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	03/27/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 Based on interview and record review, the facility failed to protect one resident (Resident #1), in a sample of 22 residents, who had diagnoses of schizoaffective disorder, bipolar disorder and psychosis and was under guardianship, from abuse when Hall Monitor A grabbed the resident around the neck/throat and took the resident to the floor by himself/herself during a Code [NAME] (response to a behavioral emergency). Hall Monitor A laid on top of the resident as the resident lay face down on the floor in the Hangout (a common area for resident activity and socialization). Witnesses reported the resident was crying and said he/she could not breathe as Hall Monitor A continued to lay on top of the resident. The resident said Hall Monitor A wrapped his/her arms around his/her throat and was choking him/her. He/She could not breathe or talk. Hall Monitor A threw him/her to the floor and he/she hit his/her chin. He/She could not speak, was scared and couldn't breathe. He/She thought he/she was going to die. Activity staff said he/she responded to the Code [NAME] and found Hall Monitor A laying on top of the resident. He/She had to tap Hall Monitor A and told him/her four or five times to get off the resident. As the hall monitor lay on top of the resident, the hall monitor aggressively told the resident, He/She messed up with the wrong one. The facility census was 162. The administrator was notified of the Immediate Jeopardy (IJ) on 3/20/24 at 4:32 P.M. which began on 3/19/24. The IJ was removed on 3/20/24 as confirmed by surveyor onsite verification. Review of the facility's policy, Abuse and Neglect, revised 1/5/23, showed the following: -It is the policy of this facility that every resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion; -Mistreatment, neglect, or abuse of residents is prohibited by this facility; -This facility is committed to protecting residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -Physical abuse was defined as purposefully beating, striking, wounding, or injuring any consumer or any manner whatsoever mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management. (continued on next page)

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Behavioral Emergency Policy, last revised 1/5/23, showed the following: -The purpose is to provide safe treatment and humane care to the residents in a behavioral crisis, to outline steps to follow to correctly care for the residents in a behavioral crisis and to ensure that the resident is not being coerced, punished or disciplined for staff convenience; -The DON/Assistant Director of Nurses (ADON)/Registered Nurse (RN)/Designee will complete an RN investigation within 24 hours of the behavioral emergency. This may include a PRN (as needed) Intervention Form and notification of state agencies in the event that criteria are met; -In the event that the resident is unable to be redirected or is requesting an as needed (PRN) medication for mood stabilization, the resident will be given PRN medication per physician's orders. If the resident receives a PO (by mouth) PRN mood stabilizing medication, the licensed nurse must complete the PRN Intervention Form. If the resident receives an IM (intramuscular, injection given in the muscle) PRN for mood stabilization a RN Investigation will be completed including the PRN Intervention Form; -The licensed nurse will document the behavioral emergency in the medical record by utilizing the BIRPEEEE documentation guidelines; -B= Behavior Emergency - define behavior -I= Intervention - document intervention, note behavior emergency policy and document interventions from the behavioral emergency policy; -R= Reaction/Response - document reaction and response of the resident after the interventions; -P= Plan - continue current plan of care, continue observing and monitoring of the resident; -E= Evaluation; -E= Evaluation; -E= Evaluation; -E= Evaluation; -Documentation of the behavior emergency in the RN Investigation will include evaluation of the resident's behavior, including consideration for precipitating events or environmental triggers,and other related factors in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible, not identifying or attempting to identify the root causes of the behaviors and not revising the plan of care with measurable goals and interventions to address the care and treatment for a resident with behavioral and/or mental/psychosocial; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Behavioral Emergency = Code [NAME] - The Licensed Practical Nurse (LPN)/ Registered Nurse (RN)/Administrator/Director of Nurses (DON) or Code Team Lead must oversee use of approved Crisis Alleviation Lessons and Methods (CALM) hold techniques and release of any resident who poses imminent danger to self or others; -There are only two reasons that staff will utilize approved CALM hold techniques. They are as follows: when a resident is in imminent danger of harming themselves or when a resident is in imminent danger of harming others; -NOTE: A Code [NAME] can be called to be proactive in ensuring that enough qualified staff are present and to warrant the potential need of utilizing approved CALM hold techniques; -Approved CALM hold techniques are never utilized for punitive reasons, discipline or for staff convenience; Residents are never threatened by the use of CALM as a scare tactic or a threat by staff; -The Nurse (unless Administrator, DON or Assistant Director of Nurses (ADON) are present) is ultimately in charge of the code green and all staff responding will follow the direction from the Team Leader. The Team Leader can be the first to be on the screen of the code green, the employee with the most experience or the employee that has the best rapport with the resident; -When a Code [NAME] is called, staff will respond promptly and professionally. A Code [NAME] does not denote that approved CALM hold techniques are automatically utilized. The central purpose of calling a Code [NAME] is recognizing that the resident has become or has the potential to become a danger to themselves or someone else. Calling a Code [NAME] also ensures that all staff is readily available to utilize approved CALM hold techniques if necessary; -Any staff that responds to a Code [NAME] where approved CALM hold techniques are used, all staff must fill out a Code [NAME] and Room Search Review Sheet. This will include writing about the events that lead up to the Code Green, if approved CALM hold techniques were properly used, and any concerns regarding the approved CALM hold techniques; -All Behavioral Emergency Code [NAME] Reviews filled out by the responding staff will become part of the RN investigation to ensure that the behavioral crisis was handled professionally, that it could not have been avoided, and was handled by CALM certified staff using appropriate techniques, following policies of the facility; -Following the Behavioral Emergency Policy is vital and all areas that the Behavioral Emergency Policy addresses must be clearly understood and documented. 1. Review of Resident #1's face sheet showed he/she had a guardian. Review of the resident's PASARR (Pre-Admission and Resident Review)/Mental Illness Level II Evaluation, dated 7/10/23, showed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-His/Her diagnoses psychotic disorder (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), cognitive disorder (any disorder that significantly impairs the cognitive functions of an individual to the point where normal functioning in society is impossible without treatment), substance-induced persisting dementia (dementia caused by substance abuse), bipolar disorder, post traumatic stress disorder (PTSD, mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety), personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways), depression, and anxiety; -He/She was admitted on [DATE] after an altercation at a family member's house. He/She grabbed a knife and was threatening a family member with it. His/Her sibling tried to calm things down which resulted in the resident throwing the knife down and breaking the sibling's door frame by punching it. He/She was making bizarre statements about the illuminati (designation in use from the 15th century, assumed by or applied to various groups of persons who claimed to be unusually enlightened) and eating chicken. In the emergency department, he/she presented with mood swings and agitation. During a recent previous hospitalization , he/she hit a nurse and was sent to jail. During his/her current admission, he/she has been restless and fidgety. He/She has expressed depression, but denied suicidal ideations. He/She is isolative and guarded. He/She continues to exhibit irritability, impaired concentration, excessive worry, hypertalkativity, distractibility, delusions, disorganized behavior, restlessness, paranoia, labile affect, poor insight and poor judgement; -Current psychiatric support/services: inpatient psychiatric treatment, secured/behavioral unit, individual therapy/counseling, group therapy/counseling, precautions: assault and elopement; -Current mood disturbance: feeling depressed most days, expansive mood, racing thoughts, risk taking behaviors, hyper talkative, pressured speech and mood lability; -Current anxiety related symptoms: symptoms of increased arousal, excessive anxiety impairing function and intrusive thoughts; -Current disturbance in thought: hallucinations, delusions, paranoia, suspiciousness, thought disorganization, thought blocking, circumstantial thought processes, illogical thought process; -Department of Mental Health (DMH) history dates back to 2009 with serious mental illness (SMI) diagnoses of PTSD, GAD (general anxiety disorder), MDD (major depressive disorder), schizoaffective disorder (Schizoaffective disorder is a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder) and psychotic disorder. Most recently, his/her symptoms have included aggression, homicidal ideations and statements, mood lability, poor insight and judgement, irritability, impaired concentration, excessive worry, hyper-talkative, distractibility, delusions, disorganized behavior, restlessness, concrete thought process, paranoia and labile affect; -He/She has been irritable and labile, however has not been aggressive. He/She has been pacing and visibly agitated; -He/She attends two to three groups a day which is an improvement. He/She is isolative to his/her room most of the day or he/she paces the hallway. He/She also makes phone calls to his/her boyfriend/girlfriend; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Does not make good decisions, follow complex directions or stay on task/complete assignments; -Individual's limitations: impulsive, poor insight and judgement and aggression; -Individual's strengths: supportive family, guardian and independent with activities of daily living; -The resident DOES NOT require mental health specialized services; -His/Her guardian is requesting a locked facility. Per his/her social worker, he/she did not do well in his/her residential care facility as they did not provide enough supervision. He/She is impulsive and labile and cannot be cared for in a less-restrictive environment. He/She has a history of wandering and eloping, so his/her team is in agreement that he/she needs somewhere that can provide safety and security; -He/She needs or continues to need the following supports and services: assessment and implantation of behavioral support plan, monitoring of behavioral symptoms and provision of behavioral supports; -He/She needs medication therapy and monitoring services: psychiatric follow up to prescribe and manage medications; medication set up/administration by staff and monitoring for compliance with prescribed medication; monitoring of interaction or adverse effects; monitoring of therapeutic effect in managing mental health symptoms including labs as indicated; address, report and implement plan to manage patient refusals/noncompliance (including cheeking and hoarding); provide education/training in drug therapy management; and pharmaceutical services/medication review; -He/She needs provision of a structured environment; provide for individual personal space; provide for sensory supports; establish consistent routines; provide schedule of daily tasks/activities; provide instructions at the individual's level of understanding; and assess and plan for the level of supervision required to prevent harm to self or others; -He/She needs implementation of an activity of daily living program to increase independence and self-determination; nutrition needs; money management; maintenance of own living environment; provide cueing, reminders, education and/or modeling of daily living skills; -Crisis Intervention Services: assess and plan for crisis intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. List need or behavior necessitating crisis intervention. Include need for suicide, assault and elopement precautions; -Crisis Plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services and/or law enforcement should be contacted. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 2/9/24, showed the following: -Makes self understood; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Able to understand others; -Cognitively intact; -Inattention and disorganized thinking present and fluctuates; -No behaviors; -Diagnoses included dementia, bipolar, psychotic disorder, and schizophrenia. Review of the resident's care plan, in place prior to 3/19/24, showed the following: -At the time of the PASRR assessment, the resident was deemed to be safe for admission to skilled facility: -Structured socialization; -Resident will be in lowest restrictive environment while maintaining protective oversight; -Provisions of structured environment; -Physician services; -Pharmaceutical services; -Medically related social services; -Develop personal support network; -The care plan failed to address crisis intervention services or a crisis plan for the resident. Review of the RN Investigation, Investigative Narrative Notes, dated 3/19/24, showed the resident went to the Hangout by himself/herself due to knowing the elevator code. Hall Monitor A went down to the Hangout as well to report and address the resident knowing the code. Words were exchanged between the two of them. Hall Monitor A called a code over the walkie while the resident was attempting to get the walkie from him/her. Hall Monitor A reported he/she felt the resident was going to hit him/her and took the resident down to the ground without assistance. The resident reports that he/she did not try to hit Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 3/20/24 at 9:56 A.M., the resident said he/she was on third floor and going down to the Hangout. Another staff person had put in the elevator code for him/her. The elevator stopped on the first floor and he/she asked Hall Monitor A to enter the code for him/her. He/She said Hall Monitor A yelled you are waiting on my time! so he/she entered the code for the elevator and went down to the Hangout. He/She was going to go tell the Activity Director that he/she knew the elevator code, but stopped to smoke in the courtyard first. Hall Monitor A came down to the courtyard and they walked towards the Activity Director's office. He/She said Hall Monitor A told him/her not to take the elevator anymore. He/She said Hall Monitor A called a code on him/her so he/she grabbed for the walkie and said there was no reason for a code. The resident denied hitting Hall Monitor A. He/She said Hall Monitor A grabbed him/her and pulled him/her down and Hall Monitor A was on top of him/her. His/Her lip got hit when he/she went down to the ground. He/She said he/she tried to speak but couldn't. He/She couldn't remember where Hall Monitor A's hands were. Other staff showed up and took Hall Monitor A away. He/She said he/she thought he/she was going to die. He/She was scared that he/she couldn't breathe. During interview on 3/20/24 at 10:36 A.M. and 2:16 P.M., Resident #4 said Resident #1 reached for Hall Monitor A's walkie and Hall Monitor A put his/her arms around Resident #1 at chest level and took him/her down. He/She said Hall Monitor A took Resident #1 down hard. Hall Monitor A wouldn't get off Resident #1. Hall Monitor A said, you're not gonna hit me [NAME]. Staff had to tell Hall Monitor A to get off Resident #1. He/She said you couldn't see Resident #1 because Hall Monitor A was on top of him/her while on the ground. During interview on 3/20/24 at 10:47 A.M., Resident #2 said Hall Monitor A and Resident #1 were in the Hangout arguing about something. Hall Monitor A tried to call a code green and Resident #1 tried to take the walkie from him/her. Hall Monitor A took his/her arm around Resident #1's neck, took him/her to the ground and was on top of Resident #1. Hall Monitor A stayed on top of Resident #1 until the Activity Director tapped on him/her to get up. He/She said Resident #1 sat up and was crying saying he/she couldn't breathe. Hall Monitor A said, don't swing at me. During interview on 3/20/24 at 1:16 P.M., the Activity Aide said he/she initially had his/her back to Hall Monitor A when he/she came into the Hangout. Hall Monitor A said not to let Resident #1 get on the elevator. Resident #1 tried to take the walkie from Hall Monitor A. Hall Monitor A called a code green then turned Resident #1 around (so Hall Monitor A was facing Resident #1's back) and had his/her arms under Resident #1's arms (around the chest area like he/she was holding him/her up). Resident #1 was moving around, and Hall Monitor A was trying to restrain the resident, then Hall Monitor A slammed Resident #1 down to the ground and Hall Monitor A was on top of the resident. He/She did not see Hall Monitor A have his/her arm around Resident #1's neck from where he/she was standing. The Activity Director came out and told Hall Monitor A to get up. He/She said Resident #1 was moving his/her arms and legs while Hall Monitor A was laying on top of him/her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 3/20/24 at 11:29 A.M., the Activity Director said he/she was in his/her office and heard Hall Monitor A coming down the hall talking about Resident #1 saying he/she could not be on the elevator anymore because he/she knew the code. He/She heard someone call a code green and when he/she came out of his/her office, he/she saw Hall Monitor A laying on top of Resident #1. Hall Monitor A had his/her arms under Resident #1's (described them looking like a frog). He/She had to tell Hall Monitor A four or five times to get off Resident #1. Hall Monitor A eventually got up and aggressively told Resident #1, you messed with the wrong one over and over. Resident #1 said he/she thought he/she was going to die. Resident #1's lip was bleeding and other staff took Hall Monitor A out of the room. Hall Monitor A did not do an appropriate take down per facility policy. During interview on 3/20/24 at 4:19 P.M., LPN H said there was a code green in the Hangout. When he/she arrived, Hall Monitor A was yelling, you swung at the wrong one, you f***ing swung at the wrong one. He/She said there were staff between the two of them. Resident #1 was on his/her knees crying and upset saying, I couldn't breathe. I thought I was going to die. Other staff removed Hall Monitor A from the area. He/She and the Maintenance Director took Resident #1 outside for some fresh air. He/She said Resident #1 had blood on his/her chin so they went up to his/her room and cleaned him/her up. The resident had a small nick on the inside of his/her lip but it had stopped bleeding. The resident went to the hospital to get checked out. During interview on 3/20/24 at 12:13 P.M., the Maintenance Director said he/she responded to the code green and saw Resident #1 sitting on his/her bottom with his/her legs out straight. Resident #1 was crying and bloody. Hall Monitor A aggressively said, you swung on me over and over. He/She sat with Resident #1 until LPN H arrived to assess the resident and get him/her cleaned up. The resident complained of his/her chin hurting and said, He/She (Hall Monitor A) choked me so bad. I tried to tell him/her I was tapping out. He/She said Resident #1 was nervous so he/she took him/her outside for a smoke break and stayed with him/her when the resident was sent to the hospital for evaluation. He/She had been trained in a five-man take down and they do not do it like it was done with Resident #1. Review of Hall Monitor A's written statement, dated 3/19/24, obtained by the facility as part of their investigation showed a third floor resident was on the elevator and asked him/her to put the code in. Hall Monitor A told the resident hold on give me a min and the resident yelled and cussed him/her out then put the code in himself/herself. Hall Monitor A wrote he/she went to get help on the floor so he/she could go down to tell the crew downstairs not to let the resident back on the elevator. The resident followed him/her to the Activity Director's office as Hall Monitor A was telling him/her what was going on, the resident yelled at him/her more, gets in his/her face and so Hall Monitor A called a code green. The resident then came up to him/her and hit him/her in the face. The resident grabbed his/her walkie, but hit him/her in the face so he/she took the resident to the ground and waited for more help. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 3/26/24 at 3:03 P.M., Hall Monitor A said Resident #1 resides on third floor and was in the elevator when it stopped on first floor. The resident asked to be keyed down (have staff enter the code for the elevator) and he/she told him/her to wait a minute. Hall Monitor A said the resident cursed and called him a derogatory name and said he/she would let it down him/herself and saw the resident put the code in. He/She let management, Maintenance and his/her team lead know that a resident knew the code for the elevator so the code could be changed. He/She went downstairs to the Hangout to tell the Activity Director not to let the resident on the elevator because he/she knew the code. The resident was in the courtyard smoking and followed him/her inside. The resident attacked him/her and punched him/her in the face. The resident went for his/her walkie and punched him/her again. He/She locked arms with the resident and went to the floor. He/She was laying beside the the resident at first until the Activity Director told him/her to get up, then in the process of getting up, he/she was on top of the resident. He/She denied having his/her arm around the resident's neck and did not hear the resident say he/she couldn't breathe. He/She had received CALM training and tried to block the resident's move and sidestep away. He/She was never told not to take down a resident by himself/herself. He/She was defending himself/herself. Review of Hall Monitor A's employee file showed on 11/2/23, he/she signed a statement indicating he/she read and understood the facility's abuse and neglect policy. Review of Hall Monitor A's employee file showed on 11/2/23, he/she signed that he/she had received CALM training. During interview on 3/27/24 at 2:45 P.M., the Administrator said the resident had been on the elevator and it stopped on the first floor. Hall Monitor A had told Resident #1 to wait a minute and Resident #1 entered the code and went to the Hangout. Hall Monitor A approached the resident about how he/she got the code and told him/her he/she would need to use the stairs instead of the elevator. Resident #1 said Hall Monitor A tried to call a code on the walkie and the resident tried to swat the walkie out of Hall Monitor A's hand. Hall Monitor A said Resident #1 tried to hit him/her in the face, not take the walkie. Hall Monitor A did a one-man take down which was not a real thing according to facility policy. Another witness said Hall Monitor A had his/her arms under Resident #1's and took the resident down. The Activity Director came out of his/her office and saw Hall Monitor A on top of Resident #1. The Activity Director shoulder tapped Hall Monitor A and told him/her to get off the resident. As Hall Monitor A was leaving building after the incident, he/she said he/she had done a one-man take down. She would have expected Hall Monitor A to wait on additional staff after calling the code to assess the situation and try to de-escalate the resident. He/She said what Hall Monitor A did would be considered abuse. Review of the resident's care plan, revised 3/19/24, showed the following: -The resident noted to grab walkie (a portable communication device) from staff related to anger with staff, attempted to call a code green; -Sent to emergency room for evaluation and treatment and returned with no new orders; -Educated that residents are not to code the elevator that only staff are to code the elevator; (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated; -Assess and address for contributing sensory deficits; -Analyze times of day, places, circumstances, triggers and what de-escalates behavior and document; -The care plan failed to address crisis intervention services or a crisis plan for the resident. 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). MO233425