resident was tired, exhausted and crying. At one point the resident limped out to the hall area to ask for help. NA H got the resident some food and took the resident's trash out. The resident was worried he/she would be in trouble for not being able to take his/her own trash out. Review of the resident's MAR showed no documentation staff administered naproxen 440 mg on 2/12/24 between 7:00 P.M. and 7:00 A.M. During an interview on 2/21/24 at 11:10 A.M. CMT G said the following: -On Saturday (2/10/24) and Sunday (2/11/24) the resident stayed in bed all day and did not move about in the facility at all. The resident complained of hip pain for at least two days and at times walked slowly in the hall. He/She did not want to go downstairs to the dining room for meals and did not want to get out of bed due to the pain; -On 2/14/24 the Transporter/Administrative Assistant took the resident to the dentist and called CMT G after returning to the facility following the dental appointment. The Transporter/Administrative Assistant was upset with the resident and said the resident would not get out of the transport van. The resident said he/she needed a wheelchair -On 2/14/24 following the dental appointment CMT G administered the resident's scheduled medications to him/her in bed. The resident was unable to get out of bed, turn over or reposition in bed. Normally the resident came to the medication cart for all medication administrations (Review of the MAR dated 2/14/24 showed scheduled Tylenol 500 mg two tablets administered for a pain level of 0) (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 had scheduled Tylenol for an ongoing toothache three times daily and naproxen as needed. No other pain medication was obtained for the resident following the fall and complaints of pain; -CMT G learned later the resident fell six or seven days before he/she was sent to the hospital; -Staff should have assessed the resident, obtained treatment for the resident when he/she first complained of pain. Staff should have determined the cause of the pain and gotten the resident help, not assumed the resident was having behaviors. During an interview on 2/21/24 at 11:15 A.M., Quality Life Assistant (QLA) E said the following: -He/She worked Resident #1's unit; -The resident fell in the shower and complained of hip pain. He/She was not sure when the resident fell but thought it was on a Friday; -The resident was visibly in pain all day on 2/15/24 (the day Resident #1 was sent to the emergency room by ambulance), could not walk and said his/her pain level was 9.5/10 scale. The resident could not get out of bed and could not stand on his/her own; -QLA E saw the resident a day or two prior to being sent to the hospital. QLA E walked with the resident from the third floor to the second floor. The resident walked slowly and required assistance. It was painful for the resident to walk so they used the elevator. Normally the resident walked up and down three flights of stairs to go the Hang Out (resident common area) and outside to smoke multiple times per day. During an interview on 2/21/24 at 12:20 P.M., the Transporter/Administrative Assistant said the following: -On 2/1/24 he/she transported the resident to a cardiology appointment in the facility van. The resident used a wheelchair, walked slowly and complained of back, hip and groin pain while walking. Transporter/Administrative Assistant told the DON after returning from the cardiologist the resident had hip pain and could not walk right. He/She had a slow shuffling gait and held onto the handrails while walking, he/she kept his/her head down and was pale. This was a change in the resident's mobility and condition; -On 2/14/24 he/she transported the resident in the facility van to the dentist. The resident walked very slowly from his/her room on the third floor, to the elevator, down the hallways and out the front doors to the van. The resident had difficulty getting in the van. At the dental office a wheelchair was obtained, and the resident sat in the wheelchair the entire visit. He/She refused to get in the dental chair. The dental appointment got ugly. The resident hollered, cussed and complained of pain. The resident acted up because he/she was in so much pain in the hips and back; - He/She told the DON and CMT G about the resident's pain at the dental appointment and the resident's hollering and cussing behaviors. The DON obtained physician's orders for x-rays. The mobile x-ray was not obtained because the resident could not get in the correct position for the x-rays; (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 had decreased mobility, hip and back pain on 2/1/24. The pain became worse with complaints of groin pain and declining mobility. Staff dropped the ball and no one did anything to find out what was wrong with the resident. During an interview on 2/21/24 at 3:00 P.M., Hall Monitor F said the following: -He/She usually worked the day shift (7:00 A.M. to 7:00 P.M.) on the resident's unit; -He/She learned on 2/11/24 the resident fell in the shower a couple of days prior. Hall Monitor F never told any other staff members the resident fell . He/She thought the other staff already knew the resident had fallen; -On 2/11/24 the resident stayed in bed all day and said his/her leg hurt; -On 2/14/24 the Transporter/Administrative Assistant took the resident to the dentist. The resident came back to the unit in a wheelchair, was upset and crying. Everyone knew the resident was in pain. The DON assessed the resident and an x-ray was attempted. The resident could not roll over to get on the x-ray film board because of the pain. The resident was incontinent of urine and had soaked the bed with urine. He/She tried to get the resident out of bed with another staff member. The resident tried to stand and his/her legs shook and was unable to walk to the bathroom. Staff encouraged the resident to get up and walk, try to move so he/she would not get worse; -The resident complained of hip and leg pain for two weeks. During an interview on 2/21/24 at 7:50 P.M., Licensed Practical Nurse (LPN) C said the following: -He/She was the night shift supervisor; -On 2/14/24 during report at the change of shift LPN C was told the resident was assessed for complaints of hip and groin pain and an x-ray would be obtained the following day. Night time mobile x-ray would not be done. LPN C was not aware the resident had increased pain, decreased mobility and required a wheelchair for mobility; -The resident asked for pain medication and LPN C administered the resident's scheduled Tylenol. He/She did not give the resident any naproxen or assess the resident's pain. He/She did not know the resident was not able to get out of bed and was urinating in the bed. During an interview on 2/21/24 at 1:45 P.M., the resident said the following: -He/She fell on [DATE] while in the shower about 7:00 A.M. The shower floor was wet and slick, he/she slid and hit his/her buttocks and back on the floor. The resident got himself/herself off the floor and told the day shift staff about the fall in the shower. No staff checked the resident over after the fall and no nurse assessed the resident; -Following the fall he/she had increased hip and back pain, groin pain and walking got harder. Staff made him/her walk in the halls to the medication cart to obtain medications. Staff gave him/her Tylenol for the pain; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 2/14/24 the Transporter/Administrative Assistant took him/her to the dentist. The Transporter/Administrative Assistant made the resident walk to the van and told the resident he/she was fine. The resident used a wheelchair at the dentist and refused to get out of the wheelchair into the dental chair because he/she hurt so bad. The resident got into trouble at the dentist office because he/she hollered and cussed. Transferring in and out of the van was hard and very painful. After getting back to his/her room, the resident demanded an x-ray. The mobile x-ray staff came and could not get the x-ray. The pain was awful in the right groin from front to back. After that he/she stayed in bed, urinated in the bed and staff brought him/her medications and food. The following night RN A called the ambulance and he/she went to the hospital. During interview on 2/21/24 at 10:30 A.M. RN A said the following: -On 2/14/24 the resident complained of hip and leg pain, the DON assessed the resident and obtained physician orders for x-rays. The mobile x-ray company attempted to get the x-rays late in the day on 2/14/24 and was not successful. The resident could not tolerate moving or rolling over due to the pain. The mobile x-ray staff said the resident had to go to the hospital for x-rays. The resident was not sent to the hospital on 2/14/24, there was no one to transport the resident. An ambulance was not called at that time. At the 7:00 P. M. change of shift RN A passed the information on to the next shift, the resident needed to go to the hospital for x-rays; -On 2/15/24 at 7:00 A.M. RN A returned to work. The resident remained in bed in pain with no x-ray completed. The resident remained in bed all day with no pain medication other than scheduled Tylenol. (Review of the resident's MAR showed no documentation staff administered naproxen 440 mg or any other pain medication except for the scheduled Tylenol three times daily). Staff were unable to give the resident the assistance he/she needed. The resident cried, was incontinent in bed because he/she was in so much pain and the resident said he/she felt suicidal. Every time the resident moved, his/her legs shook. The resident was unable to move alone without assistance. Staff could not lift the resident. -On 2/15/24 towards the end of the day shift, RN A assessed the resident, called the physician and the ambulance for transport to the hospital; -The resident fell on e to two weeks prior to transfer to the hospital. RN A was not sure the exact date the resident fell in the shower. This delay in assessment and treatment should not have happened. Staff should have sent the resident out immediately after knowing the resident fell and had pain. It was a horrible situation. Staff did not assess the resident and seek immediate treatment. The resident was in terrible pain, unable to move or walk and became incontinent with suicidal thoughts as a result of the pain. During interview on 2/21/24 at 4:00 P.M., the DON said the following: -Staff should contact the nurse or supervisor regarding a change in a resident's condition. The nurse should assess the resident, obtain vital signs, contact the physician and guardian and obtain new treatment orders and treatment plan. Staff should obtain laboratory tests and x-rays as ordered without delay; (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 fell in the shower with decline in mobility and increased pain. Staff should have assessed the resident and sent the resident out immediately once aware of the resident's decline and change in condition. The resident's pain was not controlled for five or six days following the fall. During interview on 2/21/24 at 4:15 P.M., the Administrator said he/she expected staff to assess a resident following a change in condition or fall immediately and obtain treatment and emergent care if needed immediately and not delay any treatment. Staff should provide pain management and provide care appropriately for the resident's needs and condition. During an interview on 3/11/24 at 2:30 P.M., the Nurse Practitioner said the following: -She was unaware the resident fell on [DATE], complained of groin pain on 2/1/24 and required a wheelchair during transport to the cardiologist. She was not aware the resident fell on [DATE] in the shower; -On 2/10/24 the resident was added to the NP rounding list for the week as requested by the DON. The NP was not aware the resident complained of hip pain preventing him/her from walking; -She was not aware staff took the resident to the dentist on 2/14/24, walking with pain to the transportation van and the need for a wheelchair due to the pain; -She was unaware of the resident's pain, change in mobility until 2/14/24 when the DON called the NP. The NP ordered x-rays of the resident's pelvis and hip. The NP was not aware the x-rays were not obtained on 2/14/24. Staff should have notified her of the resident's pain and inability to position correctly for the x-ray. The NP would have sent the resident to the hospital on 2/14/24; -The NP was unaware of the resident's complaints of pain and continual decline in mobility. Staff should have obtained treatment immediately following the fall on 1/26/24. The resident progressively declined with an additional fall on 2/9/24. The resident's pain was caused by the falls and resulting fractures; -Communication was important, she expected staff to assess the resident and notify her of any change in condition. It was not acceptable to leave a resident untreated and in pain for six or more days following a fall with injuries. 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). MO 00231948 MO 00231984

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35615 Based on interview and record review, the facility failed to ensure nursing staff had the appropriate competencies and skills sets to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being for one resident (Resident #1), in a review of 26 residents, who resided on a behavioral health unit. Staff assigned to the resident's unit were not certified and trained to provide the physical care of the resident who was in pain, needed assistance with mobility and personal care, including incontinence care. The facility census was 167. Review of the facility undated Hall Monitor Orientation list showed the following: -The purpose of the Hall Monitor was to know the location of every resident at all times, to ensure the safety of all residents by providing protective oversight; -Hall Monitor duties included complete face checks, provide privacy, dignity and respect, answer call lights and assist the resident with their needs. If the resident required hands-on care, the hall monitor was to notify the certified nurse aide (CNA) or the Charge Nurse to assist with the resident's needs. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/20/23, showed the following: -Cognitively intact; -Independent in Activities of Daily Living (ADLs) including showers, dressing, toileting and personal hygiene; -Independent in mobility, transfers and ambulation without an assistive device or wheelchair; -Always continent of bowel and bladder. Review of the resident's care plan updated 1/26/24 showed the following: -Diagnoses of severe morbid obesity, obsessive-compulsive disorder (characterized by unreasonable thoughts and fears that lead to repetitive behaviors), bipolar disorder (excessive mood swings ranging from depressive lows to manic highs), major depressive disorder, anxiety disorder, and pain; -Independent in ADLs, required reminders and supervision for safety. Staff should provide protective oversight and assist where needed. Review of the resident's nurses' note dated 2/15/24 at 7:01 P.M. showed Registered Nurse (RN) A documented the resident complained of intense pain in the right hip and back. The resident said he/she could not move his/her leg without it shaking, could not get out of bed and had been urinating on himself/herself. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/21/24 at 9:50 A.M., Resident #24 said the following: -He/She was Resident #1's roommate; -Resident #1 fell in the shower about two weeks ago. The resident was in pain, and urinated in the bed because he/she could not get out of bed; -Several days went by following the fall and Resident #1 got worse and worse. He/She could not walk and cried with the pain. It got to where Resident #1 could not move in the bed, urinated in the bed and could not get to the bathroom; -Resident #24 told staff the resident needed help. Staff would not help the resident to the bathroom. Hall Monitor F would not touch the resident or help clean Resident #1 up after incontinence. Resident #1 laid in urine for two days. The day Resident #1 went to the hospital, Resident #24 and another resident on the same unit cleaned Resident #1 up, washed the resident's skin the best they could and changed the resident's urine soaked clothing. The bed was soaked with urine. Someone had to help the resident. During an interview on 2/21/24 at 3:00 P.M. Hall Monitor F said the following: -He/She usually worked the day shift (7:00 A.M. to 7:00 P.M.) on the resident's unit. He/She was a Hall Monitor and was not allowed to give any physical care; -On 2/14/24, the resident was upset and crying. The resident was incontinent of urine and had soaked the bed with urine. He/She tried to get the resident out of bed with another staff member. The resident tried to stand and his/her legs shook and he/she was unable to walk to the bathroom; -He/She offered the resident a sink bath but the resident could not get out of bed and walk to the sink. During an interview on 2/21/24 at 1:45 P.M., the resident said the following: -He/She fell on [DATE] while in the shower. Following the fall he/she had increased hip and back pain, groin pain and walking got harder. The pain was awful in the right groin from front to back; -On 2/14/24 he/she went to a dentist appointment, returned in a wheelchair and after that he/she stayed in bed, urinated in the bed and staff brought him/her medications and food; -On 2/15/24 his/her roommate, Resident #24, and another resident. washed Resident #1 and put clean clothes on him/her before he/she went to the hospital. The staff would not touch the resident and the hall monitor did not know what to do. Staff working did not call any other staff to help. During an interview on 2/21/24 at 10:30 A.M., Registered Nurse (RN) A said the following: -The Resident #1's unit, was staffed with uncertified hall monitors. The residents on the that floor were independent and could provide their own cares. Certified staff were available on other floors if help was needed with resident care needs; (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	-On 2/14/24 the resident complained of hip and leg pain, the Director of Nursing (DON) assessed the resident and obtained physician orders for x-rays; -On 2/15/24 at 7:00 A.M. RN A returned to work. The resident remained in bed in pain. The resident remained in bed all day. Staff were unable to give the resident the assistance he/she needed. The resident's unit was staffed with uncertified staff. The resident cried, was incontinent in bed because he/she was in so much pain. Every time the resident moved, his/her legs shook, he/she was unable to move alone without assistance. Staff working on the resident's unit could not lift the resident, they were not trained to provide physical care. Hall Monitor F was not trained to provide incontinence care. The resident's roommate and another resident cleaned Resident #1 and changed his/her clothes before the ambulance arrived for transport. Resident #1 was soiled with urine. RN A did not help with incontinence care, he/she went to call the ambulance while Resident #1's roommate and another resident provided incontinence care and changed the resident's clothing. No other certified staff from other units were called to assist the resident with personal care. During an interview on 2/21/24 at 4:00 P.M. and on 2/29/24 at 1:50 P.M., the DON said the following: -Staff should be available to provide residents the care needed. It was inappropriate for another resident to provide Resident #1's incontinence care. Staff should have called certified staff from other floors or units to assist with the resident's care needs. The third floor was staffed with hall monitor's who were not certified to provide personal care. The residents on Resident #1's unit were independent with cares; -The facility needed to ensure the residents' needs were met, staff should be trained to provide care appropriately with appropriate response to situations. During interview on 2/21/24 at 4:15 P.M., the Administrator said the facility needed to reorganize the new employee orientation process and ensure appropriately trained staff was available to provide resident care. Certified staff should be available at all times to meet the resident's needs. The charge nurse or hall monitor should call for assistance from other floors if needed to provide care. It was inappropriate for other residents to provide a resident's incontinence care.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 35615 Based on interview and record review, the facility failed to provide staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain the highest practicable physical, mental and psychosocial well-being for two residents (Resident #5 and #23), who resided on a locked behavioral health unit, in a review of 27 residents. On his/her first day of employment, Hall Monitor I was assigned to the residents' behavioral unit without orientation and training related to residents' behavioral health needs or appropriate response to identifying and deescalating behaviors. Hall Monitor I was left alone to supervise the unit. A physical altercation occurred and Hall Monitor I was not prepared through training and staff support to intervene or deescalate the residents who presented with behaviors. Resident #23 pushed Resident #5 into a wall, the resident fell to the floor and hit his/her head. This behavioral emergency resulted in staff taking Resident #23 down during a Code [NAME] (behavioral emergency) and administered an antipsychotic injection. The facility census was 167. Review of the facility Behavioral Emergency Policy dated 1/5/23 showed the following: -The purpose was to provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis and to ensure the resident was not being coerced, punished or disciplined for staff convenience; -If the resident exhibited extreme behaviors such as resident to resident altercations the licensed nursing staff/team leader/nursing administration should assess the resident who exhibited such behaviors, ensuring the safety of the resident and others was the first priority. A one-to-one monitoring of the resident would be initiated immediately; -Behavioral Emergency Guidelines included the Behavioral Emergency = Code Green; -The licensed nurse/Administrator/Director of Nursing (DON) or Code Team Lead must oversee the use of approved Crisis Alleviations Lessons and Methods (CALM) (self-protection techniques) hold techniques and release of any resident who posed imminent danger to self or others; -There were only two reasons that staff would utilize approved CALM hold techniques. They were when a resident was in imminent danger of harming themselves or harming others; -A Code [NAME] could be called to be proactive in ensuring enough qualified staff were present and to warrant the potential need of utilizing approved CALM hold techniques; -Approved CALM hold techniques were never utilized for punitive reasons, discipline or for staff convenience. Residents were never threatened by the use of CALM as a scare tactic or a threat by staff; -The nurse (unless the Administrator, DON or Assistant DON were present) was ultimately in charge of the Code [NAME] and all staff responding would follow the direction from the Team Leader. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the facility undated Hall Monitor Orientation Job Duties showed the following: -The purpose of the hall monitor was to know the location of every resident at all times and ensure the safety of all residents by providing protective oversight; -Update the nurse on any changes in behavior of the residents. Also report if a resident was unable to be located or if a resident was noted to have any type of distress. 1. Review of Resident #23's care plan dated 2/21/24 showed the following: -Diagnoses of bipolar disorder (mental illness of extreme mood swings of deep depression to manic highs), borderline personality disorder (a mental illness characterized by unstable moods, behaviors and relationships), and impulse disorder (behavioral condition that made it difficult to control actions or reactions); -Manifestations of behaviors related to mental illness that may create disturbances that affect others. These behaviors included throwing chairs and eloping. Staff should administer and monitor medications as ordered, administer as needed mediations as needed, give positive feedback for good behavior. If the resident disturbed others, encourage the resident to go to a more private area to voice concerns/feelings. Review of the resident's nurses' note dated 2/24/24 at 6:37 P.M., showed the Director of Nursing (DON) documented the resident was upset with a peer (Resident #5). The peer tried calming Resident #23 down. Resident #23 did not want the peer to be around him/her and pushed the peer away causing the peer to fall. Resident #23 remained agitated with the inability to re-direct. As a last resort, approved CALM technique was utilized due to exhibiting increased aggression. The physician was notified with new orders for Zyprexa (antipsychotic medication), 10 mg injection. Resident #23 placed on one-on-one for protective oversight. During an interview on 2/29/24 at 3:15 P.M., the resident said the following: -On 2/24/24 he/she asked Nursing Assistant (NA) H for a PRN (as needed), medication earlier in the day because he/she felt angry for no specific reason. He/She did not receive the requested PRN medication that day. Later (unknown time) he/she heard Resident #24 talking on the telephone about him/her and got mad. Resident #5 tried to grab Resident #23's arm. Resident #23 yanked his/her arm back, turned and shoved Resident #5 down. Resident #5 went to the wall and hit his/her head on the floor. Resident #23 ran to the end of the hall exit door and tried to get the door open; -Hall Monitor I was in charge of the hall because NA H went to the hospital with another resident at the time of the incident. Hall Monitor I did not do anything until Resident #5 hit the floor. Then, Hall Monitor I called a Code Green; -A lot of staff came to the hall after the Code [NAME] was called. Staff members held Resident #23 on the floor face down for about 30 to 40 minutes until they gave him/her a shot. Review of Resident #5's care plan updated 6/21/22 showed the following: (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	-Diagnoses of traumatic brain injury (sudden injury to the brain causing brain damage and change in behavior or physical ability), bipolar disorder, and schizophrenia (mental illness with hallucination and delusions); -Verbal and physical aggressive behaviors related to mental illness that could create disturbances that affected others. Staff should administer and monitor medications as ordered, administer as needed medication as needed when non-pharmacological interventions were not effective, and give positive feedback for good behavior. If the resident was disturbing others, encourage the resident to go to a more private area to voice concerns/feelings; -Physical aggression towards peers related to peer making comments. Staff should provide physical and verbal cues to alleviate anxiety. Triggers for physical aggression when the resident felt someone was getting smart. The aggressive behavior was de-escalated by staff intervention and separation. When the resident became agitated staff should intervene before agitation escalated, guide the resident away from the source of distress, engage calmly in conversation and if response was aggressive, walk calmly away and approach the resident later; -Impaired cognitive function and impaired thought processes related to head injury. Staff should communicate with the resident and caregivers the resident's capabilities and needs, cue, reorient and supervise as needed, avoid overly demanding tasks, keep the routine consistent and try to provide consistent care givers to decrease confusion. Present just one thought, idea, question or command at a time. Review of the resident's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 12/1/23 showed the following: -Severely impaired cognition; -No hallucinations or delusions; -No physical or verbal behavioral symptoms directed at others; -Independent with ADLs. 2. During an interview on 2/29/24 at 11:45 A.M. Resident #24 said the following: -On 2/24/24 about 6:00 P.M. Resident #24 was on the telephone and Resident #23 heard the conversation. Resident #24 was talking about Resident #23. Resident #23 went to Hall Monitor I and said Resident #24 was making him/her uncomfortable. Hall Monitor I, Resident #23 and Resident #24 discussed the problem and Resident #23 said no, you are always on my ass and then called Resident #24 a bitch. At that time Resident #5 grabbed Resident #23 by the hand, Resident #23 jerked his/her hand away, pushed Resident #5, who hit his/her head and fell to the floor. Resident #23 went to the end of the hall exit door and kicked the door trying to get it open; -NA H had to leave the unit earlier and left Hall Monitor I on the unit alone. Hall Monitor I was sitting at the table while this was going on until Resident #5 fell . Then Hall Monitor I called a Code [NAME] and multiple staff came to the unit. (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	02/29/2024

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 0741 Level of Harm - Actual harm Residents Affected - Few	3. Review of the facility Registered Nurse Investigation (RNI) report dated 2/24/24 showed the Director of Nursing (DON) documented on 2/24/24 at 6:40 P.M. Resident #23 was upset with his/her roommate (Resident #24). Resident #5 attempted to calm Resident #23 down. Resident #23 wanted to get away from Resident #5 and pushed Resident #5 away. Resident #5 fell back into the wall and slid down to the floor. Resident #23 remained agitated with the inability to redirect with staff intervention. As a last resort, 5-man CALM technique was utilized. The physician was contacted with new orders received for Zyprexa (an antipsychotic medication used to treat mental illness) 10 milligrams (mg) injection. The guardian was contacted and made aware of the situation. It was recommended the injection be given versus the medication by mouth due to injections being more effective. The PRN (as needed) medication was administered by injection. Staff placed Resident on one-on-one observation (one staff member continuous monitoring of one resident) for protective oversight (safety). 4. During interview on 2/29/24 at 9:39 A.M. NA H said the following: -On 2/24/24 he/she worked the third-floor unit (Resident #23 and Resident #5's unit). Hall Monitor I was on the same hall, one-on-one with Resident #5 for most of the day; -At about 6:00 P.M. RN A sent NA H with another resident (Resident #19) to the hospital for treatment; -Hall Monitor I remained in charge on the unit without additional staff; -NA H was not aware Hall Monitor I was new to the facility. NA H would not have left Hall Monitor I in charge of the unit if he/she had known Hall Monitor I was new. RN A should have sent another staff member with Resident #19 so NA H could stay on the unit. During an interview on 2/29/24 at 11:30 A.M. Hall Monitor I said the following: -His/Her first day working at the facility was 2/24/24. He/She was assigned to be one-on-one with Resident #5 on the same unit as NA H. Hall Monitor I was not sure why Resident #5 was one-on-one, but he/she was not supposed to get more than an arm lengths away from Resident #5; -At about 6:00 P.M., NA H left the unit and went with another resident to the hospital. Hall Monitor I was left in charge of the unit with no other staff present on the unit; -At about 6:30 P.M., Hall Monitor I sat at a table at the entrance of the hallway. Resident #23 and Resident #24 got into an argument over Resident #24's telephone conversation. Resident #5 tried to defuse the situation and touched Resident #23's arm. Hall Monitor I was not sure why Resident #5 tried to intervene. Resident #23 said back up and pushed Resident #5 against the wall. Hall Monitor I heard Resident #5's head hit the wall and the resident slid to the floor. Resident #23 tried to escape at the end of the unit exit door, but the exit door would not open. Hall Monitor I called a Code [NAME] at that time and additional staff came to the unit. Two staff attended to Resident #23, took him/her down to the floor and gave the resident an injection. Staff attended to Resident #5 and checked for injuries from the fall; (continued on next page)

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	265469	A. Building B. Wing	02/29/2024

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 0741 Level of Harm - Actual harm Residents Affected - Few	-Hall Monitor I did not intervene when Resident #23 and Resident #24 were fighting over the telephone call. It was Hall Monitor I's first day and he/she did not know what to do. He/She had not received any training on behavior management. He/She learned later (after the altercation), Resident #23 and Resident #24 had an argument the previous night. During interview on 3/8/24 at 9:15 A.M. the Human Resources Manager said the following: -Hall Monitor I's date of hire was 2/23/24. He/She completed orientation that all staff received, which consisted of things such as how to page overheard. His/Her first day on the floor was 2/24/24 and he/she was assigned to work with other staff. He/She had not completed any skills training, hall monitor duties training, or CALM training; -Staff should not have put Hall Monitor I in charge of any unit or resident on 2/24/24. He/She had not had the appropriate training. The CALM class was four hours in length and scheduled with the certified instructor; -Hall Monitor training included a list of skills and techniques completed by the new employee with the supervisor in addition to the CALM class. During an interview on 2/29/24 at 2:40 P.M. Registered Nurse (RN) A said the following: -On 2/24/24 he/she was the house supervisor. Hall Monitor I was one-on-one with Resident #5 on the third floor unit. Hall Monitor I was being trained as a new employee. Resident #19 had an issue and had to be sent out to the hospital. RN A sent NA H with the resident to the hospital. This left Hall Monitor I in charge of the unit and was the only staff member present on the unit at the time of the altercation; -RN A was not aware Hall Monitor I started working 2/24/24 and had no behavioral management training. RN A should not have left Hall Monitor I on the unit alone monitoring the behavioral unit on his/her first day. Hall Monitor I did not intervene when the residents got into an altercation that escalated. If staff had intervened and called the Code Green, CALM hold and injection could possibly could have been avoided. During interview on 2/29/24 at 1:50 P.M. the DON said the following: -New staff received an all day intensive course on the CALM technique that included how to de-escalate situations and specific ways a resident might act to show signs of escalating and specific instructions on behavior management. New staff were oriented to safety and protective oversight of residents. Following the intensive orientation, new staff started working on the floors with other staff members; -Hall Monitor I did not receive training on the CALM technique that included how to de-escalate situations and specific ways a resident might act to show signs of escalating and specific instructions on behavior management; -Hall Monitor I should have had more training and should not have been left alone in charge of a floor on his/her first day without appropriate orientation. Hall Monitor I had not had the appropriate training; (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	-The facility needed a new orientation process with full orientation to mental illness and appropriate procedures to react to a situation and ensure resident safety and appropriate behavior management for all staff. During interview on 2/29/24 at 2:15 P.M. the Administrator said staff should intervene and avoid a resident altercation. Staff should react to a situation that was occurring and not wait for the situation to escalate to an altercation. Staff should not be responsible for a unit without the proper training to ensure protective oversight and prevent dangerous situations. Hall Monitors should be trained to ensure care was provided appropriately with appropriate response to the situation. Hall Monitor I should have intervened and called for help immediately.