STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265464	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Riverview Manor	1200 West Hall, Ozark, MO 65721

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure an effective pain management program was in place for all residents when staff failed to document complete assessments of pain and failed to document administration of pain medication after complaints of pain for one resident (Resident #1) who suffered a broken hip. The facility census was 74. Review of the facility's policy Pain Assessment and Management, dated March 2020, showed the following:-The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying caused of pain;-Pain management program is based on a facility wide commitment to appropriately assess and treat pain;-Pain management is defined as the process of alleviating the resident's pain based on his/her clinical condition;-Pain management is a multidisciplinary care process that includes the following: assessing the potential pain, recognizing the presence of pain, identifying the characteristics of pain, addressing underlying causes of pain, developing and implementing pain management, monitoring for the effectiveness of interventions, and modify as needed;-Acute pain or significant and worsening pain, should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained;-Possible behavioral signs of pain include, groaning, crying, screaming, grimacing, frowning, resisting care or participation in activities, guarding or rubbing a part of the body;-Possible physiological signs include increased blood pressure, increased respirations. 1. Review of Resident #1's face sheet (brief resident profile sheet) showed the following:-admission date of 06/10/26;-Diagnoses included stroke, depression, anxiety, aphasia (disorder that impairs the ability to speak), vascular dementia (decline in thinking and memory skills), sciatica on right side lower back pain (nerve pain), and cognitive communication deficit. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/10/26, showed the following:-Severe cognitive impairment;-Usually understood by others, difficulty communicating some words, but usually understands others but missed some or part of the message. Review of the resident's care plan, dated 06/11/26, showed the following:-Resident had a communication problem related to a stroke, resulting in neurocognitive communication deficit;-Resident had impaired thought process related to left parietal ischemic stroke with petechial hemorrhages (blockage of blood flow in the parietal lobe of the brain leading to tissue damage). Ask yes or no questions to determine needs;-Resident had acute/chronic pain related to stroke;-Monitor/record/report to nurse any signs or symptoms of non-verbal pain;-Monitor and report to the nurse resident complaints of pain or request for pain treatment. Observe and report changes in usual routine, or decreased functional abilities;-Pain management as needed, provide alternative comfort measures as needed. Review of the resident's progress note dated 06/13/26, at 5:54 P.M., showed the following:-The resident was found in the floor beside the wheelchair next to the bed in his/her room;-Resident said he/she fell and hurt his/her right leg and landed on his/her butt. His/her butt hurt as well;-Border gauze placed on scrape of lower right leg below shin;-Upon assessment, there was weakness with no obvious sign of broken bone, bruising or bleeding;-Resident had right sided weakness from previous stroke and will have to be closely monitored for activity level;-Resident did not respond to questions well and had obvious deficits processing information and (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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answering questions;-Initial vitals indicate continued elevated blood pressure with no fever. Review of the resident's June 2026 Physician Order Sheet (POS) showed an order, dated 06/13/26, for Tylenol tablet (pain reliever) 325 milligrams (mg), two tablets by mouth, every four hours, as needed for pain. Review of the resident's June 2026 Medication Administration Record (MAR) showed the following:-On 06/13/26, at 6:42 P.M. Certified Medication Technician (CMT) B administered Tylenol 325 mg, two tablets for pain rated 4 out of 10 and medication. The CMT noted the pain medication was effective. (Staff did not document where the pain was located.); -On 06/14/26, at 3:54 A.M., staff administered Tylenol 325 mg, two tablets for pain rated 5 out of 10 and medication. Staff noted the pain medication was effective. (Staff did not document where the pain was located.) Review of the resident's progress note dated 06/14/26, at 10:10 A.M., showed a certified nurse aide (CNA) reported resident's foot fell off of the wheelchair foot rest when attempting to push wheelchair, causing second digit of right foot to have toenail torn almost completely off from nail bed. Review of the resident's June 2026 MAR showed on 06/14/26, at 4:52 P.M.,CMT B administered Tylenol 325 mg, two tablets for pain. The CMT noted the pain medication was effective. (The CMT did not document a pain level or the location of the pain.) Review of resident's occupational therapy notes, dated 06/15/26, showed the following:-Resident grimaced with pain with right knee and leg when being touched;-Nursing confirmed resident had fallen this weekend;-While in therapy, resident participated in dynamic and strengthening exercises of the upper extremities to improve self-care;-Resident refused to stand;-Wheeled resident to the nurses' station to decrease risk of repeat falls. Review of resident's physical therapy notes, dated 06/15/26, showed the following:-Resident had a fall over the weekend;-Significant, increased right knee pain with range of motion (ROM) and weight bearing with minimal redness around the right knee;-Resident had difficulty with transfers and weight bearing and range of motion with increased knee pain, nursing aware. Review of the resident's medical record, dated 06/15/26, showed staff did not document follow-up assessment or treatment of pain noted in therapy notes. Review of the resident's June 2026 MAR showed on 06/16/26, at 1:43 A.M., Registered Nurse (RN) G administered Tylenol 325 mg, two tablets for pain rated 6 out of 10. The RN noted the pain medication was effective. (The RN did not document where the pain was located.) Review of resident's occupational therapy notes, dated 06/16/26, showed the resident unable to stand at this time due to pain in the right knee and big toe. Resident demonstrating level of confusion and inability to solve simple instructions. Review of resident's physical therapy notes, dated 06/16/26,showed the following:-Resident provided with skilled instruction for performing sit-to-stand transfers;-Resident provided with max verbal and tactile cues for hand and feet placement for set up, verbal cues for improved positioning including scooting forward and increased forward weight shift;-Resident provided with substantial assist of two and was unsuccessful in achieving standing this date due to decreased processing and increased pain in right lower extremity. Review of the resident's progress note dated 06/16/26, at 3:58 P.M., showed the following:-Resident had vocal complaints of pain of new location;-Right anterior elbow and right knee with pain level of 7 out of 10;-Non-medication interventions did not provide relief;-Physician notified of need for stronger as needed pain medication, currently only has Tylenol. Review of the resident's pain assessment and evaluation dated 06/16/26, at 4:06 P.M., showed the following:-Resident able to communicate appropriately;-Resident had frequent pain in the last five days;-The resident rated his/her pain intensity of 6 out of 10;-Frequency of which resident complained or showed evidence of pain or possible pain, showed indicators of pain the last three to four days;-Received as needed pain medication;-Received non-medication intervention for pain and it was somewhat helpful. Review of the resident's June 2026 POS showed the following:-An order dated 06/16/26, at 5:45 P.M., for right hip and right upper extremity x-ray related to pain and recent fall;-An order, dated 06/17/26, for tramadol (narcotic used to treat moderate to severe pain) 50 mg, give one syringe by mouth every six hours, as needed for pain. Review showed of the resident's medical record, dated 06/16/26, showed staff did not document administration of pain medication to address the residents reported pain. Review of resident's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical therapy notes, dated 06/17/26, showed the following:-Sit to stand transfers with mod assist of two with front wheeled walker, pain to the right lower extremity;-Static (maintain stable, motionless upright posture against gravity) standing with minimal weight bearing on right lower extremity;-Resident continued to have significant pain with right knee and lower extremities with range of motion and standing. Nursing was notified. Review of the resident's progress notes, dated 06/17/26, showed the following: -At 5:34 P.M., order received for tramadol, 50mg, one syringe by mouth every six hours as needed for pain;-At 7:11 P.M., resident vocalizes pain in right upper arm and right thigh with pain level 4 out of 10. Review of the resident's record, dated 06/17/26, showed staff did not document an assessment of the resident's pain or pain medication administered. Review of the resident's progress notes, dated 06/18/26, showed the following:-At 12:13 A.M., x-ray called and informed staff that resident had a fractured right hip. Staff called on-call physician and who directed staff to send resident out to the emergency room for evaluation;-At 7:30 A.M., hospital communicated update on resident. Resident had right hip fracture and was scheduled for surgery. Review of the resident's hospital records, admission date of 06/18/26, showed the following:-Resident had a fall at the nursing home about six days ago;-The resident presented to the hospital in a delayed fashion at about four days out from the fall;-Resident found to have right displaced femoral neck fracture (broke hip on the right side);-Surgical management in the form of a hip hemiarthroplasty (replaces only the ball portion of the hip joint) in order to restore stability to the hip and allow for early mobilization and improve pain control. During an interview on 06/25/26, at 2:24 P.M., the Director of Rehabilitation said the following:-Therapy began working with the resident on 06/11/26;-When the resident began with therapy he/she didn't show any signs of pain, he/she had some upper hemiplegic (paralysis on one side) and some stiffness. The resident couldn't tell staff exactly where he/she hurt, if staff touched various body parts he/she wouldn't be able to tell staff what hurts;-On Friday, 06/12/26, the resident needed little assistance with walking and transfers. On 06/15/26, after the fall over the weekend, the resident needed two of the staff to transfer him/her and it took more strength from the staff. The resident would not put weight on the right leg;-On 06/15/26, the resident gave non-verbal signs of pain like grimacing and he/she said ow. When moving the resident's right leg, he/she showed pain and grimaced. Staff tried to figure out exactly where the pain stemmed because the resident couldn't tell them;-When doing range of motion at first itpainful for the resident then he/she seemed to relax and it was some better. The therapy staff completed assistive range of motion;-He/she let a nurse know on 06/15/26, the concerns regarding the residents changes;-Therapy continued to work with the resident on 06/16/26 and 06/17/26 and the resident continued to show pain so they did not work with the right side. He/she discussed obtaining an x-ray with the nurse on 06/16/26. During an interview on 06/25/26, at 2:30 P.M., CNA A said the following:-When staff assisted the resident with personal cares before the fall the resident didn't display any pain, after the fall the resident would curse when moving him/her;-When he/she assisted the resident the following Monday, after the fall, the resident needed more help. The resident didn't say he/she was in pain, but when he/she transferred the resident, he/she would curse and yell and one time patted his/her right hip;-He/she informed the nurse and the Assistant Director of Nursing (ADON). During an interview on 06/25/26, at 2:52 P.M., CNA C said the following:-The resident could verbalize when he/she had pain;-On 06/15/26, the resident was a two-person max assist, sometimes three. When rolling the resident, he/she would scream and curse in pain. He/she alerted the nurses;-The resident showed pain each time he/she assisted him/her after the fall. During an interview on 06/25/26, at 2:45 P.M., CMT B said the following:-The resident was quiet, but he/she would moan if he/she was in pain and could tell staff yes or no;-If a resident had pain, he/she would look to see if they have an order for pain medication, and administer the medication;-He/she did not remember if the resident had pain, or if he/she administered pain medication to the resident. During an interview on 06/25/26, at 3:07 P.M., RN D said the following:-He/she did not recall any aides or therapy telling him/her the resident was having pain. If they had told him/her about pain, he/she would have told the CMT to administer pain (continued on next page)

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