

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  06/03/2025
NAME OF PROVIDER OR SUPPLIER  Ozark Nursing and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview, and record review, the facility failed to the resident's right to be free from physical and verbal abuse by staff when one staff member (Certified Nurses Aide (CNA) B) grabbed the arm and wrist of one resident (Resident #1) and cursed at this resident. A sample of seven residents was selected for review out of a facility census was 64.</p> <p>Review of the facility's Abuse and Neglect Policy and Procedure, undated showed the following:</p> <ul style="list-style-type: none"> <li>-It is the policy and the right of each resident to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms;</li> <li>-Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes the deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being;</li> <li>-Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking.</li> </ul> <p>Corporal punishment, which is physical punishment, used to connect or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object;</p> <p>-Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to the residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> <li>-admission date of 5/26/25;</li> <li>- Diagnoses included cancer, nutritional deficiency, dementia with agitation, depression, and Parkinson's (a progressive neurogenerative disorder that primarily affects the brains ability to control movement, leading to a range of motor and non-motor symptoms).</li> </ul> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's baseline care plan, dated 05/26/25 showed the following:</p> <ul style="list-style-type: none"> <li>-Resident had confusion;</li> <li>-Resident was elopement risk;</li> <li>-Resident had a history of falls;</li> <li>-Resident required help from staff for most activities of daily living;</li> <li>-Resident used a walker and wheelchair for mobility.</li> </ul> <p>Review of the resident's progress note dated 05/28/25, at 10:24 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-A nurse documented the resident was very agitated, exit seeking, and setting off the emergency exit door alarms;</li> <li>-Multiple attempts by staff to redirect were unsuccessful;</li> <li>-The resident struck a CNA in the face while attempting to redirect.</li> </ul> <p>Review of the facility's investigation, dated 05/31/25, showed the following:</p> <ul style="list-style-type: none"> <li>-On 05/28/25, the Assistant Director of Nursing (ADON) was notified at approximately 9:15 A.M. that CNA B said the resident, a new resident in Special Care Unit (SCU) had hit him/her;</li> <li>-The ADON went and spoke with CNA B who did not give more information than the resident hit him/her in the face. There was no redness or bruising noted. CNA B was moved from B to C wing at that time;</li> <li>-The ADON requested CNA B fill out an incident report and write a statement and notified the Administrator;</li> <li>-At approximately 1130 A.M., the Administrator instructed the Director of Nursing (DON) and the Maintenance Supervisor to look at the cameras surrounding the incident due to different stories and the staff walking out;</li> </ul> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At approximately 11:38 A.M., the DON asked the Administrator to come to the camera room to view the incident. When the Administrator viewed the cameras, it was seen that at approximately 9:00 A.M., on 05/28/25, the resident and CNA B were in the dining room on B wing. The resident, was in his/her wheelchair self-propelling and touching cups and dishes on the table. CNA B came into the dining room and told the resident Stop touching stuff, if you need something you need to ask. The resident continued to touch Items on the table and dish cart. CNA B repeatedly told the resident to stop and he/she physically removed his hands off of dishes, drink cart, etc. CNA B attempted to remove the resident from the dining room by pushing his/her wheelchair and the resident put his/her feet down to stop CNA B from moving him/her. CNA B removed the residents hands from the dish cart again and the resident responded, Fuck you bitch. CNA B responded fuck you too. CNA B then leaned down in front of the wheelchair to move the resident and the resident hit the CNA in the face. CNA B told the resident to stop and began pushing his/her arms away and grabbing his/her arms and trying to move him/her out of the dining room. CNA B eventually walked out of the dining room and the resident continued touching cups and plates on the drink cart and dining room table;</p> <p>-The Administrator completed self-report.</p> <p>Observation of the facility provided video showed the following:</p> <p>-Staff identified the resident as Resident #1 and the staff member as CNA B;</p> <p>-The resident was sitting in the dining room next to a cart;</p> <p>-CNA B approached the resident and said You want something on there you need to ask;</p> <p>-The CNA then began to move the resident's wheelchair without permission or explanation. The CNA said you need to get out, we need to clean;</p> <p>-The CNA continued to try and move the resident's wheelchair. The resident attempted to stop the CNA by placing his/her feet on the ground. The CNA's began to jerk the wheelchair in a attempt to move the resident. The CNA did so multiple times, including lifting up the front of the wheelchair so the reisdent's feet did not touch the ground;</p> <p>-The resident continued to resist and made a comment to the CNA. The CNA replied with fuck you;</p> <p>-During the process, the resident reached out to a different cart. The CNA pushed the resident arm abruptly back towards the resident and told the resident to stop;</p> <p>-The resident reached again and the CNA moved his/her arm abruptly and into the resident's lap. The CNA then began to try and grab/move the resident's feet/legs. The resident swung at the CNA;</p> <p>-The CNA reached out to slap at and grab both of the resident's hands said stop and that shit hurts;</p> <p>-The CNA tried to move the resident again, then walked out of the dining room saying I'm not playing you.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident resistant the CNA's actions and appeared irritated. The CNA did not ask for assistance or leave and reapproach.</p> <p>During an interview on 06/03/25, at 11:22 A.M., CNA B said the following:</p> <p>-Cursing at a resident would be considered verbal abuse;</p> <p>-Any physical redirection like holding/grabbing a resident's arm or hand or pushing a resident's arm or hand away would be considered abuse;</p> <p>-He/she did not like working in the special care unit (SCU);</p> <p>-The morning of 05/28/24, at around 9:00 A.M., breakfast was over so the staff had to get all the residents out of the dining room to clean up;</p> <p>-The resident sat in his/her wheelchair near a cart of dirty dishes in the dining room;</p> <p>-CNA B asked the resident to get out of the dining room;</p> <p>-The resident planted his/her feet on the floor and would not leave the dining room;</p> <p>-He/she tried to turn the resident around and he/she kept dragging his/her feet;</p> <p>-The resident started moving his/her arms and legs and tried to hit him/her and caught him/her off guard and hit him/her in the face;</p> <p>-He/she was irritated and grabbed the resident's arms and said please stop socking him/her and don't hit him/her;</p> <p>-He/she did not know what really happened after the resident socked him/her in the face;</p> <p>-The resident was cursing at him/her;</p> <p>-He/she denied cursing back at the resident;</p> <p>-Staff are not allowed to get physical with residents or curse at resident this would be considered abusive.</p> <p>During an interview on 06/03/25, at 1:52 P.M., Licensed Practical Nurse (LPN) A said CNA B would sometimes have an attitude toward staff members.</p> <p>During an interview on 06/03/25, at 3:41 P.M., Assistant Director of Nursing (ADON) said the following:</p> <p>-He/she reviewed the camera footage of CNA B and the resident and stated CNA B handled the situation wrong;</p> <p>-CNA B should have left the resident alone and not attempted to move him/her after he/she refused;</p> <p>(continued on next page)</p>		

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