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	12/17/2025

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and facilitate the right of self-determination for every resident when staff failed to honor reasonable shower preferences for four residents (Resident #61, #74, and #6) . The facility census was 77.Review showed the facility did not provide a shower policy. 1. During interviews on 09/22/25, at 9:58 A.M., during the resident council group meeting, the residents said there were issues with receiving showers. Some residents receive two showers per week, but most only receive one. 2. Review of Resident #61's face sheet (a general information sheet) showed the following:-admission date of 11/16/23;-Diagnoses included congestive heart failure, morbid obesity, and depression. Review of the resident's quarterly Minimum Data Set (MDS - federally mandated assessment instrument completed by facility staff), dated 08/15/25, showed the following:-No cognitive impairment;-Partial/moderate assistance with shower/bathing;-Staff supervision with personal hygiene. Review of the resident's care plan, last reviewed on 09/24/25, showed the following:-Resident had an activities of daily living (ADL – shower, grooming, toileting, etc.) self-care performance deficiency due to limited mobility, congestive heart failure and reduced mobility;-If agrees, he/she preferred to shower on Wednesdays. Review of the resident's August 2025 shower sheets showed the following:-On 08/06/25, resident received a shower;-On 08/13/25, the resident refused a shower (seven days after the last offered shower);-On 08/20/25, the resident received a shower (14 days after the previous shower and seven days after the last offered shower);-On 08/27/25, the resident refused a shower (seven days after the last offered shower). Review of the resident's August 2025 nursing notes showed staff did not document any additional showers, addition shower attempts, or additional refusals by the resident. Review of the resident's September 2025 shower sheets showed the following:-On 09/02/25, the resident received a shower;-On 09/05/25, the resident refused a shower;-On 09/10/25, the resident received a shower (eight days after the last shower and five days after the last offered shower);-On 09/12/25, the resident received a shower;-On 09/18/25, the resident received a shower (six days after the last shower);-On 09/26/25, the resident received a shower (eight days after the last shower). Review of the resident's September 2025 nursing notes showed staff did not document any additional showers, addition shower attempts, or additional refusals by the resident. Observation and interview on 09/23/25, at 10:00 A.M., showed the following;-The resident's hair appeared oily;-He/she said she/she would like to have a shower two times per week but only receives one shower per week. During an interview on 09/26/25, at 12:39 P.M., the Assistant Director of Nursing (ADON) said the (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident sometimes refused showers depending on what he/she was doing when staff asked. During an interview on 09/26/25, at 2:28 P.M., the Director of Nursing (DON) said the resident used to like to shower on Wednesdays and lately has taken more showers. 3. Review of Resident #74's face sheet showed the following:-admission date of 04/30/25;-Diagnoses included chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), chronic kidney disease, morbid obesity, Type 2 Diabetes, and end stage renal disease. Review of the resident's care plan, last reviewed on 02/18/25, showed the following:-Resident had an ADL self-care performance deficit;-Staff to check nail length and trim and clean on bath day and as necessary. Review of the resident's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-Substantial/maximum assistance for showers/bathing;-Partial/moderate assistance with personal hygiene. Review of the resident's August 2025 shower sheets showed the following:-On 08/06/25, the resident received a shower;-On 08/13/25, the resident received a shower (seven days after the prior shower);-On 08/19/25, the resident received a shower (six days after the prior shower);-On 08/26/25, the resident refused a shower (seven days after the last shower);-On 08/29/25, the resident received a shower (ten days after the last shower and three days after the last offered shower). Review of the resident's August 2025 nursing notes showed staff did not document any additional showers, addition shower attempts, or additional refusals by the resident. Review of the resident's September 2025 shower sheets for showed the following:-On 09/01/25, the resident received a shower;-On 09/08/25, the resident received a shower (seven days after the prior shower);-On 09/15/25, the resident received a shower (seven days after the prior shower);-On 09/22/25, the resident received a shower (seven days after the prior shower);-On 09/25/25, the resident received a shower. Review of the resident's September 2025 nursing notes showed staff did not document any additional showers, addition shower attempts, or additional refusals by the resident. Observation and interview on 09/24/25, at 2:49 P.M., showed the following: -The resident's hair appeared oily;-He/she said he/she would like showers the night before dialysis;-He/she said it is important for him/her to be clean before leaving for dialysis, as the clinic is a sterile environment, and he/she does not want to risk bringing in germs. During an interview on 09/26/25, at 12:39 P.M., the ADON said he/she was not aware of the resident refusing showers. During an interview on 09/26/25, at 2:28 P.M., the DON said the resident's shower schedule depends on his/her dialysis schedule. He/she leaves early and comes back late. He/she could possibly receive two showers, but probably not three. During an interview on 09/25/25, at 4:38 P.M., Certified Medication Technician (CMT)/Shower Aide (CMT/SA) O said the resident occasionally refused showers if one falls on his/her dialysis day. He/she has requested to receive showers before dialysis. His/her shower days are Monday and Thursday. He/she attends dialysis on Tues, Thursday and Saturday. He/she could receive his/her two showers on Monday and Wednesday, but it would be too long to go from Wednesday to Monday. There is not staff available to provide showers on Saturday. 4. Review of Resident #6's face sheet (a brief information sheet about the resident) showed the following:-admission date of 10/13/23;-Diagnoses included COPD, chronic respiratory failure with hypoxia (condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), type 2 diabetes mellitus, chronic pain syndrome, and overactive bladder. Review of the resident's care plan, last updated 02/20/25, showed the following:-Resident needed partial to maximum assist with transfers, toileting, bed mobility and dressing;-Staff provide supportive care, assistance with mobility as needed and document assistance as needed.(Staff did not care plan related to the resident's resident shower preferences.) Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Used of wheelchair for (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility;-Required partial to moderate assistance of staff for oral hygiene, toileting hygiene, showering, dressing, personal hygiene, transfers. Review of the facility CNA Shower Forms, showed the following:-On 09/01/25 (Monday), received shower. Staff marked no new skin issues;-On 09/03/25 (Wednesday), received shower. Staff marked no new skin issues;-On 09/09/25 (Tuesday), received shower. Staff marked no new skin issues. (Six days since last shower);-On 09/12/25 (Friday), received shower. Staff marked red areas noted;-On 09/17/25 (Wednesday), received shower (one shower this week);-As of 09/26/25 resident had not had a shower for the week. Review of the resident's medical record showed staff did not document in nursing progress notes information related to showers. During an interview on 09/21/25, at 4:15 P.M., the resident said that staff had been a little lax with showers. He/she had not received two showers per week and would prefer at least two times per week. He/she said it feels good to have a shower. During an interview on 09/24/25, at 8:50 A.M., the resident said he/she had not had a shower for over one week, he/she would prefer to receive two per week and thought he/she was scheduled for Tuesday and Fridays. He/she said he/she did not feel good when had not received a shower. 5. During an interview on 09/25/25, at 2:30 P.M., Certified Nurse Aide (CAN) F said the facility had two shower aides. The shower aides were pulled to work on the floor as an aide when staff call in. Residents should receive two showers per week. Some residents only receive one shower per week and CNA F believes this coincided with when the aides were being pulled to the floor to work. During an interview on 09/25/25, at 3:18 P.M., CNA H said the facility had a shower aide. The facility would pull the shower aide to the floor to assist with resident care. Residents should receive two showers per week. The facility would sometimes ask staff to stay late to complete showers. During an interview on 09/25/25, at 4:38 P.M., CMT/SA O said the following: -Residents get at least one shower per week. He/she tried to ensure residents receive two, but it was difficult because there were a lot of residents, and he/she was sometimes pulled to the floor to work as a CMT;-Residents or nurses will inform him/her of a resident's shower preference. He/she can also refer to the care plan;-Shower days are Monday/Thursdays or Tuesday/Fridays. He/she used Wednesday as a make-up day to ensure all residents get a least one shower per week;-Approximately two weeks ago, several residents complained about not getting showers, as CMT/SA O was off work for approximately two weeks. During an interview on 09/26/25, at 9:45 A.M., Licensed Practical Nurse (LPN) I said the facility had shower aides. He/she believed residents received two showers per week. Occasionally, shower aides will be pulled to the floor to work as an aide. During an interview on 09/26/25, at 10:02 A.M., LPN J said the facility has shower aides. Residents should receive two per week, but he/she was unsure if residents receive two. The shower aides were sometimes pulled to the floor to work as aides. During an interview on 09/26/25, at 12:39 P.M., the ADON said the goal was for residents to have two showers per week, however some receive more and some less. Shower aides were pulled to the floor occasionally to work as aides. Some residents have voiced concerns about not receiving showers. Residents can receive showers on Saturday. During an interview on 09/26/25, at 2:28 P.M., the DON said the residents should be receiving at least one shower per week, hopefully two. A few residents ask for three, but that doesn't always work out. There was one shower aide per side of the facility. The facility tried to get a third person a day or two a week. The shower aide was pulled to the floor to work as an aide, but normally the restorative aide was pulled before shower aide. Periodically, residents will voice concerns about not getting two showers. During an interview on 09/26/25, at 4:03 P.M., the Administrator said he/she was unsure of the shower schedule, but residents should be receiving two showers per week. The shower aide is occasionally pulled to the floor to work as an aide. Residents can receive three showers a week. If a resident would like to receive a shower on the weekend, they would need to let staff know in advance.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not correctly reconciling each month. The facility managed funds for 25 residents. The census was 77.Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account by not correctly reconciling each month. The facility managed funds for 25 residents. The census was 77.Review showed the facility did not provide a policy related to the resident funds. 1. Review of the corporate maintained bank statements for account ending in #7994, dated September 2024, showed the last check number to clear was #2481. Review of the corporate maintained reconciliation form for account ending in #7994, dated 09/30/24, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained bank statements for account ending in #7994, dated October 2024, showed the following:-On 10/11/24, check #2482 for $97.20 was deducted from the account;-On 10/17/25, check #2483 for $395.00 was deducted from the account. Review of the corporate maintained reconciliation form for account ending in #7994, dated 10/31/24, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05;-Check number #2483 for $395 deducted from the account. Review of the corporate maintained reconciliation form for account ending in #7994, dated 11/30/24, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 12/31/24, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 01/31/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 02/28/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 03/31/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 04/30/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 05/31/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 06/30/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 07/31/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. Review of the corporate maintained reconciliation form for account ending in #7994, dated 08/31/25, showed the following:-An outstanding check #2482 for $97.30;-An outstanding check #2483 for $155.05. During an interview on 09/26/25, at 11:48 A.M., the Financial Specialist (FS) said the following:-The data entry error was made by his/her predecessor;-The Chief Financial Officer (CFO) reviewed the reconciliation;-The company has an outside entity conduct a yearly audit. During an interview on 09/26/25, at 1:18 P.M., the CFO said the following:-The FS conducted the reconciliation of the resident trust;-The employee who made the data entry error is no longer with the company.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper assessment and documentation was completed before side rail use, failed to document risk versus benefit review, failed to obtain informed consent, and failed to care plan use of side rails for two residents (Residents #8 and #75), and failed to complete gap measurements to reduce risk of entrapment for three residents (Resident #8, #12, and #75). The facility census was 77. Review of the facility policy titled Proper Use of Side Rails, dated December 2016, showed the following:-The purpose of these guidelines is to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms;-Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents;-An assessment will be made to determine the resident's symptoms, risk of entrapment, and reason for using side rails;-When used for mobility or transfer, an assessment will include a review of the resident's bed mobility, ability to change positions, transfer to and from bed or chair, and to stand and toilet, risk of entrapment from the use of side rails, and that the beds dimensions are appropriate for the resident's size and weight;-The use of side rails as an assistive device will be addressed in the resident's care plan;-Consent for restrictive devices will be obtained from the resident or legal representative per facility protocol;-The risks and benefits of side rails will be considered for each resident;-Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks;-Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails;-The resident will be checked periodically for safety relative to side rail use;-When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment. 1. Review of Resident #12's face sheet showed the following information:-admission date of 10/01/15;-Diagnoses included right-sided weakness and paralysis following a stroke, history of transient ischemic attack (TIA; mini-stroke), unable to speak, gastrostomy (tube inserted through the abdominal wall into the stomach to provide nourishment and/or medications), muscle wasting, epilepsy/convulsions/seizures, low blood pressure, major depressive disorder, anxiety, osteoporosis (weakening of bones, contracture, difficulty sleeping, and chronic pain. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 07/25/25, showed the following information:-Severely impaired cognition;-Range of motion impaired to upper and lower extremities, one sided. Review of the resident's physician order sheet (POS) showed an order, dated 01/04/24, for side rails x 2 while resident was in bed due to diagnosis of convulsions, epilepsy, and seizure disorder for resident's safety. Review of the resident's care plan, last updated 07/25/25, showed resident had full side rails x 2 per family's request for safety and a sense of security. The rails do not limit resident's access to his/her body or prevent him/her from doing what he/she wants as he/she was total care. Side rails do not restrict mobility and are not a restraint. Durable Power of Attorney (DPOA) does not want padding on side rails due to it scares resident. Observation on 09/21/25, at 5:10 P.M., showed the resident in bed watching television. Bilateral side rails were in the raised position. A photo blanket was draped over the resident's right (wall side) rail. Observation on 09/22/25, at 12:15 P.M., showed the resident in bed. Bilateral side rails were in the raised position. A photo blanket was draped over the resident's right (wall side) rail. A family member said the side rails were requested for the resident's safety due to a long history of seizures. Observation on 09/25/2025, at 10:30 A.M., showed the resident in bed watching television. Bilateral side rails were in the raised position. A photo blanket (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was draped over the resident's right (wall side) rail. By signing yes, the resident said he/she wanted the side rails in place. Review of the resident's electronic record showed a copy of an informed consent form for the use of bilateral side rails, dated 01/04/24. Review of maintenance logs pertaining to safety/gap measurements of residents' side rails showed no documentation for Resident #12's bilateral side rails. 2. Review of Resident #8's face sheet showed the following:-admission date of 03/26/19;-Diagnoses included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), post-traumatic stress disorder (PTSD – disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), generalized anxiety disorder, history of falling, and weakness. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Use of wheelchair;-Supervision or touching assistance with transfers;-Setup or clean-up assistance for toilet transfers;-Partial to moderate assistance with personal hygiene, dressing, showering, toileting hygiene. Observation and interview on 09/21/25, at 4:48 P.M., showed the resident in bed with a grab bar (side rail) on left side of the bed. The resident said he/she used the bar for mobility and transfer assistance. Review of the resident's Care Plan, last updated 03/05/25 , showed staff did not care plan related to the use of the grab bar. Review of the resident's POS, current as of 09/26/25, showed staff did not document an order for grab bars or side rails. Review of the resident's electronic medical record showed the following:-A bed rail assessment, dated 08/20/24, for side rails used to assist and serve as an enabler to promote independence;-No risk and benefits consent;-No side rail measurements or routine monitoring noted in chart. 3. Review of the face sheet for Resident #75, showed the following:-admission date of 04/24/25;-Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), fibromyalgia (chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), and chronic pain syndrome. Observation and interview on 09/22/25, at 3:41 P.M., showed the resident had grab bars on both sides of his/her bed. The resident said he/she used the grab bars to move around in bed and to help roll for staff when providing personal cares. Review of the resident's care plan, last updated 04/24/25, showed the following:-Resident had an activities of daily living self-care performance deficit related to fibromyalgia;-Resident used grab bars x 2 to maximize independence with transferring and repositioning. Review of the resident's significant change in condition MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Use of wheelchair;-Dependent of staff for toileting hygiene, showering;-Required substantial to moderate assistance for dressing, personal hygiene. Review of the resident's POS, current as of 09/26/25, showed staff did not document orders related to grab bar usage. Review of the resident's electronic medical record showed the following:-No bed rail assessment;-No risk and benefits consent;-No side rail measurements or routine monitoring noted in chart 4. During an interview on 09/24/25, at 12:30 P.M., the Corporate Nurse said the positioning only bars were not felt to be a risk and therefore do not have measurements or consent completed. There were no gap measurements for Resident #8's grab bar. During an interview on 09/26/25, at 10:00 AM., the Maintenance Supervisor said he/she was told by staff when a resident needed bed rails and when he/she was told that the therapy evaluation indicated they could have the rails. He/she installed the bed rails. He/she did not have measurements or routine safety checks. During an interview on (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/26/25, at 2:27 P.M., the Director of Nursing (DON) said therapy should evaluate a resident to determine if eligible for a side rail or grab bar. The staff notify maintenance, and he/she installed the bars. The DON did not know if there was routine assessments or measurements. During an interview on 09/26/25, at 3:32 P.M., Administrator said residents should have an assessment for use of side rail or grab bar. The therapy staff will evaluate and determine if beneficial for the resident. The maintenance staff will do gap measurements and install the rails. And there should be a review done quarterly. The staff are good to let us know something needs looked at. Not sure there is an informed risk and benefit consent. Grab bars should be evaluated and measured.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on observation, interview, and record review, the facility failed to nurse aides were not employed and used for resident care longer than four months without proper certification when four nurse aides (Nurse Aide (NA R, NA S, NA T, and NA U), of fifteen sampled NAs, failed to complete a certified nurse aide (CNA) training program within four months of employment in the facility as a nurse aide. The facility census was 84. Review showed the facility did not provide a policy regarding nurse aide certification or training. 1. Review of NA R's personnel information showed the following:-Date of hire of 01/24/25 (eight months and two days since date of hire);-Staff did not have documentation NA R had completed the nurse aide training program.Review of the state agency CNA registry, on 09/26/25, showed the NA R did not have an active CNA certification.Review of the nursing staff schedule, dated 09/21/25 through 09/26/25, showed the following:-On 09/21/25, NA R worked on the evening shift;-On 09/22/25, NA R worked on the evening shift;-On 09/25/25, NA R worked on the day shift;-On 09/25/25, NA R scheduled to work on the evening shift;-On 09/26/25, NA R scheduled to work on the evening shift.Observations on 09/21/25, at 3:45 P.M., showed NA R working, providing direct care to residents in the facility.Observation on 09/22/25, at 3:20 P.M., showed NA R working, providing direct care to residents in the facility. 2. Review of NA S's personnel information showed the following:-Date of hire of 04/15/25 (five months and nine days since date of hire);-Staff did not have documentation NA S had completed the nurse aide training program. Review of the state agency CNA registry, on 09/26/25, showed the NA S did not have an active CNA certification.Review of the nursing staff schedule, dated 09/21/25 through 09/26/25, showed on 09/25/25, NA S scheduled to work on the evening shift.3. Review of NA T's personnel information showed the following:-Date of hire of 04/29/25 (four months and twenty-seven days since date of hire);-Staff did not have documentation NA T had completed the nurse aide training program.Review of the state agency CNA registry, on 09/26/25, showed the NA T did not have an active CNA certification.Review of the nursing staff schedule, dated 09/21/25 through 09/26/25, showed on 09/22/25, NA T worked on the day shift.Observation on 09/22/25, at 10:30 A.M., showed NA T working, providing direct care to residents in the facility. 4. Review of NA U's personnel information showed the following:-Date of hire of 05/13/25 (four months and thirteen days since date of hire);-Staff did not have documentation NA U had completed the nurse aide training program.Review of the state agency CNA registry, on 09/26/25, showed the NA U did not have an active CNA certification.Review of the nursing staff schedule, dated 09/21/25 through 09/26/25, showed the following:-On 09/24/25, NA U worked on the evening shift;-On 09/25/25, NA U scheduled to work on the evening shift;-On 09/26/25, NA U scheduled to work on the evening shift.Observation on 09/24/25, at 3:15 P.M., showed NA U working, providing direct care to residents in the facility.Review of the state agency CNA registry (a state-maintained list that confirms a Certified Nursing Assistant's (CNA) eligibility to work by verifying they have completed state-approved training and passed the required competency exam), on 09/26/25, showed the Nurse Aides were not listed with an active certificate. 5. During an interview on 09/25/25, at 12:45 P.M., the Director of Nursing (DON) said the CNA instructor should be monitoring the students to ensure they complete their course work and test within 120 days. NA R and NA U were close to done. She was not aware that they were over 120 days. During an interview on 09/25/25, at 3:00 P.M., Administrator said NA staff should be certified within four months of hire.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative nursing services to maintain or improve residents' functional status as directed by therapy for three residents (Residents #55, #72, and #75). The facility census was 77.Review of the facility's policy, Restorative Nursing Services, revised July 2017, showed the following information:-Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies);-Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care;-Restorative goals and objectives are individualized and resident-centered and outlined in the resident's plan of care;-Restorative goals may include, but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities, developing, maintaining or strengthening his/her physiological and psychological resources, maintaining his/her dignity, independence and self-esteem, and participating in the development and implantation of his/her plan of care. 1. Review of Resident #55's face sheet (gives basic profile information) showed the following information: -admission date of 01/23/25;-Diagnoses included hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke) and chronic pain. Review of resident's Restorative Hand-off Form, dated 03/05/25, showed the following:-Tentative date for Physical and Occupational Therapy discharge of 02/27/25;-Therapy delivered range of motion (ROM), strength, balance, transfers, and activities for daily living (ADL);-Goals of ROM, strengthening, and transfers. Review of Restorative Therapy (RT) log, dated August 2025, showed the following:-Resident received RT on 08/05/25 and 08/06/25;-Resident refused RT on 08/07/25;-No RT received the week of 08/11/25;-Resident received RT on 08/19/25, 08/20/25, and 08/21/25;-No RT received the week of 08/25/25. Review of resident's care plan meeting summary, dated 08/19/25, showed not applicable (N/A) for therapy concerns. Review of resident's comprehensive Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 08/29/25, showed the following:-Upper and lower extremity impairment on one side;-Wheelchair use;-Substantial/maximal assistance with personal hygiene;-Dependent on staff for transfers;-Restorative therapy range of motion occurred once in seven-day period. Review of resident's Restorative Therapy log, dated September 2025, showed the following:-No RT received the week of 09/01/25;-Resident received RT on 09/08/25;-No RT received the week of 09/14/25;-Resident received RT on 09/21/25. Review of resident's care plan, last updated 09/22/25, showed the following:-Resident has an activity of daily living (ADL - self-care performance deficit due to intercranial hemorrhage with hemiplegia (stroke with paralysis);-Resident is dependent on staff for all ADL's;-Physical Therapy and Occupational Therapy evaluation and treatment as per physician orders;-Resident is a risk for falls sure to left side hemiplegia;-Physical therapy evaluate and treat as ordered or as needed (PRN). Review of the resident's Physician Order Sheet (POS), current as of 09/26/25, showed staff did not document orders related to restorative therapy. Observation and interview on 09/22/25, at 2:06 P.M., showed the resident was observed to have weakness on his/her left side. The resident said he/she should receive restorative therapy but does not receive it regularly. During an interview on 09/25/25, at 2:21 P.M., the resident said when he/she does not receive restorative therapy, he/she starts to tighten up which can be painful. During an interview on 09/25/25, at 3:18 P.M., Restorative Aide (RA) H said the resident sometimes refuses. During an interview on 09/26/25, at 2:28 P.M., the Director of Nursing (DON) said he/she does not believe the resident has refused RT. 2. Review of Resident #72's Face Sheet showed the following:-admission date of 11/08/24;-Diagnoses included complete amputation at knee level. Review of resident's care plan dated 06/11/25, showed the following:-Resident had an ADL self-care performance deficit due to recent below the knee amputation;-Resident required assistance for ADL's, transfers, and mobility using Hoyer lift (mechanical lift for non0weightbearing (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents) and wheelchair;-Resident will improve current level of function in all ADL's through the next review date. Review of resident's care plan meeting summary, dated 06/12/25, showed not applicable (N/A) for therapy concerns. Review of resident's care plan meeting summary, dated 09/09/25, showed no information next to therapy concerns. Review of resident's Restorative Nursing screener, section GG of the MDS, dated [DATE], showed the following:-Self-Care: Unknown;-Indoor Mobility (Ambulation): Unknown;-Stairs: Unknown;-Functional Cognition: Unknown;-Manual wheelchair;-Mechanical lift;-Resident was able to effectively communicate using their current method(s);-Resident was currently not receiving rehabilitation therapy;-No comments noted. Review of resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Resident was dependent on staff for bathing, personal hygiene, and mobility;-No restorative therapy indicated. Review of the resident's Physician Order Sheet (POS), current as of 09/26/25, showed staff did not note orders for restorative therapy. During an interview on 09/22/25, at 3:02 P.M., the resident said the following:-He/she was supposed to received RT;-He/she has a contracture and has pain;-He/she and her family have requested RT in the last two care plan meetings. During an interview on 09/25/25, at 2:14 P.M., the resident's next of kin (NOK) said at the resident's care plan meeting in June 2025, they requested restorative therapy. At the care plan meeting in September 2025, they asked again about restorative therapy and were told the resident would be put on the list. Last week, they asked the restorative aide and were informed the resident was not on the list. The resident's ankle is declining and becoming contracted. During an interview on 09/25/25, at 3:18 P.M., RA H said the resident did not receive RT. During an interview on 09/26/25, at 12:39 P.M., the Assistant Director of Nursing (ADON), said the following:-The resident's next of kin asked yesterday about him/her receiving RT;-The ADON spoke to the RA and he/she advised the resident was not on the list;-The ADON does not know if RT was addressed in the resident's care plan meetings as he/she does not attend. During an interview on 09/26/25, at 1:30 P.M, the MDS Coordinator said he/she did not recall the resident or his/her family requesting RT during their care plan meeting. During an interview on 09/26/25, at 2:28 P.M., the DON said he/she was unsure if the resident had requested RT. 3. Review of Resident #75's face sheet showed the following:-admission date of 04/24/25;-Diagnoses included chronic pain syndrome. Review of the resident's form titled Restorative Hand-Off Form, dated 06/17/25, showed the following:-Tentative therapy discharge on [DATE];-Diagnosis of weakness;-Interventions included active ROM and transfer training/ balance;-Specific tasks included bilateral upper and lower extremity, strength exercises with 0 to 1 pound and sitting balance on edge of bed. Review of the resident's POS, current as of 09/26/25, showed an order, dated 09/10/25, for activity as tolerated. Review of the resident's baseline care plan, dated 09/10/25, showed the following:-Resident required two-person physical assist for transfers;-Resident used a wheelchair for mobility;-Physical therapy goal was to improve functional status through restorative nursing. Review of the resident's significant change in condition MDS, dated [DATE], showed the following:-Moderate cognitive impairment;-Use of wheelchair;-Dependent of staff for toileting hygiene, showering;-Required substantial to moderate assistance for dressing, personal hygiene. Review of the restorative aide notebook, undated, showed the following:-Sheet dated 08/18/25 to 08/23/25, with 08/19/25 note of resident sat on edge of bed for 5 minutes;-Sheet dated 08/25/25 to 08/30/25, with 08/27/25 notes of ROM upper extremity active, ROM lower extremity active, upper extremity exercise with no weight, lower extremity with no weights;-Sheet dated 09/01/25 to 09/06/25 marked as at the hospital;-Sheet dated 09/07/25 to 09/12/25 no marks as completed or not (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed;-Sheet dated 09/21/25 to 09/23/25 showed transfers to be done three times per week with no marks of completed or not completed;-Sheet dated 09/14/25 to 09/20/25, no marks of completed or not completed; During an interview on 09/24/25, at 1:30 P.M., the resident said that he/she would like to go and exercise. Staff used to do that with him/her. He/she could not make his/her leg work, but would really like to exercise. 4. During an interview on 09/25/25, at 2:30 PM Certified Nurse Aide (CAN) F said the following:-The RA was sometimes pulled to the floor to complete aide duties;-RT should be in the care plan. During an interview on 09/25/25, at 3:18 P.M., RA H said the following:-Residents receive RT three times per week;-Therapy notifies him/her who receives RT and he/she was provided with an updated list every 30 days;-Residents do not always receive RT three times per week;-He/she gets pulled to the floor to work as an aide;-He/she had started documenting refusals;-RT should be in a resident's care plan. During an interview on 09/26/25, at 9:45 A.M., Licensed Practical Nurse (LPN) I said he/she was unfamiliar with restorative therapy and believed therapy provides all services. During an interview on 09/26/25, at 10:02 A.M., LPN J said the following:-The facility utilized a RA;-He/she was unsure how often residents receive RT;-The RA gets pulled to the floor to perform aide duties;-RA should be documented in the care plan. During an interview on 09/26/25, at 12:39 P.M., the Assistant Director of Nursing (ADON) said the following:-He/she was unsure how often residents receive RT;-Residents can request RT or they can be referred by therapy; -The RA is sometimes pulled to the floor as an aide;-Some residents have voiced concerns due to not receiving RT;-RT should be documented in the care plan. During an interview on 09/26/25, at 1:30 P.M, the MDS Coordinator said RT should be documented in the care plan. During an interview on 09/26/25, at 2:28 P.M., the DON said the following:-Residents receive RT close to three days per week;-There is only one RA. If he/she was pulled to the floor to perform aide duties, residents do not receive RT;-The RA was pulled to work on the floor before the shower aide;-Residents can request RT, and will be assessed by therapy;-RT should be documented in the care plan. During an interview on 09/26/25, at 4:03 P.M., the Administrator said the following:-Residents should receive RT three times per week;-The RT gets pulled to the floor to work as an aide;-Residents can request RT, or they are recommended for RT after completing therapy;-RT should be documented in the care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to establish and maintain a complete infection control program when staff failed to use Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs - microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) per nursing standards of infection control during wound care for one resident (Resident #5), during urinary catheter (thin tube that remains in the bladder for continuous urine drainage, often held in place by a small balloon and connected to a collection bag) care for one resident (Resident #67), and during medication administration via peg tube for one resident (Resident #12). The facility census was 77. Based on observation, record review, and interview, the facility failed to establish and maintain a complete infection control program when staff failed to use Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs – microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) per nursing standards of infection control during wound care for one resident (Resident #5), during urinary catheter (thin tube that remains in the bladder for continuous urine drainage, often held in place by a small balloon and connected to a collection bag) care for one resident (Resident #67), and during medication administration via peg tube for one resident (Resident #12). The facility census was 77. Review of the facility provided policy titled Enhanced Barrier Precautions, dated May 2024, showed the following:-EBPs employ target gown and glove use during high contact resident care activities when contact precautions do not otherwise apply;-Glove and gown are applied prior to performing the high contact resident care activity;-Personal protective equipment (PPE - equipment worn to minimize exposure to hazards include gown, gloves, face mask) is changed before caring for another resident;-Examples of high-contact resident care activities requiring use of gown and gloves for EBPs include dressing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheter, feeding tube, tracheostomy/ventilator) and wound care (any skin opening requiring a dressing);-EBPs are indicated of resident infected or colonized with methicillin-resistant staphylococcus aureus (MRSA - type of staph germ that has become resistant to many common antibiotics, making infections harder to treat);-EBPs are indicated for residents with wounds and/or indwelling devices regardless of MDRO colonization;-EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk;-The use of EBPs does not impose limitation on group activities or room restrictions for residents;-Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status;-Staff are trained prior to caring for residents on EBP;-Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required;-PPE is available outside of the resident rooms;-Residents, families and visitors are notified of the implementation of EBPs throughout the facility. 1. Review of Resident #5's face sheet showed the following:-admission date of 08/13/24;-Diagnosis included stage 3 pressure ulcer (full-thickness skin loss that extends into the subcutaneous tissue but does not involve muscle, tendon, or bone) of sacral region (area at the lower back, above the buttocks). Review of the resident's Physician Orders Sheet (POS), current as of 09/26/25, showed an order, dated 09/12/25, for sacral wound care. The orders did not address use of EBP. Review of the resident's annual assessment Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 07/25/25, showed the following:-Cognitively intact;-Resident had one or more unhealed pressure ulcer;-Resident had one (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stage 3 pressure ulcer that was not present on admission. Review of the resident's care plan, last updated 01/23/25, showed the following:-Resident had a stage 3 pressure wound to coccyx (tailbone);-Staff should provide treatment to coccyx as ordered daily;-Staff should document weekly treatment to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations(Staff did not care plan related to EBP.) Oservation on 09/24/25, at 8:35 A.M., showed the Assistant Director of Nursing (DON) and Certified Nurse Aide (CNA) B entered the resident's room. ADON and CNA provided incontinent care and wound care to the resident. Both wore gloves, but neither of them wore a gown. There was an EBP sign on the resident room door that advised staff to wear PPE, including gown and gloves, while working with the resident. During an interview on 09/25/25, at 2:40 P.M., Licensed Practical Nurse (LPN) A said EBP should be used with residents that have wounds. During an interview on 09/25/25, at 3:10 P.M., LPN E said EBP required staff to wear gown and gloves when providing care to residents that have any wound. During an interview on 09/25/25, at 3:20 P.M., the ADON said residents with wounds should be on EBPs. He/she should have worn a gown when completing wound care for Resident #5. During an interview on 09/26/25, at 2:27 P.M., the Director of Nursing (DON) said staff should follow the EBP policy for residents that have wounds. During an interview on 09/26/25, at 3:32 P.M., the Administrator said staff should wear gown, gloves, and mask if needed when providing cares for residents with wounds. 2. Review of the facility policy titled Urinary Catheter Care, September 20214, showed the following:-The purpose of this procedure is to prevent catheter-associated urinary tract infections;-Use standard precautions when handling or manipulating the drainage system;-Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. Review of Resident #67's face sheet showed the following:-admission date of 08/07/25;-Diagnoses included flaccid neuropathic bladder (nerve damage causes the bladder muscle to lose its ability to contract properly) and chronic kidney disease stage 3 (CKD – kidneys are damaged and can't filter blood the way they should, mild to moderate damage). Review of the resident's physician orders, current as of 09/26/25, showed the following:-An order, dated 09/05/25, to change foley (catheter) every shift starting on the first and ending on the fifth of every month and as needed for occlusion or leakage;-An order, dated 09/05/25, for urinary catheter care every shift.(Staff did not care plan related to EBP.) Review of the resident's admission MDS, dated [DATE], showed the following:-Cognitively intact;-Resident had an indwelling catheter. Review of the resident's care plan, last updated 09/11/25, showed the following:-The resident had an indwelling catheter for neurogenic bladder;-Staff should monitor and document for pain or discomfort due to catheter;(Staff did not care plan related to EBP.) Observation on 09/25/25, at 2:00 P.M., showed CNA B and CNA C entered the resident's room. The resident was seated in his/her wheelchair with a catheter bag under the wheelchair. There was an EBP sign on the resident's door advising staff to wear gown and gloves with resident cares. The staff washed hands at the sink and applied gloves. The staff did not apply gowns. The aides transferred the resident, emptied the resident's catheter bag and provided catheter care, and removed the resident's shoes and resident pants. During an interview on 09/25/25, at 2:20 P.M., Nurse Aide (NA) D said catheter care does not require a gown to be worn, only gloves. During an interview on 09/25/25, at 2:40 P.M., LPN A said EBP should be used with residents that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheters to protect the resident. During an interview on 09/25/25, at 3:10 P.M., LPN E said EBP required for staff to wear gown and gloves when providing care to residents that have any catheter. During an interview on 09/25/25, at 3:20 P.M., the Assistant Director of Nursing (ADON) said with catheters should be on EBPs. During an interview on 09/26/25, at 2:27 P.M., the DON said staff should follow the EBP policy for residents that have catheters. Staff should wear gown and gloves when providing care to a resident with a catheter. During an interview on 09/26/25, at 3:32 P.M., Administrator said staff should wear gown, gloves, and mask if needed when providing cares for residents with catheters. 3. Review of Resident #12's face sheet showed the following information:-admission date of 10/01/15;-Diagnoses included gastrostomy (tube inserted through the abdominal wall into the stomach to provide nourishment and/or medications. Review of the resident's quarterly MDS, dated [DATE], showed feeding tube present while a resident. Review of the resident's POS showed current orders for feeding tube care and administration of medication in feeding tube. Staff did not note any orders related to EBP. Review of the resident's care plan, last updated 07/25/25, showed resident required EBP due to PEG tube (feeding tube), post signage on the door or wall of the room indicating precautions for PPE, utilize PPE as indicated during cares, ensure standard precautions are used when handling PEG tube per facility protocol and provide treatment care to tube site as ordered and observe for signs/symptoms of infection at tube site. Observation on 09/25/25, at 11:45 A.M., showed LPN J used sanitizer and donned gloves, but did not don a gown. LPN J adjusted the resident's bed covers and clothing to expose the feeding tube site. He/she administered medication through the tube retrieved the administration tubing and syringe from a drawer, primed the tubing, During an interview on 09/26/25, at 11:35 A.M., LPN J said staff should wear both gown and gloves while performing any care or medication administration involving the resident2's G-tube. He/she had forgotten to don a gown prior to the antibiotic administration during the observation on 09/25/25. During an interview on 09/25/25, at 2:40 P.M., LPN A said EBP should be used with residents that have wounds tube feedings. Staff should wear a gown when completing medications by peg tube. During an interview on 09/25/25, at 3:10 P.M., LPN E said EBP is required for staff to wear gown and gloves when providing care to residents that have any tube feeding. During an interview on 09/26/25, at 3:32 P.M., Administrator said staff should wear gown, gloves, and mask if needed when providing cares for residents feeding or peg tube. 4. During an interview on 09/25/25, at 2:20 P.M., NA D said EBP signs mean the resident has a transmittable illness and staff should wear gown, gloves, and mask. During an interview on 09/25/25, at 2:30 P.M., CNA B said he/she would have to check with the nurse about the EBP signs. At previous facilities he/she had worked, they required staff to wear gown and gloves with catheter care and direct resident care for residents when there was an EBP sign. During an interview on 09/26/25, at 3:32 P.M., Administrator said staff should follow the EBP policy.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure each residents' representatives were notified timely of changes in condition when staff failed to notify one resident's (Residents #72) representatives regarding a change in condition and new orders. A sample of 26 residents was reviewed for notification of changes; the facility census was 77. Review showed the facility did not provide a policy regarding notification of resident representatives. 1. Review of Resident #72's Face Sheet (resident information) showed the following:-admission date of 11/08/24;-Diagnoses included complete amputation at knee level, anorexia, depression, anxiety, and heart failure;-Contact Emergency Contact (EC) #1 if any new orders are received or if a change in condition. Review of resident's care plan, dated 06/11/25, showed the following:-Resident has an ADL self-care performance deficit due to recent below the knee amputation;-Resident requires assistance for ADL's, transfers, and mobility using Hoyer lift and wheelchair;-Resident will improve current level of function in all ADL's through the next review date. Review of resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 09/12/25, showed the resident to be cognitively intact. Review of resident's progress note, dated 08/08/25, showed the following:-Physician group rounded this afternoon;-New order received for Midodrine (treats low blood pressure);-Order processed;-Resident informed;-Staff did not document EC notification. Review of resident's progress note dated 08/18/25, at 2:30 P.M., showed the following:-Resident with no further emesis (vomiting), but had some diarrhea;-PRN (as needed) Zofran (used to treat nausea) administered for continued nausea;-Resident refused all oral medication due to nausea;-Physician notified;-Staff did not document EC notification. Review of resident's progress note dated 08/18/25, at 6:57 P.M., showed the following:-Staff observed a small amount of pink urine present between the resident's legs during incontinent care;-Earlier physician contacted and requested a stool sample for C-Diff (a bacterium that can cause inflammation of the colon (colitis));-Staff did not document EC notification. Review of resident's progress note, dated 08/19/25, showed the following:-An order for ondansetron oral tablet disintegrating (used to treat nausea) 4 milligrams (mg);-Give one tablet by mouth three times a day for nausea for three days;-Staff did not document EC notification. Review of resident's progress note, dated 08/21/25, showed the following:-Optometry rounded on 08/20/25;-New orders received for Ocuvite (medication to support eye health);-Order processed;-Staff did not document EC notification. Review of resident's progress notes, dated 08/25/25, showed the following:-Physician group rounded this evening;-Received orders for urology referral and potassium daily;-Orders processed and resident aware;-Received order to resume apixaban (blood thinner), order resumed;--Staff did not document EC notification. Review of resident's progress note, dated 09/01/25, showed the following:-Resident with new order for Miralax (medication for constipation);-No gastrointestinal distress voiced;-Staff did not document EC notification. Review of resident's progress note, dated 09/05/25, showed the following:-Resident with small-moderate amount of bloody urine in brief;-Staff will continue to monitor;-Staff did not document EC notification. Review of resident's progress note, dated 09/11/25, showed the following:-Resident had gastric tube that was not being utilized for feedings/medication at this time;-Dressing change to site with a large amount of bloody discharge and gas escaping from the stoma (a surgically created opening on the abdomen);-Granulation tissue (wound healing tissue) appeared to be irritated causing slight bleeding;-No signs or symptoms of infection noted;-Staff will continue to monitor and report changes as needed;-Staff did not document EC notification. Review of resident's progress note, dated 09/14/25, showed the following:-Resident's feeding tube is leaking a large amount of brownish contents;-Dressing changed;-Area is slightly red and sore to the touch;-Staff did not document EC notification. Review of resident's progress note, dated 09/16/25, (continued on next page)

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	265464	A. Building B. Wing	12/17/2025

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the following:-Urine screen collected via catheter (tube used to drain urine from the bladder);-Staff did not document EC notification. Review of resident's progress note, dated 09/19/25, showed the following:-Physician rounded this afternoon;-Received orders for fortified and milk between meals;-Orders processed;-Resident aware;-Staff did not document EC notification. Review of resident's progress note, dated 09/24/25, showed the following:-Order for ciprofloxacin oral tablet (used to treat infection) 500mg;-Give one tablet by mouth two times a day for urinary tract infection for seven days;-Order for Imodium oral tablet 2mg;-Give one tablet by mouth three times a day for diarrhea for three days;-Staff did not document EC notification. During an interview on 09/22/25, at 2:35 P.M., with the resident and his/her next of kin (NOK) they said the following:-The NOK had requested the facility contact him/her regarding all medication changes and changes in the resident's condition;-The facility does not regularly contact the NOK concerning new orders or when a resident had a change in condition;-The facility will sometimes notify the NOK when he/she is in the facility, but that is often several days after the medication was ordered;-The NOK has voiced her concerns facility staff. During an interview on 09/26/25, at 2:28 P.M., the Director of Nursing (DON) said the resident's NOK had voiced concerns over not being notified. Most of the correspondence with the resident's NOK was through email, but it should be documented in the resident's record. During an interview on 09/26/25, at 4:03 P.M., the Administrator said he/she was not aware of any concerns regarding NOK notification concerning the resident. During an interview on 09/25/25, at 2:30 P.M., Certified Nursing Assistant (CNA) F said nurses notify the resident's NOK if the resident has a change in condition. This should be documented in the resident's progress notes. During an interview on 09/25/25, at 3:00 P.M., CNA G said nurses and possibly Certified Medication Technicians (CMT) notify the resident's NOK if there is a change. This information should be documented in the resident's notes. During an interview on 09/25/25, at 3:18 P.M., CNA H said NOK notifications are made by the nurses. During an interview on 09/25/25, at 4:38 P.M., CMT O said nurses notify families regarding resident concerns. Any contact with the family should be documented. During an interview on 09/26/25, at 9:45 A.M., Licensed Practical Nurse (LPN) I said nurses notify a resident's family anytime there are new orders or a change in condition. The contact is documented in the resident's progress notes. During an interview on 09/26/25, at 10:02 A.M., LPN J said nurses notify a resident's family when there is a change in condition or a medication change. This notification is documented in the progress notes. During an interview on 09/26/25, at 12:39 P.M., the Assistant Director of Nursing (ADON) said normally the Registered Nurse (RN) Supervisor would notify the family, but any nurse can made the contact. The NOK should be notified of medication changes or change in condition. The contact should be documented in progress notes. During an interview on 09/26/25, at 2:28 P.M., the DON said the resident's NOK should be notified of new medications or if there has been a change in condition. The floor nurse, or the nurse entering the order should contact the family. The contact should be documented in the resident's record. During an interview on 09/26/25, at 4:03 P.M., the Administrator said the resident's NOK should be notified of changes in condition or medication changes. The charge nurse normally contacts the NOK, but it could be the DON, whomever receives the new order. All notifications should be documented in the resident's progress notes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide appropriate oral care for one resident (Resident #12) who was dependent on staff for all activities of daily living. The facility census was 77.Review showed the facility did not provide a policy specific to assisting residents with oral care. 1. Review of Resident #12's face sheet showed the following information:-admission date of 10/01/15;-Diagnoses included right-sided weakness and paralysis following a stroke, history of transient ischemic attack (TIA - mini-stroke), unable to speak, gastrostomy (tube inserted through the abdominal wall into the stomach to provide nourishment and/or medications), muscle wasting, epilepsy/convulsions/seizures, low blood pressure, major depressive disorder, anxiety, difficulty swallowing, osteoporosis (weakening of bones), history of urinary tract infections (UTI), contracture, history of COVID-19, difficulty sleeping, and chronic pain. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 07/25/25, showed the following information:-Severely impaired cognition;-Range of motion impaired to upper and lower extremities, one sided;-Dependent on others for oral hygiene;-Feeding tube present while a resident. Review of the resident's care plan, last updated 07/25/25, showed the resident needed total assist with all activities of daily living (ADLs) related to right sided hemiplegia. Staff to do oral care every shift and after meals and as needed. Staff to provide appropriate oral care for moisture and hygiene throughout the day and night between brushings. During an interview on 09/22/25, at 12:15 P.M., the resident's family member said staff did not do daily oral care every shift, and sometimes not even daily. He/she said the resident often had horrible breath when he/she arrived to visit. The resident had his/her own supplies on hand, including an electric toothbrush and toothpaste. Observation on 09/25/25, at 10:00 A.M., showed the resident's breath was very malodorous. When the surveyor asked if the staff had cleaned his/her mouth that morning, the resident signed no. Observation on 09/26/25, at 10:30 A.M., showed the resident's breath was malodorous. When the surveyor asked if the staff had cleaned his/her mouth and teeth that morning, the resident signed no. When asked if he/she wanted that done, the resident signed yes. During an interview on 09/26/25, at 12:10 P.M., Licensed Practical Nurse (LPN) J said the staff should really be doing more oral care for the resident. The aides should do the care every day. During an interview on 09/26/25, at 12:14 P.M., Certified Mediation Technician (CMT) V said the resident usually cooperates with him/her regarding care. The floor aides don't usually do the oral care; it is done by the shower aide on Mondays, Wednesday, and Fridays. During an interview on 09/26/25, at 1:45 P.M., Certified Nurse Aide (CNA) F said the resident had an electric toothbrush provided by the resident's family. The shower aide does the oral care on shower days, or the resident's family does the care. The other aides should probably do oral care, too. The resident will allow the aides to do oral care if his/her family isn't present. During an interview on 09/26/25, at 1:54 P.M. LPN I said for residents who need assist, oral care should be done after mealtime. During an interview on 09/26/25, at 2:28 P.M., the Director of Nursing (DON) said the aides or nurses should do oral care for residents at least every shift. The DON said the resident bites down on the toothbrush and doesn't always like the care, but the CNA's should try to do it anyway. During an interview on 09/26/25, at 3:52 P.M., the Administrator said staff should assist residents as needed with oral care at least every morning and every evening, including the resident. Oral care should be done by the CNAs unless the care is specified to be done by the nurse.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities when staff failed to provide preferred activities to one resident (Resident #72) who voice importance of attending activities. The facility census was 77. Review showed the facility did not provide a policy related to activities. 1. Review of Resident #72's face sheet (resident information) showed the following:-admission date of 11/08/24;-Diagnoses included complete amputation at knee level, anorexia, depression, anxiety, and heart failure. Review of resident's Activities-Initial Review Assessment, dated 11/11/24, showed the following:-Resident liked to read, watch TV, and do puzzles;-Resident attended church services in the community, and it was unknown if he/she would like clergy visits in the facility;-Resident did not wish to participate in activities in the facility. Review of resident's care plan, dated 02/17/25, showed the following:-Resident had little or no activity involvement;-Resident came to activities per his/her choice;-Resident liked to attend church services or stay in his/her room and watch TV;-Modify daily schedule and treatment plan as needed (PRN) to accommodate activity participation as requested by the resident. Review of resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/20/25, showed the following:-Cognitively intact;-Resident was dependent on staff for bathing, personal hygiene, and mobility;-Preference of listening to music was very important;-Preference of being around animals was important;-Preference in participating in favorite activities was very important;-Preference in going outside to get fresh air was important;-Preference in participating in religious services or practices was important. Review of the facility's August 2025 Activity Calendar showed the following:-Bingo every Monday, Wednesday, and Friday at 2:00 P.M.;-Bible study every Tuesday at 10:00 A.M.;-On 08/08/25, zoo program;-On 08/14/25, gospel music;-On 08/21/25, a music program. Review of resident's Activity Notes dated August 2025, showed the following:-The Daily Chronicle (facility newsletter) was delivered to the resident every Monday-Friday;-The Activity Director (AD) conducted room visits once per week (varied days);-On 08/12/25, resident had his/her nails done;-On 08/19/25, resident declined to have her nails done.(Staff did not document offering the resident the opportunity to attend bible study, zoo program, or music programs.) Review of resident's Activities-Quarterly/Annual Participation Review, dated 09/09/25, showed the following:-Resident preferred to stay in bed, but did agree to try to come to more activities, maybe bingo or music;-Activity related focus remained appropriate/current as per current care plan;-Activity goals were met;-Activity interventions/approaches had been effective in reaching goals;-Unknown if assistance should be provided to get the resident to the activity. Review of the facility's September 2025 Activity Calendar showed the following:-Bingo every Monday, Wednesday, and Friday at 2:00 P.M.;-Church every Tuesday and Wednesday at 10:00 A.M.;-On 09/05/25 and 09/18/25, a music program was held. Review of resident's Activity Notes dated September 2025, showed the following:-The Daily Chronicle was delivered to the resident every Monday-Friday;-On 09/02/25, the AD conducted a room visit;-On 09/16/25, resident had his/her nails done.(Staff did not document offering the resident the opportunity to attend church or music programs.) During an interview on 09/22/25, at 2:13 P.M., the resident said staff never ask or notify him/her of activities. He/she would at least like to go to bingo. During an interview on 09/24/25, at 1:15 P.M., the resident said staff had not asked if he/she would like to go to bingo today (2:00 P.M. start time). During an interview on 09/24/25, at 2:47 P.M., the resident said staff did not offer to take him/her to bingo. During an interview on 09/25/25, at 2:14 P.M., the resident said staff had not come by his/her room to notify him/her of any activities for the day. During an interview on 09/25/25, at 2:30 P.M., Certified Nurse Aide (CAN) F said the following:-He/she believed the resident was asked by staff if they would like to attend activities, however, he/she does not attend;-He/she did not know if the resident's activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participation or refusals was documented. During an interview on 09/25/25, at 3:00 P.M., CNA G said he/she was not aware if the resident attended activities. During an interview on 09/25/25, at 3:18 P.M., CNA H said he/she believed the resident was invited to activities. During an interview on 09/25/25, at 4:38 P.M., Certified Medication Technician (CMT) O said the resident had started getting up more, but was unsure if he/she was attending activities. During an interview on 09/26/25, at 11:15 A.M., the Activities Director (AD) said the following: -The resident enjoyed watching tv and reading;-The resident would participate in pet therapy;-He/she believed the resident was invited to attend the music program last week, but refused;-The resident was often tired after lunch;-He/she was unsure if staff had asked the resident if he/she would like to attend bingo. During an interview on 09/25/25, at 2:30 P.M., CNA F said staff remind residents in the morning of the daily activities. The activities calendar was posted in the hallways. During an interview on 09/25/25, at 3:00 P.M., CNA G said the following:-Activity sheets were passed out to all residents;-Staff invited resident to activities;-Activity preferences should be listed in the care plan. During an interview on 09/25/25, at 3:18 P.M., CNA H said the following:-Residents should have an activity calendar posted in their room;-CNAs notified residents of activities and offered assistance;-Activity preferences should be documented in the care plan. During an interview on 09/25/25, at 4:38 P.M., CMT O said the following:-Residents were notified of activities through calendars placed on their doors and around the facility;-Staff reminded residents of activities, especially of the popular ones;-Activities preferences should be in the care plan. During an interview on 09/26/25, at 9:45 A.M., Licensed Practical Nurse (LPN) I said the following:-Activities were posted on the bulletin board;-Aides ask residents if they would like to attend activities;-Activity preferences should be in the care plan. During an interview on 09/26/25, at 10:02 A.M., LPN J said the following:-Activities were posted in hallway and a printout is provided to residents;-Activities staff come by resident rooms in the morning and check if there were any activities the resident wanted to attend that day;-CNAs also ask residents if they would like to attend activities. During an interview on 09/26/25, 11:15 A.M., AD said the following:-He/she would discuss with residents their activity preferences and complete the activity assessment;-Preferences are placed in the care plan, and he/she also kept information about preferences; -He/she distributed a monthly calendar to residents and also wrote it on the window in the activities area;-He/she passed out the Daily Chronicle and would advise residents of the upcoming activities for the day;-If a resident showed interest in that day's activities, prior to the activity, he/she would remind the resident and would ask if they need assistance to the activity. If assistance was needed, he/she would inform the aides;-If an aide knew a resident liked to attend a certain activity, they invited them to the activity;-He/she checked in with residents and encouraged residents to attend;-If the resident did not want to attend group activities, he/she would offer a one-on-one activity with the resident; -He/she only documented if a resident refuses a one-on-one meeting. During an interview on 09/26/25, at 2:28 P.M., the Director of Nursing (DON) said the following: -Activity preference was obtained by conducting an activity assessment;-The AD should be discussing activity preferences with the residents;-Activity calendars are posted in resident rooms and at the nurses' station;-The AD will walk around the building and ask residents if they would like to attend;-CNAs can ask residents if they would like to attend activities;-If staff are aware of a resident's activity preference, they should ensure the resident is invited to that activity;-Refusals to attend activities should be documented. During an interview on 09/26/25, at 4:03 P.M., the Administrator said the following:-Activity preferences should be discussed at the resident's care plan meeting;-Residents should be encouraged to attend activities;-If a resident's activity preference change, it should be documented;-Activity calendars are provided to each resident;-Staff remind residents of upcoming activities;-The AD reminds residents of the daily activities when passing out the Daily Chronicle;-The AD highlights on a calendar what each resident attended;-He/she is unsure if the AD documents refusals.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure access to survey results to family, visitors, and residents when the prior survey results were not kept in a readily accessible, public location. The facility census was 77.Review showed the facility did not provide a policy regarding survey results accessibility. 1. Observation on 09/24/25, at 2:00 P.M. showed the following:-A white binder located behind the front desk, lying flat in a wire bin;-Two sets of public bathroom keys lying on top of the binder;-The height of the desk counter was approximately four feet tall;-The binder was not visible behind desk if seated in a wheelchair;-No signage was present notifying of the location of the survey results. During interviews on 09/22/25, at 9:58 A.M., during the resident council group meeting, the residents said they were unaware that they previous year's survey results were available for residents to review. None of the resident were aware of the location of the survey results in the facility. During an interview on 09/24/25, at 11:00 A.M., the Administrator said the facility does not currently have a receptionist at the front desk. During an interview on 09/25/25, at 2:30 P.M., Certified Nursing Assistant (CNA) F said he/she was unsure of the location of the survey results and would have to ask a nurse. During an interview on 09/25/25, at 3:00 P.M., CNA G said he/she does not know where survey results were kept. If a resident asked to see the results, he/she would ask the charge nurse. During an interview on 09/25/25, at 3:18 P.M., CNA H said if a resident asked to see the survey results, he/she would ask the Administrator where the results were located. During an interview on 09/26/25, at 9:45 A.M., Licensed Practical Nurse (LPN) I said he/she was unsure where the survey results were kept. He/she would ask the Assistant Director of Nursing (ADON) or the Director of Nursing (DON) for the location of the results. During an interview on 9/26/25, at 10:02 A.M., LPN J said he/she was unsure of the location of the survey results. He/she would ask the DON. During an interview on 09/26/25, at 2:28 P.M., the DON said survey results were kept in a binder behind the front desk. There was no signage indicating the location. During an interview on 09/26/25, at 4:03 P.M., the Administrator said the following:-The survey results were located behind the front desk;-The survey results used to be on top of the counter at the front desk, but the binder would disappear;-No residents have asked to view the survey results;-Residents often used the front restrooms, and could see the survey results under the bathroom keys;-No signage was present indicating the location of the survey results.