STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265787	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laverna Manor Health & Rehabilitation	904 Hall Avenue 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two sampled residents (Resident #2 and Resident #3) had the right to be free from misappropriation when staff failed to follow protocol and conduct an investigation when each resident had missing fentanyl pain patches and staff did not account for the missing patches. The facility census was 55.Review of the facility provided policy titled, Storage of Controlled Substances, dated 8/2020 showed:-Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately; -The Director or Designee investigates and makes every reasonable effort to reconcile all reported discrepancies.1. Review of Resident #2's Medical Record showed:-He/She admitted to the facility on [DATE]-He/She had a diagnoses of Anoxic Brain injury (brain damage caused by complete loss of oxygen to the brain), major depressive disorder, quadriplegia, convulsions, low heart rate, and atrial fibrillation; -He/She had significant cognitive loss; -He/She was dependent on staff for Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);Review of the Physician's Order Sheet (POS) dated November 20205 showed:-Physician's order for Fentanyl (a highly addictive pain medication) transdermal patch 72 hour, 12 micrograms (mcg)/hour (hr), apply one patch transdermally (on the skin) in the morning every 3 days for pain, Ordered 11/20/25 and discontinued 11/26/25;-Physician's order for Fentanyl transdermal patch 72 hour, 12 micrograms (mcg)/hour (hr), apply one patch transdermally (on the skin) in the morning every 3 days for pain, cover Fentanyl patch with transparent dressing: ordered 11/26/2025.Review of the Medication Administration record (MAR), dated November 2025 showed:-A patch was placed on the resident's right front shoulder on 11/20/25 at 4:39 P.M.; -Patch placed on right upper arm on 11/23/25 at 4:18 P.M.; -On front left shoulder 11/26/25 at 6:00 A.M; -A patch was placed on the resident's front right shoulder on 11/27/25 at 8:57 A.M Review of Nurse Progress Notes dated 11/23/25 at 6:05 P.M. showed: -The resident did not have his/her patch that was applied 11/20/25 on;-The nurse and the Certified Nurse Aide (CNA) looked through the linens, under the bed and the surrounding areas;-The fentanyl patch was not found;-A message was left for management staff in a communication application;-A new patch was applied to the resident's upper outer right arm and covered it with a tegaderm (a clear adhesive dressing). During an interview on 12/10/25 at 1:30 P.M. Licensed Practical Nurse (LPN) A said:-On 11/23/25 Resident #2's patch was not on when he/she went to place a new patch; -He/She notified the Director of Nursing (DON) via a communication application the patch was missing; -It is not part of medication patch orders to check the patch daily; -He/She looked for the patch in the bedding and on the floor;-The DON, Assistant DON or the Administrator did not ask him/her any questions about the missing patch;-He/She is not aware any investigation was done.2. Review of Resident #3's Medical Record showed:-He/She admitted to the facility on [DATE];-He/She had diagnoses of: Heart disease, falls, atrial fibrillation, pain, unspecified dementia and anxiety.-He/She has mild cognitive loss. Review of the resident's comprehensive care plan dated 9/24/25 showed:-He/She was received pain medication for chronic pain; -The resident will verbalize adequate relief of pain; -The staff were supposed to administer the resident's pain medication as ordered; -Evaluate the effectiveness of pain interventions;-He/She needed moderate assistance of staff for ADLs.Review of the resident's December MAR showed and order dated 12/6/25 for Fentanyl transdermal patch 72 hour 12mcg/hr, apply 1 patch in the afternoon every 3 days for pain and remove per schedule. During an interview on 12/10/25 at 3:00 P.M. Resident #3 said:-He/She was in a lot of excruciating pain 12/9/25; -He/She had a pain patch applied after his/her bath on 12/6/25 but the patch was not there when the nurse put his/her new patch on, on 12/9/25; -The nurse got a new patch applied on the afternoon of 12/9/25 and his/her pain was much better on 12/10/25;-He/She was not asked any questions about his/her patch missing.During an interview on 12/9/25 at 3:20 P.M. the DON said:-She was aware a Resident #2's pain patch was missing after a shower; -She did not do an investigation where everything was written down; -Pain patches should be removed and placed in a special dissolving agent to dispose of the patch;-Pain patches should be counted at the beginning and ending of every shift, like other narcotic medications;-She was not aware Resident #3's pain patch was missing. During an interview on 12/10/25 at 3:50 P.M. the Medical Director said:-He would expect to be notified of missing narcotics; -He would expect the facility staff to notify him, or the Nurse Practitioner if a patch was not in place at the time of change;-He was not notified that Resident #2 and #3 had Fentanyl patches missing and unaccounted for.During an interview on 12/11/25 at 2:55 P.M. the [NAME] President of Clinical Operations said:-She would expect staff to look for the patch, ask the resident, report

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to follow physician's orders for one resident (Resident #1)when the physician ordered for the resident to be sent to the hospital for X-rays and an evaluation after the resident fell from a mechanical lift sling and experienced pain, and was not. The facility census was 55.Review of the facility's undated policy titled, Medication Orders, showed: -The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders;-Supervision by a Physician: Each resident must be under the care of a Licensed Physician authorized to practice medicine in the state and must be seen by the Physician at least every sixty (60) days;-A current list of orders must be maintained in the clinical record of each resident;-Orders must be written and maintained in chronological order; -When recording treatment orders, specify the treatment, frequency and duration of the treatment. 1.Review of Resident #1's Face Sheet on 12/9/25, showed:-He/She had the diagnoses of cerebral infarction due to embolism of cerebral artery (damage to tissues in the brain due to a loss of oxygen to the area, stroke), chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), dysphagia (difficulty swallowing), aphasia (a language disorder that affects a person's ability to communicate), hemiplegia and hemiparesis following cerebral infarction affecting dominant right side (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), insomnia, pain, abnormal involuntary movements, anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities), polyneuropathy (occurs when multiple peripheral nerves become damaged. Symptoms include problems with sensation, coordination, or other body functions), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), seizures (a burst of uncontrolled electrical activity between brain cells (neurons, nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations or states of awareness). Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff) dated 9/6/25, showed:-The resident had adequate hearing, unclear speech, was sometimes able to make self-understood and usually understands others;-He/She scored one on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents) indicating the resident had severely impaired cognitive functioning;-He/She required substantial to maximum assistance with all Activities of Daily Living (ADLs), including dressing, bathing, personal hygiene and transfers. Review of the comprehensive care plan, dated 12/3/25, showed:-Interventions related to ADLs, bathing and showering, required extensive assist of one to two staff to turn and reposition in bed;-The resident required extensive assistance of two staff with a mechanical lift to move between surfaces:- The resident had limited physical mobility and required assistance of one staff for locomotion using a wheelchair:- The resident had impaired cognitive functioning related to stroke and Alzheimer's Disease:- The resident had difficulty communicating;- Was at moderate risk for falls, the facility staff were supposed to ensure resident was securely and safely in mechanical lift before moving him/her;- The resident experienced pain related to hemiparesis (weakness on one side of the body). (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 12/3/25, Licensed Practical Nurse (LPN) A showed:-12/3/25 at 4:54 P.M. This nurse was called to resident's room by Certified Nurses Assistant (CNA) A who stated the nurse was needed in the room;-The resident was laying on the floor, between the feet of the mechanical lift;-A blanket was over the resident, and the resident was not moving or making any noise with no complaints of pain;-The resident was not able to respond in long worded sentences but responded with simple yes and no answers;-The resident was assessed, and blood pressure was within normal limits for this resident;- A skin assessment was completed, checked range of motion that was within normal limits for this resident;-No complaints of pain or shortness of air;-Provider was notified, guardian was notified of the fall;-Director of Nursing (DON) was notified and resident was assisted back to bed;-The resident's physician provided an order to send the resident to the hospital and obtain two view thoracic (mid back) and lumbar (lower back) spine x-ray of left hip STAT (immediately)-- X-rays were obtained;-The resident was resting in bed with call light within reach;-Fall was witnessed and resident did not hit head. Review of the progress note dated 12/4/25, Primary Care Physician (PCP) A documented: -Patient was examined;-Staff called and stated he/she was dropped four feet from a mechanical lift;-It was reported the resident was in significant pain and it appeared he/she had deformities;-An order was given to send him/her to the hospital, however the facility did not want to do that.-Mobile x-rays are not as good as hospital x-rays and could miss fractures being seen. During an interview on 12/10/25 at 11:29 A.M., LPN A said:-He/She was the charge nurse on 12/3/25 when Resident #1 fell from the mechanical lift; -When entering the room after being called by staff, LPN A observed the mechanical lift was facing toward the window, feet open, and the resident laying in-between the legs of the lift;-The resident was covered by a blanket;-LPN A began assessing the resident;-Staff informed LPN A the hooks on the sling had come undone, but they are unsure how this happened;-The resident complained of pain across his/her shoulders and in left hip;-The resident hit his/her shoulder on one of the legs of the lift when he/she fell, and also landed on his/her left hip;-LPN A called PCP A who gave the order to send the resident to the hospital for x-rays and evaluation;-LPN A was informed by facility corporate personnel and the administrator that the facility would not be sending the resident out for x-rays but will be calling for mobile x-rays to come to the facility;-LPN A informed PCP A of the instructions from the administration;-PCP A agreed only if mobile x-rays could be taken within the hour. During an interview on 12/10/25 at 3:19 P.M., PCP A said:-Facility staff notified him/her on 12/3/25 the resident had fallen approximately four feet from a mechanical lift and hit his/her shoulder and left hip during the fall; -PCP A gave the order to send the resident to the hospital for x-rays and evaluation; -A short time later, facility staff notified him/her the facility administrator gave staff instructions to not send the resident to the hospital but the resident would receive mobile x-rays at the facility;-He/She was unaware why this decision was made;-He/She disagreed with this decision, as mobile x-rays are not as good as ones taken in a hospital, but agreed if the mobile x-rays could be taken within the hour; -It was his/her expectation that orders given to facility staff be followed unless it would be a risk to the resident's life to send the resident to the hospital;-He/She expected if a resident's had a fall from that height, they should be sent to the hospital every time for evaluation. During an interview on 12/10/25 at 2:44 P.M, the Medical Director (MD) said he/she would absolutely expect facility staff to follow an order given by a physician. Not doing so is unacceptable. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/25 at 3:20 P.M., the Director of Nursing (DON) said:-He/She started at the facility in July 2025 as a floor nurse, then became the DON in September 2025. -It was his/her expectation that staff follow orders given by a physician;-He/She is unsure why staff did not follow the order given to send the resident to the hospital for x-rays after the resident fell from the mechanical lift. During an interview on 12/12/25 at 2:05 P.M., the Administrator said:-He/She expected staff to use the mobile x-ray services that the facility had a contract with;-If they physician gives an order to send a resident to the hospital for x-rays, the nurse should inform the physician that the facility uses mobile x-ray services, and x-rays will be completed at the facility. Intake 2684304

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview, and record review, facility staff failed to properly transfer one resident (Resident #1), in a safe manner, when the staff failed to ensure the resident's sling was securely connected to the mechanical lift (a mechanical device used to safely lift and transfer people with limited mobility, like the elderly or disabled, from one surface (bed, chair, toilet) to another, using a sling for full-body support, preventing caregiver strain and patient falls) when transferring the resident, and the resident fell from the lift to the floor causing pain to the resident's shoulders and left hip. The facility census was 55. Review of the facility's Safe Lifting and Movement of Residents policy, dated July 2017, showed:-In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents; -Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents; -Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis; -Staff will document resident transferring and lifting needs in the care plan; -Such assessment shall include a resident's preferences for assistance, resident's mobility/degree of dependency, resident's size, weight-bearing ability, cognitive status, if the resident is usually cooperative with staff and resident's goals for rehabilitation; -Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices;-Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary; -Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents; -Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques; -Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. Back-up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hour a day while batteries are being recharged. -Enough slings, in the sizes required by residents in need, will be available at all times. As an alternative, residents with lifting and movement needs will be provided with single-resident use disposable slings. -Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. -All equipment design and use will meet or exceed guidelines and regulations concerning resident safety and the use of restraints. -Safe lifting and movement of residents is part of an overall facility employee health and safety program, which involves employees in identifying problem areas and implementing workplace safety and injury prevention strategies, addresses reports of workplace injuries, provides training on safety/ergonomics/proper use of equipment, and continually evaluates the effectiveness of workplace safety and injury-prevention strategies. 1. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff) dated 9/6/25, showed:-The resident had adequate hearing, unclear speech, was sometimes able to make self understood and usually understands others;-He/She scored one on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents), indicating severely impaired cognitive functioning;-He/She required substantial to maximum assistance with all Activities of Daily Living (ADLs), including dressing, bathing, personal hygiene and transfers. Review of the comprehensive care plan, dated 12/3/25, showed:- Staff were supposed to help the resident with bathing and showering, turn and reposition in bed, getting dressed, required extensive assistance of two staff with mechanical lift to move between surfaces;-The resident required assistance of one staff for locomotion;-He/She had impaired cognitive functioning related to stroke and Alzheimer's Disease;-He/She had difficulty communicating;-He/She was a moderate risk for falls and the staff were supposed to ensure the resident was secure and safe in the mechanical lift before moving him/her;- The resident had pain related to hemiparesis (weakness of one side of the body).Review of a progress note dated 12/4/25 at 5:00 P.M. Primary Care Physician (PCP) A documented: -Staff called and stated the resident was dropped four feet from a mechanical lift;-It was reported the resident was in significant pain and it appeared the resident had deformities; -An order was given to send the resident to the hospital, however the facility did not want to do that;-We will write an order for pain medication;-Mobile x-rays are not as good as x-rays obtained at he hospital and could miss fractures. Review of the resident's Physician Order Sheet (POS), dated 12/5/25, showed:-An order for Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligrams (MG) Give one tablet by mouth three times daily for pain. Review of the facility investigation, dated 12/4/25 showed: -On 12/3/25 at approximately 3:35 P.M.