STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Nursing and Care Center	1486 North Riverside Rd 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the Department of Health and Senior Services (DHSS) within the required two hour timeframe when a staff member Certified Nursing Assistant (CNA) C allegedly witnessed CNA D being rough with one resident (Resident #1) and failed to report an allegation of misappropriation within the required twenty-four hour timeframe when staff received an allegation from one resident (Resident #2) of multiple personal items taken from his/her room. Seven residents were sampled. The facility census was 66. Review of the facility's policy titled Abuse and Neglect Definition and Policy, updated 11/27/17, showed the following: -Abuse is the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm or corporation; -A person commits the crime of financial exploitation of an elderly or disabled person if such person knowingly and by deception, intimidation, or force obtains control over the elderly or disabled person's property with the intent to permanently deprive the elderly or disabled person of the use, benefit or possession of his or her property thereby benefiting such person or detrimentally affecting the elderly or disabled person; -All allegations of abuse and neglect or allegations of neglect, exploitation or mistreatment, misappropriation of resident property, including Injuries of unknown origin Injury will be reported to the Administrator and Director of Nursing (DON) Immediately after an allegation is made; -All allegations of abuse and neglect or allegations of neglect, exploitation or mistreatment, and misappropriation of resident property that result In serious bodily Injury, will be reported to the State Survey Agency In accordance with federal requirement Immediately, but no later than 2 hours after an allegation Is made. If the alleged violation does not Involve abuse and does not result In serious bodily Injury It will be reported to the State Survey Agency In accordance with federal requirements no later than 24 hours. Investigation results will be provided to the State Survey Agency no later than 5 working days after reporting; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Any reasonable suspicion of a crime against a resident will be reported to the Administrator or DON immediately. Suspicious crimes Involving serious bodily Injury will be reported Immediately but no later than 2 hours to State Survey Agency and one or more law enforcement entitles. Suspicious crime that do not Involve serious bodily Injury will be reported to State Survey Agency and one or more law enforcement entitles no later than 24 hours. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admission date of 09/22/99; -Diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures (sudden, brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms)), severe intellectual disabilities and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy (a group of conditions that affect movement and posture) where all four limbs are affected, resulting in limited voluntary movement, muscle stiffness, and potentially other developmental disabilities like intellectual impairment, seizures, or vision/hearing/speech problems). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/26/24, showed the following: -The resident had severe cognitive impairment; -The resident was dependent on staff for activities of daily living (ADL - dressing, eating, bathing, etc.) with the exception of requiring maximum assist from staff for eating; -The resident required maximum assistance from staff to roll left and right, go from sitting to lying and lying to sitting. The resident was dependent on staff for transfers and wheelchair mobility. Review of the resident's care plan, revised 12/11/24, showed the following: -The resident was at risk for falls and required assistance with all ADLs. The resident had poor safety awareness and depended on staff for assistance with ADLs and safety precautions; -Provide care without judgement; -Provide space for increased participation at any time the resident desired; -Assist with cares at anytime while maintaining dignity and privacy; -Assist with dressing; -Continue to praise and encourage active participation without judging; -He/she was a two person assist with transfers with a Hoyer lift (mechanical lift); -He/she required moderate assistance with meals. He/she was dependent on staff for transfers, dressing, grooming, locomotion, toileting, hygiene and bathing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation, dated 03/15/25, completed by the former Administrator, showed the following: -On 03/15/25, at 2:02 P.M., the former Administrator became aware of a complaint against another CNA for yanking around a resident and being aggressive. The CNA was sent home and placed on suspension pending investigation. The former Administrator obtained written statements from the staff that was in the building at the time; -At 3:00 P.M., a full head to toe assessment was completed on the resident that showed a small circle on his/her right knee approximately 5 cm. by 5 cm; -On 03/16/25, several staff and residents were interviewed; -On 03/19/25, the investigation was completed and the conclusion of the investigation was that it was a personality conflict. CNA D had been an employee at the facility for nine years with no write-ups. The former Administrator provided abuse and neglect education to staff; -The former Administrator did not document reporting the allegation of abuse to DHSS. Review of the resident's nurse's progress note dated 03/15/25, at 3:30 P.M., showed staff completed a skin assessment. Skin was warm, dry, and intact. There was an approximately 5 centimeter (cm) by 5 cm circular red spot on the right knee cap that was blanchable (capable of becoming pale or white when pressed). The resident did not grimace or recoil when the area was touched. Review of CNA C's written statement, dated 03/15/25, showed the following: -He/she was working on B Hall with CNA D and CNA D was in a hateful mood; -CNA D kept having an attitude towards the residents and was upsetting them; -When he/she walked in to the resident's room, CNA D was yanking the resident around changing the resident and being aggressive; -He/she assisted CNA D with getting the resident into the Hoyer lift (mechanical lift) and the resident's chair. During an interview on 03/18/25, at 2:28 P.M., CNA C said the following: -On 03/15/25, at approximately 7:00 A.M., he/she entered the resident's room and saw CNA D on the mat in front of the resident and CNA D yanked the resident's legs over the CNA's shoulders and pulled the resident's pants and brief up hard. The CNA then put the resident's legs down and pushed the resident over on the resident's side and placed the Hoyer pad under the resident. The CNA then yanked the resident back over. He/she felt the CNA was tossing the resident around like a rag doll; -He/she left the hall and reported to the receptionist and the receptionist told him/her to tell the nurse. He/she reported to the receptionist within 30 minutes; -He/she reported the incident to the nurse after breakfast sometime after 8:00 A.M.; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse called the Administrator and the owner came to the facility immediately and took his/her statement. Review of Registered Nurse (RN) E's typed statement, dated 03/15/25, showed the following: -After CNA D left, CNA C informed the RN that CNA D was rude and disrespectful to him/her and the residents. CNA C said CNA D was aggressive with a resident when they were changing the resident. CNA C said that CNA D was yanking a non-verbal resident, putting the resident's legs up and over CNA D's shoulder with force and used force when he/she rolled the resident over. The CNA said it was like CNA D was throwing the resident around like a rag doll; -CNA C said he/she was scared to say something to anyone because he/she was a new staff member and did not want any confrontation; -The resident was okay when staff checked on him/her after the incident and appropriate personnel were notified. During an interview on 03/18/25, at 3:42 P.M., RN E said the following: -On 03/15/25, between 12:30 P.M. and 1:00 P.M., CNA C reported to him/her that CNA D was yanking on the resident, used force, and threw the resident around like a rag doll; -CNA C reported the incident happened before lunch; -CNA C should have reported the incident to him/her immediately; -CNA C said there was a conflict between him/her and CNA D and he/she was afraid to tell anyone about the incident; -He/she notified the former Administrator immediately and assessed the resident; -He/she had already sent CNA D home before the report. During an interview on 03/19/25, at 9:06 A.M., the Receptionist said the following: -On 03/15/25, CNA C reported to him/her around 10:00 A.M. that CNA D was being rude to CNA C and he/she told the CNA to report this to the nurse; -Around 12:00 P.M., the CNA told him/her that CNA D was being rough with the resident when they were changing the resident and he/she told the CNA to report this to RN E. The CNA did not say what time the incident occurred. Review of DHSS records showed the facility self-reported the allegation of abuse on 03/15/25 ,at 4:15 P.M. (over two hours after the CNA was aware of the potential abuse). During an interview on 03/19/25, at 10:52 A.M., the Social Services Designee (SSD) said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not know what time CNA C witnessed the incident between CNA D and the resident; -He/she went with the former Administrator to assess the resident between 1:00 P.M. and 3:00 P.M. on 03/15/25; -CNA C should have immediately reported to the charge nurse. During an interview on 03/19/25, at 12:00 P.M., the former Administrator said the following: -CNA C told him/her about the incident involving the resident and CNA D on 03/15/25, at 2:02 P.M. and said the incident happened that morning; -CNA C did not report the incident immediately. 2. Review of Resident #2's face sheet showed the following: -admitted on [DATE]; -The resident had a responsible party; -Diagnoses included respiratory infection, diabetes and chronic cough. Review of the resident's significant change MDS, dated [DATE], showed the following: -The resident was cognitively intact; -The resident required set up assistance from staff for eating and oral hygiene and substantial to total assistance for all other ADLs; -The resident used a wheel chair for mobility and required moderate to total assist from staff for transfers and bed mobility. Review of the resident's care plan, updated 03/13/25, showed the following: -The resident required limited to extensive assist with ADLs; -Provide care without judgement; -Provide space for increased participation at anytime the resident desired; -Assist with bathing as needed; -Assist with dressing as needed; -Continue to praise and encourage active participation without judging; -The resident required limited to extensive assistance with dressing, bathing, transfers, toileting and personal hygiene and limited assist for all transfers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Grievance Form dated 03/13/25, at 8:38 A.M., showed the following: -The resident filed a grievance that one lip balm was removed from a closed set, three sharpies missing from a zipper bag bag that had ten in it to begin with, and about ten teddy bears and stuffed animals had gone missing; -The grievance was reported to the DON, Administrator, and all management staff on 03/13/25 and was not reportable to an outside agency; -The grievance was resolved on 03/13/25, at 12:15 P.M. The resident came up to the SSD office asking him/her for help to connect his/her computer to the wifi. The internet was working by the time him/her and the resident got back to the resident's room. The SSD saw right below the resident's computer screen in a small white porcelain dish was the fanta lipstick that was missing from the pack. The resident said that was from the old set and he/she had the SSD look at it. The SSD opened the lid and twisted the bottom up showing it had barely been used. The resident said it was still the old one and not the new one. The SSD could still see the straight edge of the lip balm showing barely used. During an interview on 03/20/25, at 8:44 A.M., the resident said the following: -He/she had several items including clothing, skin care items, electric toothbrushes, nail clippers and stuffed animals taken from his/her room; -He/she reported this to the former Administrator within the past 2 to 3 months and the former Administrator told him/her to make a list of items and then never followed up with him/her; -He/she thought a staff member took his/her belongings but did not know who it was. During an interview on 03/20/25, at 9:47 A.M., the SSD said the following: -The resident reported someone took his/her stuffed animals and red fanta lip balm; -The resident reported items were disappearing from his/her room, but since the resident did not see the items taken or who took the items, the SSD put the resident reported items missing on the grievance form on 03/13/25; -He/she found a tube of red fanta lip balm in the resident's room and the resident said it was an old stick; -He/she reported this to the Administrator and DON in the morning meeting; -He/she did not report the allegation of misappropriation to DHSS; -The report of the stuffed animals should have been reported to DHSS, but not the lip balm. He/she did not know how long the facility had to report misappropriation. During an interview on 03/20/25, at 10:05 A.M., the Administrator said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The former Administrator did not notify him/her about the resident's report of misappropriation; -If the resident reported items disappearing from his/her room, he/she considered this misappropriation and the allegation should have been reported to DHSS. 3. During an interview on 03/18/25, at 1:52 P.M., CNA F said if he/she witnessed abuse, he/she immediately reported to the charge nurse. The Administrator reported to DHSS within two hours. During an interview on 03/18/25, at 2:06 P.M., CNA G said if he/she witnessed abuse, he/she notified the charge nurse immediately. The DON reported to DHSS within 24 hours. During an interview on 03/18/25, at 2:28 P.M., CNA C said if he/she witnessed abuse, he/she reported to his/her supervisor immediately. The DON or Administrator reported to DHSS within 24 hours. During an interview on 03/18/25, at 4:06 P.M., CNA H said if he/she witnessed abuse, he/she reported to the charge nurse immediately. The DON reported to DHSS within 2 hours. During an interview on 03/18/25, at 4:14 P.M., CNA D said if he/she witnessed abuse, he/she reported to the charge nurse immediately. The Administrator reported to DHSS within 2 hours. During an interview on 03/20/25, at 11:06 A.M., CNA J said if a resident reported misappropriation, he/she reported to the charge nurse immediately and helped the resident look for the item. The Administrator reported allegations of abuse to DHSS within 2 hours. During an interview on 03/19/25, at 9:06 A.M., the receptionist said if he/she witnessed abuse, he/she reported immediately to the charge nurse. The Administrator reported to DHSS within 2 hours. During an interview on 03/19/25, at 9:54 A.M., Certified Medication Tech (CMT) I said if a resident reports misappropriation, he/she reported to the charge nurse immediately and the Administrator or DON reported to DHSS within 2 hours. If he/she witnessed abuse, he/she reported to the charge nurse immediately. The Administrator or DON reported to DHSS within 2 hours. During interviews on 03/19/25, at 10:15 A.M. and on 03/20/25, at 12:30 P.M., Licensed Practical Nurse (LPN) A said if a CNA witnessed abuse, they reported to the charge nurse immediately. He/She reported to the DON and the DON reported to DHSS within 2 hours. If a resident reported misappropriation, he/she reported this to the Administrator and made a nurse's progress note about the resident's report. The DON reported to DHSS within 2 hours. During interviews on 03/19/25, at 11:39 A.M., and on 03/20/25, at 11:26 A.M., LPN B said if a staff member witnessed abuse, they reported to the charge nurse immediately. The charge nurse reported to the DON or Administrator immediately and the DON or Administrator reported to DHSS immediately. If a resident reported misappropriation, he/she reported this to the SSD and the SSD or Administrator reported to DHSS. He/She did not know how long the facility had to report misappropriation to DHSS. During an interview on 03/18/25, at 3:42 P.M., RN E said if staff witnessed abuse, they reported immediately to the charge nurse who then immediately reported to the Administrator. The Administrator reported to DHSS within 2 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 03/19/25, at 10:52 A.M., and on 03/20/25, at 9:47 A.M., the SSD said the following: -If staff witnessed abuse they immediately reported to the charge nurse. The charge nurse reported to the DON or Administrator and they reported to DHSS within 2 hours; -If a resident had an allegation of misappropriation, he/she completed a grievance form and reported to the Administrator; -All allegations of misappropriation should be reported to DHSS, but he/she did not know how much time the facility had to report allegations of misappropriation. During an interview on 03/19/25, at 12:00 P.M., the former Administrator said he/she reported to DHSS within 2 hours. The DON was responsible for ensuring nursing staff knew when to report allegations of abuse, but he/she was ultimately responsible for ensuring all staff knew abuse and neglect policies. During interviews on 03/20/25, at 8:20 A.M., 10:05 A.M., and 1:24 P.M., the Administrator said the following: -All allegations of abuse and misappropriation should be reported to DHSS within 2 hours; -If a staff member witnessed abuse, they should report to the charge nurse immediately. The charge nurse reports to the DON or Administrator and they reported to DHSS within 2 hours. MO00251130, MO00251329

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to take steps to protect all residents after staff failed to report that a staff member (Certified Nursing Assistant (CNA) D) acted in an abusive manor by roughly caring for one resident (Resident #1) and the CNA continued to work independently with residents. The facility also failed to investigate an allegation of misappropriation of property for one resident (Resident #2). Seven residents were sampled and the facility census was 66. Review of the facility's policy titled Abuse and Neglect Definition and Policy, updated 11/27/17, showed the following: -The Administrator or his/her designated representative will immediately initiate a thorough investigation after an allegation is made; -The results of the investigation will be reported to State Survey Agency within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action will be taken; -Any employee with allegations of abuse will immediately be placed on unpaid suspension until conclusion of the investigation. If an abuse complaint is substantiated, the employee will be terminated per employer policy; -Appropriate concerns will be hot-lined to the Missouri Department of Health and Senior Services (DHSS) and local law enforcement; -Residents will be removed from harm and protected, according to circumstances of report. 1. Review of Resident #1's face sheet, a document that gives a patient's information at a quick glance, showed the following: -admission date of 09/22/99; -Diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures (sudden, brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms)), severe intellectual disabilities and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy (a group of conditions that affect movement and posture) where all four limbs are affected, resulting in limited voluntary movement, muscle stiffness, and potentially other developmental disabilities like intellectual impairment, seizures, or vision/hearing/speech problems. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 10/26/24, showed the following: -The resident had severe cognitive impairment; -The resident was dependent on staff for Activities of Daily Living (ADL - dressing, eating, bathing, etc.) with the exception of requiring maximum assist from staff for eating; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident required maximum assistance from staff to roll left and right, go from sitting to lying and lying to sitting. The resident was dependent on staff for transfers and wheelchair mobility. Review of the resident's care plan, revised 12/11/24, showed the following: -Provide care without judgement; -Provide space for increased participation at any time the resident desired; -Assist with cares at anytime while maintaining dignity and privacy; -Assist with dressing; -Continue to praise and encourage active participation without judging; -He/she was a two person assist with transfers with a Hoyer lift (mechanical lift).\; -He/she was dependent on staff for transfers, dressing, grooming, locomotion, toileting, hygiene and bathing. Review of the facility's investigation, dated 03/15/25, completed by the former Administrator, showed the following: -On 03/15/25, at 2:02 P.M., the former Administrator became aware of a complaint against another CNA yanking around a resident and being aggressive. The CNA was sent home and placed on suspension pending investigation. The former Administrator obtained written statements from the staff that was in the building at the time. Review of the resident's nurse's progress notes showed the following: -On 03/15/25, at 3:30 P.M., staff completed a skin assessment. Skin was warm, dry, and intact. There was an approximately 5 centimeter (cm.) by 5 cm. circular red spot on the right knee cap that was blanchable (capable of becoming pale or white when pressed). The resident did not grimace or recoil when the area was touched. Review of the facility's abuse investigation, received 03/19/25, showed the allegation was made after CNA D had left the facility; Review of Registered Nurse (RN) E's typed statement, dated 03/15/25, showed the following: -RN E was notified of a staffing issue related to CNA D stating he/she was going to lunch and then leaving; -After CNA D left, CNA C informed the RN that CNA D was rude and disrespectful to him/her and the residents. CNA C stated that CNA D was aggressive with a resident whey they were changing the resident. CNA C said that CNA D was yanking a non-verbal resident, putting the resident's legs up and over CNA D's shoulder with force and used force when he/she rolled the resident over. The CNA said it was like CNA D was throwing the resident around like a rag doll; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C said he/she was scared to say something to anyone because he/she was a new staff member and did not want any confrontation. During an interview on 03/18/25, at 3:42 P.M., RN E said on 03/15/25, between 12:30 P.M. and 1:00 P.M., CNA C reported to him/her that CNA D was yanking on the resident and used force and threw the resident around like a rag doll; -He/she had already sent CNA D home before the report. Review of CNA C's written statement, dated 03/15/25, showed he/she knew the resident needed to still get up so he/she headed to the resident's room. When he/she walked in, CNA D was yanking the resident around changing the resident and being aggressive . He/she assisted CNA D with getting the resident into the Hoyer lift and the resident's chair. During an interview on 03/18/25, at 2:28 P.M., CNA C said the following: -On 03/15/25, at approximately 7:00 A.M., he/she entered the resident's room and saw CNA D on the mat in front of the resident and CNA D yanked the resident's legs over the CNA's shoulders and pulled the resident's pants and brief up hard. The CNA then put the resident's legs down and pushed the resident over on the resident's side and placed the Hoyer pad under the resident. The CNA then yanked the resident back over. He/she felt the CNA was tossing the resident around like a rag doll; -The nurse asked CNA D to leave the facility around 11:00 A.M. During an interview on 03/19/25, at 10:52 A.M., the Social Services Designee (SSD) said he/she did not know what time CNA C witnessed the incident between CNA D and the resident. CNA C should not have allowed CNA D to continue caring for the resident. CNA D should have been sent home immediately and not cared for residents until lunch time. During an interview on 03/19/25, at 12:00 P.M., the former Administrator said the following: -CNA C told him/her about the incident involving the resident and CNA D on 03/15/25, at 2:02 P.M. and said the incident happened that morning; -CNA D remained in the building until some time between 12:00 P.M. and 12:30 P.M.; -CNA C was on B hall with CNA D until 11:20 A.M. and then CNA D was alone on the hall until he/she left the facility; -The residents were technically not protected due to CNA D continuing to provide cares after CNA C observed the incident. During an interview on 03/20/25, at 1:24 P.M., the Administrator said the following: -CNA C should not have allowed CNA D to continue caring for the resident and CNA D should not have stayed in the facility caring for other residents; -When CNA D left the facility, the CNA was not sent home due to an allegation of abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Ozark Nursing and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1486 North Riverside Rd Ozark, MO 65721	

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-The grievance was resolved on 03/13/25 at 12:15 P.M. The resident came up to the SSD office asking him/her for help to connect his/her computer to the wifi. The internet was working by the time him/her and the resident got back to the resident's room. The SSD saw right below the resident's computer screen in a small white porcelain dish was the fanta lip balm that was missing from the pack. The resident said that was from the old set and he/she had the SSD look at it. The SSD opened the lid and twisted the bottom up showing it had barely been used. The resident said it was still the old one and not the new one. The SSD could still see the straight edge of the lip balm showing barely used.

During an interview on 03/20/25, at 8:44 A.M., the resident said the following:

-He/she had several items including clothing, skin care items, electric toothbrushes, nail clippers and stuffed animals taken from his/her room;

-He/she reported this to the former Administrator within the past 2 to 3 months and the former Administrator told him/her to make a list of items and then never followed up with him/her;

-He/she thought a staff member took his/her belongings but did not know who it was.

During an interview on 03/20/25, at 9:47 A.M., the SSD said the following:

-The resident reported someone took his/her stuffed animals and red fanta lip balm;

-The resident reported items were disappearing from his/her room, but since the resident did not see the items taken or who took the items, the SSD put the resident reported items missing on the grievance form on 03/13/25;

-The Administrator or DON should have investigated the allegation, but he/she did not know if this was done.

During interview on 03/20/25, at 10:05 A.M. and 1:24 P.M., the Administrator said the following:

-The former Administrator did not notify him/her about the resident's report of misappropriation;

-If the resident reported items disappearing from his/her room, he/she considered this misappropriation and an investigation should have been initiated immediately;

-The former Administrator did not complete an investigation.

3. During an interview on 03/18/25, at 1:52 P.M., CNA F said if he/she witnessed abuse, he/she got the resident to safety.

During an interview on 03/18/25, at 2:06 P.M., CNA G said if he/she witnessed abuse, he/she got the resident to safety.

During an interview on 03/18/25, at 2:28 P.M., CNA C said if he/she witnessed abuse, he/she protected the resident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/18/25, at 4:06 P.M., CNA H said if he/she witnessed abuse, he/she intervened. During an interview on 03/18/25, at 4:14 P.M., CNA D said if he/she witnessed abuse, he/she protected the resident. During an interview on 03/20/25, at 11:06 A.M., CNA J said if a resident reported misappropriation, the Administrator investigated. During an interview on 03/19/25, at 9:06 A.M., the receptionist if he/she witnessed abuse, he/she protected the resident. During an interview on 03/19/25, at 9:54 A.M., Certified Medication Tech (CMT) I said if a resident reported misappropriation, the Administrator or DON completed an investigation. If he/she witnessed abuse, he/she separated the resident from the abuser. During interviews on 03/19/25, at 10:15 A.M., and on 03/20/25, at 12:30 P.M., Licensed Practical Nurse (LPN) A said if a CNA witnessed abuse, they should remove the staff member. The accused staff member should be either removed from the hall or the building immediately. If a resident reported misappropriation, the Administrator completed an investigation. During interviews on 03/19/25, at 11:39 A.M., and on 03/20/25, at 11:26 A.M., LPN B said if a staff member witnessed abuse, they should protect the resident. The staff member who witnessed the abuse should not go on and assist the accused party with cares. They should separate and get the resident to safety and then the accused party was suspended immediately. If an incident happened before breakfast, the accused party should not be in the building until lunch time. The SSD investigated all allegations of misappropriation. During an interview on 03/18/25, at 3:42 P.M., RN E said if staff witnessed abuse, they should intervene. During interviews on 03/19/25, at 10:52 A.M., and on 03/20/25, at 9:47 A.M., the SSD said if staff witnessed abuse they got the resident to safety. The Administrator investigated all allegations of misappropriation. During an interview on 03/19/25, at 12:00 P.M., the former Administrator said the following: -If staff witnessed abuse they should stop the abuse; -Staff who witnessed abuse should not assist the accused party with cares before reporting the incident; -An accused staff member was suspended immediately pending investigation; -He/she had not received any reports of misappropriation; -If he/she received a report of misappropriation, he/she started an investigation immediately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 03/20/25, at 8:20 A.M., 10:05 A.M., and 1:24 P.M., the Administrator said the following: -If he/she received an allegation of abuse, the staff member was suspended immediately and he/she started an investigation; -If he/she received an al legation of misappropriation, he/she started an investigation immediately. -Investigations included interviews with staff and residents, assessing the resident, notifying the resident's responsible party and physician and informing the resident and the resident's responsible party of the outcome of the investigation. MO00251130, MO00251329

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the current daily nurse staffing information in a clear and readable format and in a prominent place readily accessible to all residents and visitors. The facility census was 66. Review of the facility's Nursing Staff of Duty, undated, showed the form included the following; -Date, census, number of residents in house and number of residents in hospital; -Registered nurse (RN) hours; -RN and Licensed practical nurse (LPN) hours for 7:00 A.M. to 7:00 P.M. shift and 7:00 P.M. to 7:00 A.M. shift; -Certified medication technician (CMT) hours for 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 7:00 P. M., and 7:00 P. M. to 7:00 A.M. shifts; -Certified nursing assistant (CNA) and nursing assistant (NA) hours for 7:00 A.M. to 3:00 P.M., 3:00 P.M. to 7:00 P.M., 7:00 P.M. to 11:00 P.M. and 11:00 P.M. to 7:00 A.M. shifts; -Restorative Aide and Bath Aide hours. Observations on 03/17/25, at 11:05 P.M., on 03/18/25, at 10:27 A.M. and 12:23 P.M., and on 03/19/25, at 8:42 A.M., showed daily nurse staffing information posted on a clipboard near the front entrance across from the main office with sheets dated 02/19/25, 02/20/25, 02/23/25, 02/24/25, 03/02/25, 03/03/25, 03/04/25, 03/05/25, and 03/08/25. Observations on 03/19/25,, at 10:50 A.M. and 11:53 A.M., and on 03/20/25, at 8:25 A.M., showed the clipboard that held the daily nurse staffing information was empty with no daily nurse staffing posted. During an interview on 03/19/25, at 10:15 A.M., LPN A said the following: -Daily nurse staffing sheets were posted at the front of the facility by the receptionist desk; -C Wing night shift nurse completed the form at midnight daily; -Newly hired nurses may not know this was their responsibility; -The nurse responsible for training a new nurse on C Wing should educate them on when and how to fill the form and where to post the form; -The nurse staffing sheets on the clipboard should be current; -The Director of Nursing (DON) was responsible for ensuring the nurse staffing sheet was posted daily. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/19/25, at 11:39 A.M., LPN B said the following: -Daily nurse staffing sheets were posted in the front of the facility; -C Wing night nurses completed these daily at midnight; -The nurse staffing sheets posted should be current; -The front office staff and DON were responsible for ensuring the forms were completed daily. During an interview on 03/19/25, at 12:00 P.M., the former Administrator said the following: -The daily nurse staffing hours were posted on a clipboard across from the main office; -The form was filled out daily by the C Wing night shift nurse at midnight; -The form posted should be current; -The receptionist checked the form daily and if not completed, notified the nurses; -He/she was responsible for ensuring the form was completed daily. Review of the daily nurse staffing hours in a binder at the receptionist desk showed no forms for 02/21/25, 02/22/25, 02/25/25 through 03/01/25, 03/06/25, 03/07/25, and 03/09/25 through 03/19/25. During an interview on 03/19/25, at 1:42 P.M., the Receptionist said the following: -The daily nurse staffing hours were posted on a clipboard across from his/her desk; -The night shift nurse completed this form daily; -He/she did not know who was responsible for checking them daily and had not been told this was one of the receptionist job duties. He/she just took them down and placed them in a binder; -The DON was responsible for ensuring the form was completed daily. During an interview on 03/20/25, at 1:24 P.M., the Administrator said the following: -The daily nurse staffing hours were posted on a clipboard by the front office; -The night shift nurses were responsible for completing these daily at midnight; -She was responsible for ensuring the forms were completed daily. MO00249185