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	10/10/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from physical abuse for one of four residents (Resident (R) 42) reviewed for abuse out of 23 sample residents when R23, with a history of hitting another resident, hit R42 in the shoulder unprovoked. This failure had the potential to affect all the residents on the secured unit who were at risk of abuse. The facility census was 57. Findings include: Review of the facility's policy titled, "Abuse Prevention Program," revised 10/16, revealed our residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. 1. Review of R42's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, depression, and psychotic disorder. Review of R42's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/02/24 revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 which indicated R42 was severely cognitively impaired. 2. Review of R23's "Admission Record" located in the "Profile" tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's, major depressive disorder, insomnia, and restlessness and agitation. Review of R23's quarterly "MDS" with an ARD of 07/02/24 revealed a BIMS score of one out of 15 which indicated R23 was severely cognitively impaired. Review of R23's care plan, located under the "Care Plan" tab of the EMR and dated 07/20/24, revealed "The resident has potential to be physically aggressive related to dementia." Interventions in place were to intervene when the resident became agitated to prevent escalation, document and report any signs or symptoms of danger to self or others, offer resident a distraction or offer space and reassurance to de-escalate. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a "Nurse's Notes" located in the EMR under the "Notes" tab, revealed no documentation related to the incident that occurred on 09/28/24 between R42 and R23. Review of the undated Follow-up Investigation Report provided by the facility revealed the conclusion of the allegation was verified through the investigation. During an interview on 10/09/24 at 2:03 PM, Hospitality Aide (HA) 1 stated R23 could be sweet but she could change with the flip of a switch. She stated R23 could get angry and cuss at you. HA1 stated she had not had any behavior for about a month before the incident on 09/28/24. HA1 stated on that day it was somewhere between 12:30 PM and 12:45 PM because she was picking up hall trays after lunch when she heard R42 yelling. She stated she walked down the hall towards R42's room and observed R23 standing right outside the doorway. She stated R42 was just inside the room by the doorway. HA1 stated she redirected R23 and sat her down by the nurse's station and asked R23 what happened, and she said, she was trying to vote. She stated she went back and spoke with R42 who said R23 came into her room and just hit her on the shoulder with a closed fist. She said R42 made a knuckle when she told her that R23 hit her. HA1 stated R42 said R23 never said anything and just hit her. HA1 stated she reported it to Licensed Practical Nurse (LPN) 1 who was in the west hall at that time. During an interview on 10/10/24 at 1:27 PM, LPN1 stated an aide came to her on 09/28/24 that a resident hit another resident, but she could not remember who the residents were. She said she was told the names at the time it was reported to her. She stated she went to the unit and assessed both residents' arms, but she did not document that she completed a skin assessment, or a progress note about what occurred because she forgot. She stated she did notify the Director of Nursing (DON), but she was overwhelmed that day. During an interview on 10/10/24 at 1:27 PM, the DON stated she was unsure what happened because she was out of town. She said the Administrator handled the investigation. During an interview on 10/10/24 at 3:34 PM, the Administrator stated she was notified about the incident on 09/28/24 and she got to the facility shortly after it was reported to her. She said she spoke with the aide who told her that R23 went into R42's room, who was in her bathroom, and when R42 came out she told R23 to leave and R23 hit R42. The Administrator stated R42 said R23 took her hand and pushed it up against her chest area. She said they did substantiate that the allegation occurred. She stated R23 was placed on 1:1 supervision until she was discharged for a psychiatric evaluation. MO242786

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and policy review, the facility failed to ensure two of two residents (Resident (R) 29 and R61) reviewed for discharge to the hospital were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, and other information regarding the transfer, out of 23 sample residents. This failure has the potential to affect the residents by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. The facility census was 57. Findings include: Review of the facility's policy titled, Transfer or Discharge Notice, revised December 2016, showed: .Policy Interpretation and Implementation .2. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: a. The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility .3. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; d. A statement of the resident's rights to appeal the transfer or discharge, including: (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; g. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); h. The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and i. The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices . 1. During an interview on 10/08/24 at 9:38 AM, R29 stated she had gone to the hospital in June for kidney stones. When asked if she had received a written notice of transfer that stated where and why she was being transferred she stated, No. Review of R29's Admission Record from the electronic medical record (EMR) Profile tab showed a facility admitted [DATE] with medical diagnoses that included chronic obstructive pulmonary disease (COPD), cerebral infarction, contractures, hemiplegia, and hemiparesis of dominant side. Review of R29's EMR Census tab showed no hospitalization s in June but there was a hospitalization in April. Review of R29's EMR Progress Notes tab showed: 4/24/2024 08:13 [8:13 AM] Nurse's Note. Note Text: this nurse called hospital to speak with charge nurse for update on resident condition. Spoke with [Name], RN [Registered Nurse]. She states resident was admitted through the ER [emergency room] yesterday evening . she states there are no plans to d/c [discharge] resident today. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's EMR Miscellaneous tab, Progress Notes tab, and Assessments tab showed no evidence of the provision of a written notice of transfer. 2. Review of R61's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included cystitis, dementia, and uterine cancer. Review of R61's EMR Census tab showed a hospital leave effective 07/20/24. Review of R61's EMR Progress Notes tab showed: Effective Date: 07/26/2024 15:48 [3:48 PM] Type: Nurse's Note. Note Text: Remains in the hospital and Effective Date: 07/21/2024 11:00 [AM] Type: Nurse's Note. Note Text: Resident was transported to the ER after she was found outside last night . Review of R61's EMR Miscellaneous tab, Progress Notes tab, and Assessments tab showed no evidence of the provision of a written notice of transfer. During an interview on 10/10/24 at 11:20 AM in response to a request for evidence of the provision of written transfer notices, the Administrator provided policies and stated she was unable to find any documentation regarding the written notice of transfer provision. During an interview on 10/10/24 at 12:30 PM regarding the emergent transfer process, RN1 stated, I get the order to transfer to the ER. Print out the face sheet and med [medication] list. Call EMS [Emergency Medical Services]. Notify the Director of Nursing and family [clarified, this notification is by phone] - if emergent situation. If not emergent, we will generally talk to the family, you know, do you want them transferred, some families don't; but for emergencies we send them, then call. After they leave, we call the ER and give the report. When asked if there was anything provided in writing regarding the transfer to the resident and representative, RN1 responded, We tell them on the phone, generally speaking, it's just a verbal we get from the family. If it's not emergent we give them a written bed hold, but nothing in writing regarding the transfer. When asked to see the notice provided, RN1 provided two sheets, one a bed hold notice, and one was a transfer notice. When asked about the transfer notice, RN1 stated, Well, yes, after the fact we do use it. [Name] Social Services usually does that. During an interview on 10/10/24 at 12:37 PM, the Social Services Director (SSD) reviewed the transfer notice and asked about the provision of the form; the SSD stated, If I'm here I will help them out. If I'm not here the nursing staff would do this. Nursing staff is supposed to do the bed hold - contact family for verbal consent if not here. The SSD reviewed R61's EMR and stated it wasn't done. Once she got to the hospital there was no contact. The SSD reviewed R29's EMR and stated, There is nothing.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and review of facility policy, the facility failed to ensure two of two residents (Resident (R) 29 and R61) reviewed for facility initiated emergent transfer to the hospital received a written bed hold notice that included all required information of 23 sample residents. This failure had the potential to contribute to possible denial of re-admission and loss of the residents' home following a hospitalization for residents transferred to the hospital. The facility census was 57. Findings include: Review of the facility's policy titled, Bed-Holds and Returns, revised March 2017, showed: Policy Statement. Prior to transfers and therapeutic leaves, residents or resident representative will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation.3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. the rights and limitations of the resident regarding bed-holds; b. the reserve bed payment policy as indicated by the state plan (Medicaid resident); c. the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. the details of the transfer (per the notice of transfer) . 1. During an interview on 10/08/24 at 9:38 AM, R29 stated she had gone to the hospital in June for kidney stones. When asked if she had received a written bed hold notice, she stated, No. I was there three days. Review of R29's Admission Record from the electronic medical record (EMR) Profile tab revealed a facility admitted [DATE] with medical diagnoses that included chronic obstructive pulmonary disease (COPD), cerebral infarction, contractures, hemiplegia, and hemiparesis of dominant side. Review of R29's EMR Census tab showed no hospitalization s in June but there was a hospitalization in April. Review of R29's EMR Progress Notes tab showed: 4/24/2024 08:13 [8:13 AM] Nurse's Note. Note Text: this nurse called hospital to speak with charge nurse for update on resident condition. Spoke with [Name], RN [Registered Nurse]. She states resident was admitted through the ER [emergency room] yesterday evening . she states there are no plans to d/c [discharge] resident today. Review of R29's EMR Miscellaneous tab, Progress Notes tab, and Assessments tab showed no evidence of the provision of a written bed hold notice. 2. Review of R61's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included cystitis, dementia, and uterine cancer. Review of R61's EMR Census tab showed a hospital leave effective 07/20/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R61's EMR Progress Notes tab showed: Effective Date: 07/26/24 15:48 [3:48 PM] Type: Nurse's Note. Note Text: Remains in the hospital and Effective Date: 07/21/24 11:00 [AM] Type: Nurse's Note. Note Text: Resident was transported to the ER after she was found outside last night . Review of R61's EMR Miscellaneous tab, Progress Notes tab, and Assessments tab showed no evidence of the provision of a written bed hold notice. During an interview on 10/10/24 at 11:20 AM in response to a request for evidence of the provision of written bed hold notice, the Administrator provided policies and stated she was unable to find any documentation regarding the written bed hold notice. During an interview on 10/10/24 at 12:30 PM regarding the emergent transfer process, RN1 stated, I get the order to transfer to the ER. Print out the face sheet and med [medication] list. Call EMS [Emergency Medical Services]. Notify the Director of Nursing and family [clarified, this notification is by phone] - if emergent situation. If not emergent, we will generally talk to the family, you know, do you want them transferred, some families don't; but for emergent we send them, then call. After they leave, we call the ER and give the report. When asked if there was anything provided in writing regarding the transfer to the resident and representative, RN1 responded, We tell them on the phone, generally speaking, it's just a verbal we get from the family. If it's not emergent we give them a written bed hold . During an interview on 10/10/24 at 12:37 PM, the Social Services Director (SSD) reviewed the bed hold form and was asked about the provision of the form; the SSD stated, If I'm here I will help them out. If I'm not here the nursing staff would do this. Nursing staff is supposed to do the bed hold, contact family for verbal consent if not here. The SSD reviewed R61's EMR and stated it wasn't done. Once she got to the hospital there was no contact. The SSD reviewed R29's EMR and stated, There is nothing.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed and submitted for processing for one of one resident (Resident (R) 14) triggered for no assessment in over 120 days from 23 residents reviewed in the sample. This failure has the potential to adversely affect care planning and care provision for any resident that may not have received a thorough assessment. The facility census was 57. Findings include: Review of the facility's policy titled, Comprehensive Assessments, revised March 2022, revealed: .Policy Interpretation and Implementation. 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual . Review of the October 2023 RAI Manual revealed on page 2-18: Quarterly (Non-Comprehensive) .ARD [Assessment Reference Date] of previous . assessment of any type + 92 calendar days . On page 2-34: The ARD of an assessment drives the due date of the next assessment. The next noncomprehensive assessment is due within 92 days after the ARD of the most recent .assessment (ARD of previous . assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days) . Review of R14's Admission Record from the electronic medical record (EMR) Profile tab showed an initial facility admitted [DATE] and a readmitted [DATE] with medical diagnoses that included cerebral infarction, hemiplegia, dysphagia, esophageal obstruction, heart failure, Alzheimer's dementia, depression, hypothyroidism, atrial fibrillation, chronic respiratory failure, anxiety disorder, and pain. Review of R14's EMR MDS tab showed the last completed and accepted MDS was an annual with an ARD of 05/16/24. The EMR MDS tab page showed a quarterly MDS with an ARD of 08/15/24 which was listed as In Progress but not yet signed and submitted as of 10/08/24 at 11:25 AM. During a telephone interview on 10/10/24 at 11:54 AM, the MDS Coordinator (MDSC) reviewed R14's EMR and stated, Apparently this one did get missed. She [R14] was on my list for a quarterly in August, looks like it's all filled out. It looks like I missed signing and submitting it.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on observation, record review, interview, review of the RAI [Resident Assessment Instrument] manual, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for five out of 23 sampled residents (Residents (R) 37, R29, R30, R34, and R57) reviewed for MDS. The coding failures have the potential to affect the appropriate care planning and provision for the residents. The facility census was 57. Findings include: During an interview on 10/10/24 at 3:15 PM, the Director of Nursing (DON) stated the facility used the RAI Manual. Review of the facility policy titled Comprehensive Assessments, revised March 2022, revealed .Policy Interpretation and Implementation. 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. Review of the October 2023 RAI Manual showed on page N-8: Coding Tips and Special Populations .- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant. Regarding smoking on page J-26: J1300: Current Tobacco Use Item Rationale Health-related Quality of Life -The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. Planning for Care -This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. -If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. DEFINITION TOBACCO USE Includes tobacco used in any form. 1. Review of R37's Admission Record from the electronic medical record (EMR) Profile tab revealed a facility admitted [DATE] with medical diagnoses that included atrial fibrillation, congestive heart failure (CHF), pleural effusion, anxiety disorder, and epilepsy During observations on 10/07/24 at 12:30 PM and 10/08/24 at 11:30 AM, R37 was in the courtyard smoking. Review of R37's EMR Progress Notes revealed on 12/03/23 a practitioner note that showed: .Social History: Nicotine: Current every day cigarette user. 0.5 packs per day Cigarette smoker for [AGE] years . Review of R37's EMR MDS tab revealed the annual MDS with an Assessment Reference Date (ARD) of 12/30/23 did not show R37 used tobacco. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R37's EMR Assessments tab revealed a quarterly smoking evaluation, dated 10/03/23, that showed R37 was a safe smoker; and a smoking evaluation on 07/03/24 that showed the resident was a safe independent smoker and the facility would keep the smoking materials. Another smoking evaluation, effective 10/04/24, showed that R37 was appropriate for unsupervised smoking and was able to maintain his own smoking materials. During a telephone interview on 10/10/24 at 1:50 PM regarding the tobacco use coding, the MDS Coordinator (MDSC) stated, It might have been an oversight because he does smoke. 2. Review of R29's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included chronic obstructive pulmonary disease (COPD), cerebral infarction, contractures, hemiplegia, and hemiparesis of dominant side. Review of R29's quarterly MDS with an ARD of 03/17/24, an admission MDS with an ARD of 05/02/24, and a quarterly MDS with an ARD of 08/01/24 showed R29 received anticoagulation medication. Review of R29's EMR Orders tab for current and historical anticoagulant physician's orders showed no results. R29 did have orders for two anti-platelet medications, aspirin, and Plavix. 3. Review of R30's Admission Record from the EMR Profile tab showed a facility admitted [DATE], readmission on 06/02/21, with medical diagnoses that included dementia, type II diabetes, acute respiratory failure, and lymphocytosis. Review of R30's annual MDS with an ARD of 03/29/24 and quarterly MDS with an ARD of 09/26/24 showed R30 was receiving an anticoagulant medication. Review of R30's EMR Orders tab for current and historical anticoagulant (blood thinner) physician's orders showed no results. R30 did currently receive a low dose aspirin (antiplatelet medication) for atherosclerotic heart disease. 4. Review of R34's Admission Record from the EMR Profile tab showed a facility admitted [DATE], readmission on 08/15/24, with medical diagnoses that included cerebral infarction, dementia, cervical fracture, femur fracture, and tibia fracture. Review of R34's admission MDS with an ARD of 08/22/24 and five-day admission MDS with an ARD of 09/25/24 both showed R34 received anticoagulation medication. Review of R34's EMR Orders tab for current and historical anticoagulant physician orders showed only an anticoagulation medication that discontinued 01/06/23. During a telephone interview on 10/10/24 at 11:54 AM, the MDSC stated she was now aware that there was an issue with anticoagulation medication coding. The MDSC commented that So, we have an outside company, they audit our MDS, and they told me to do it that way. [Clarified, to code aspirin but not Plavix as anticoagulation medication]. When asked if the MDSC used a facility policy or the RAI Manual, the MDSC responded, We do have an RAI Manual, but that company does audits and on average I get one email a week with suggestions. I should verify the suggestions with RAI Manual then go through the patient's chart and documents. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35693 5. Review of R57's undated Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R57 was admitted to the facility on [DATE]. R57's diagnoses included acute on chronic combined systolic and diastolic congestive heart failure, atherosclerotic heart disease, and supraventricular tachycardia. Review of an MDS located in the EMR under the MDS tab, with an ARD of 09/17/24 indicated R57 was taking an anticoagulant agent. Review of R57's active Orders located in the EMR under the Orders tab revealed an order dated 09/07/24, for aspirin low dose oral tablet delayed release 81 mg (antiplatelet agent) but no order for an anticoagulant agent. During an interview on 10/07/24 at 1:15 PM and a second interview on 10/10/24 at 11:54 AM, the MDSC stated she received advisement from a consulting group that aspirin should be coded as an anticoagulant, so she had been coding all residents on aspirin as anticoagulant on the MDS assessment. During an interview on 10/10/24 at 1:05 PM the Administrator stated she expected the MDS to be an accurate assessment of the resident condition.