| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265787 | A. Building<br>B. Wing | 05/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Laverna Manor Health & Rehabilitation | 904 Hall Avenue<br>Savannah, MO 64485 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44939<br><br>Based on interview and record review, the facility failed to keep one resident (Resident #1) safe from sexual abuse when another resident (Resident #2) ran his/her hand up the inside of Resident #1's thighs and grabbed his/her genital area. The facility census was 61.<br><br>On 5/5/25, the Administrator was notified of the past noncompliance which began on 4/14/25. Upon discovery, the facility administration immediately conducted an investigation and corrective actions were implemented including: Resident #1 and #1 were seperated immediately, the facility staff assessed both residents and neither resident had injuries, Resident #2 was placed on 1:1 monitoring on 4/14/25, Resident #2's physician ordered Sertraline (a medication to treat anxiety and depression) for Resident #2, Abuse training was started for staff on 4/15/25. The noncompliance was corrected on 4/17/25.<br><br>Review of the facility's Abuse Prevention Program policy, dated July 2017, showed:<br><br>-Residents have the right to be free from abuse. This includes, but is not limited to freedom from sexual abuse;<br><br>-As part of the resident abuse prevention, the administration will: Protect residents from abuse by anyone including, other residents;<br><br>-Abuse is defined as the willful infliction of injury, confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.<br><br>1. Review of Resident #1's medical record on 5/5/25 showed:<br><br>- Diagnoses included: Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia with agitation (a group of thinking and social symptoms that interferes with daily functioning), delusional disorder (a mental illness characterized by the presence of one or more delusions that persist for at least a month).<br><br>Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 2/20/25, showed:<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265787 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/05/2025 |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - He/She had adequate hearing, unclear speech, is sometimes understood and sometimes makes self understood;<br><br>-He/She scored zero on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients), indicated severely impaired cognition;<br><br>-He/She displays wandering behavior and rejection of care.<br><br>Review of the residents comprehensive care plan, dated 4/3/25, showed interventions related to wandering and requiring a secure environment, aggression, cognition, communication and hospice.<br><br>2. Review of Resident #2's medical record on 5/5/25 showed:<br><br>- Diagnoses included: Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), traumatic subdural hemorrhage (a collection of blood between the dura mater (the outermost layer of the brain's covering) and the brain itself, often caused by head trauma.), mild cognitive impairment (the in-between stage between typical thinking skills and dementia).<br><br>Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>-He/She had adequate hearing, clear speech, understands others and usually makes self understood;<br><br>-He/She scored 1 on the BIMS, indicating severely impaired cognition.<br><br>Review of the resident's comprehensive care plan, dated 4/14/25, showed interventions related to wandering and need for a secure environment, behavior problem related to sexual outbursts and grabbing staff (staff are to redirect the resident when making inappropriate comments, provide distractions).<br><br>Review of the facility investigation showed that on 4/14/25 at approximately 5:30 P.M., the residents were in the common area of the memory care unit, waiting for dinner to be served. Certified Medication Technician (CMT) A was at the medication cart across the common area from the seating area, preparing to pass medications with dinner. CMT A observed Resident #2 sitting in a recliner and Resident #1 walking in the common area. As Resident #1 walked passed Resident #2, Resident #2 reached out, ran his/her hand up between Resident #1's thighs and lightly squeezed his/her genital area. CMT A separated the two residents and notified the charge nurse. Both residents were assessed an no injuries were noted. Due to their declined cognition, neither resident was able to provide information regarding the incident. The physician and responsible parties were notified of the incident the evening of 4/14/25. Resident #2 was placed on 1:1 supervision. Resident #2 was receiving antibiotics for a urinary tract infection at the time of the incident. Approximately two weeks prior to the incident, Resident #2's family expressed concerns the resident was too sedated and they physician decreased the resident's Risperdal (medication used to treat a variety of mental health conditions). When notified of the incident on 4/14/25, the physician gave the facility orders to start Resident #2 on Sertraline. The facility also initiated abuse and neglect education for all staff on 4/15/25. The physician assessed the residents again on 4/17/25, and gave the facility orders to restart Resident #2's Risperdal.<br><br>During an interview on 5/5/25 at 2:38 PM, CMT A said:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 4/14/25 at approximately 5:30 P.M., CMT A was getting the evening medications ready at the medication cart in the dining area of the common area. Resident #2 was sitting in a recliner in the front part of the common area near the television. CMT A observed Resident #1 walking through the common area. As Resident #1 walked by Resident #2, Resident #2 reached out, ran his/her hand up between Resident #1's thighs and then grabbed his/her groin area. Resident #1 did not react and continued walking past Resident #2 and through the common area. CMT A had resident #1 come sit by the medication cart and then called the charge nurse to come to the memory care unit.<br><br>During an interview on 5/5/25 at 3:10 P.M., the Director of Nursing said:<br><br>-The residents were immediately separated and assessed;<br><br>-Staff education on abuse and neglect was started on 4/14/25 and concluded on 4/17/25;<br><br>-Resident #2 was placed on one to one supervision;<br><br>-The physician was contacted the evening of the incident on 4/14/25 and gave orders to start Sertraline and Risperdal;<br><br>-The physician assessed the resident at the facility on 4/15/25;<br><br>-The physician assessed the resident again on 4/17/25 and gave orders to increase Resident #2's Risperdal.<br><br>During an interview on 5/5/25 at 3:20 P.M., the Administrator said:<br><br>-The resident was removed from one to one supervision on 4/21/25 as the resident has had no additional behaviors;<br><br>-The facility approached Resident #2's family about in-patient placement at a geriatric behavioral health facility. The family declined, elected to see if the recent medication adjustments were effective.<br><br>MO252749 |