

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  Heart of the Ozarks Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2004 Crestview Street Ava, MO 65608	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43193</p> <p>Based on record review, observation, and interview, the facility failed to ensure all residents were treated with dignity and respect by all staff when one staff member (Certified Medication Technician (CMT) A) spoke to one resident (Resident #1) in an undignified manner, including raising his/her voice and arguing. A sample of eight residents was reviewed in a home with a census of 78.</p> <p>Review of the facility's policy titled Dignity, dated 02/2021, showed the following:</p> <ul style="list-style-type: none"> <li>-Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem;</li> <li>-Residents are treated with dignity and respect at all times;</li> <li>-The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay;</li> <li>-Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs;</li> <li>-Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents;</li> <li>-Staff are expected to treat cognitively impaired residents with dignity and sensitivity.</li> </ul> <p>1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included pain, heart failure, and myasthenia gravis (a condition caused by a breakdown in communication between nerves and muscles. Symptoms include weakness in the arm and leg muscles, double vision, and difficulties with speech and chewing).</li> </ul> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated 05/02/24, showed the resident needed two-person extensive assistance with activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) and transfers. He/she used a wheelchair for mobility.</p> <p>Observations on 05/03/24, at 12:53 P.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat in the hallway in his/her wheelchair approximately three doors down from the nurses' station;</li> <li>-CMT A was heard arguing with the resident about the resident not picking his/her feet up;</li> <li>-The CMT said if the resident thought someone eight months pregnant was going to pick the residents feet up, the resident was wrong;</li> <li>-The CMT continued to argue with the resident saying he/she knew the resident could pick up their feet because the resident just moved them;</li> <li>-The CMT spoke in a loud, chastising voice;</li> <li>-Licensed Practical Nurse (LPN) B intervened, removed the CMT from the situation and reported the incident to the Director of Nursing (DON).</li> </ul> <p>During an interview on 05/03/24, at 12:51 P.M., LPN B said the following:</p> <ul style="list-style-type: none"> <li>-CMT A was not speaking to the resident appropriately;</li> <li>-The CMT and another staff member were attempting to get the resident back to his/her room after lunch;</li> <li>-Staff should treat residents with dignity and respect;</li> <li>-If he/she heard a staff member not treating a resident appropriately, he/she intervened, removed the staff member, educated the staff member and reported the incident to the DON;</li> <li>-Staff could not force a resident to pick up their feet if a resident does not want to;</li> <li>-If resident did not want to pick up their feet, staff should walk away and reapproach later. Staff should give the resident space and readdress later as long as the resident was not in immediate danger.</li> </ul> <p>During an interview on 05/03/24, at 12:56 P.M., CMT A said the following:</p> <ul style="list-style-type: none"> <li>-He/she knew the resident could move their legs and attempted to get the resident to move them and if the resident would not move them, he/she planned to assist the resident;</li> <li>-He/she did not speak to the resident appropriately;</li> <li>-Staff should treat residents with kindness;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If a resident did not want to do something, he/she attempted to motivate the resident and then assisted the resident;</p> <p>-Staff could not force a resident to move;</p> <p>-It was not appropriate for staff to tell a resident they knew the resident could move their feet and the resident was not going to get a pregnant staff member to do it for them.</p> <p>During an interview on 05/03/24, at 1:14 P.M., Certified Nursing Assistant (CNA) C said the following:</p> <p>-One of the kitchen staff was pulling the resident backwards in his/her wheelchair because the resident did not want to pick up his/her feet;</p> <p>-He/she stopped the kitchen staff and told the kitchen staff they could not do this;</p> <p>-The CNA asked the resident if he/she wanted help to scoot back in his/her wheelchair;</p> <p>-CMT A was coming down the hall and the CNA asked the CMT to assist him/her;</p> <p>-The CMT told the resident to pick up his/her feet and the resident said he/she could not do it;</p> <p>-The CMT told the resident he/she was not going to assist the resident due to being pregnant;</p> <p>-The CNA told the CMT that he/she would handle the situation due to the CMT not being very nice to the resident;</p> <p>-He/she did not think the CMT was speaking to the resident appropriately;</p> <p>-LPN B came over and handled the situation;</p> <p>-Staff should treat residents with respect and kindness;</p> <p>-If he/she heard a staff speak inappropriately to a resident, he/she told the staff member to leave and he/she took care of the resident. He/she then reported the incident to the charge nurse;</p> <p>-If a resident did not want to do something, he/she respected the residents wishes, walked away and checked back with the resident later.</p> <p>During an interview and observation on 05/03/24, at 1:22 P.M., the resident said the following:</p> <p>-He/she had problems lifting his/her feet;</p> <p>-The resident sat in the television room in front of the nurses' station with a family member. The resident appeared distressed as he/she burrowed his/her brow and spoke in a voice that sounded on the verge of tears.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/03/24, at 1:22 P.M., the resident's family member said the resident had myasthenia gravis and had no control of his/her legs.</p> <p>Review of the facility's investigation, received 05/09/24, showed the following:</p> <p>-On 05/03/24, the resident asked a dietary staff member to wheel him/her back to his/her room. The dietary staff member was wheeling the resident down the hallway, however, the resident was unable to pick up his/her feet because he/she was positioned too far down in the wheelchair. The dietary staff member asked CNA C for assistance. CNA C asked CMT A to assist with positioning the resident in the wheelchair and the CMT made a comment to the resident along the lines of if you think an eight month pregnant lady is going to pick up your feet for you, you are mistaken;</p> <p>-CNA C stated that he/she asked CMT A for assistance repositioning the resident in the resident's wheelchair. The resident could not pick up his/her feet because the resident was too far down in the wheelchair. The CMT came to assist and made the above comment to the resident. The CNA stated he/she told the CMT that the CMT needed to remove him/herself from the situation;</p> <p>-LPN B said that he/she overheard CMT A make the above comment to the resident. LPN B removed CMT A from the situation after that. The LPN and CNA C repositioned the resident in the wheelchair. The LPN said the resident was unable to pick up his/her feet due to his/her positioning, however, once they repositioned him/her, he/she was able to pick up his/her feet like usual;</p> <p>-CMT A said that he/she did make the above comment to the resident;</p> <p>-The allegation was verified due to being witnessed by staff members, surveyor, and from an interview with CMT A.</p> <p>During an interview on 05/03/24, at 2:28 P.M., CMT D said the following:</p> <p>-Staff should treat residents with respect, courtesy, and dignity;</p> <p>-If he/she heard a staff member treating a resident inappropriately, he/she reported this to the charge nurse;</p> <p>-If a resident did not want to do something, they had the right to refuse;</p> <p>-If he/she asked a resident to pick up their feet and they would not do it, he/she attempted to encourage the resident and if they still refused, he/she left and reapproached the resident later;</p> <p>-It was not appropriate for staff to tell a resident they saw a resident pick up their feet so knew they could or that an eight month pregnant person was not going to help them. He/she did not consider this treating a resident with dignity and respect.</p> <p>During an interview on 05/03/24, at 2:46 P.M., the DON said the following:</p> <p>-He/she expected staff to treat residents with dignity and respect;</p> <p>(continued on next page)</p>		

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