

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  12/12/2025
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)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview and record review, the facility failed to maintain an ongoing monitoring process to include accurate documentation, destruction and accountability of expired or unusable medications, and failed to ensure medications that could not be returned to the pharmacy were destroyed in a timely manner for 34 residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34). The facility census was 78. Review of the facility's policy titled Narcotic Control Logging, Documentation, Count and Discrepancies, undated, showed the following:-It is the policy to ensure the proper handling and tracking of controlled medications;-Controlled medications will be subject to special receipt, record-keeping, medication assistance, change of shift count verification, storage, and disposal procedures;-Nurse must sign the individual narcotic sheet for every card received. Do not put two cards on one individual narcotic sheet;-The nurse must sign their name and document doses received;-All expired and discontinued narcotics should be removed from the count as soon as possible and given to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) for disposal;-The DON as well as the ADON destroy the narcotics, then yellow them out in the narcotic logbook;-All narcotics will be stored under a double lock system;-The destruction/disposal process of controlled medications should always include two licensed nurses;-Discontinued controlled medications shall be retained in a securely locked area with restricted access until disposed of by the DON and ADON;-Documentation on the narcotic record will include the date of disposition, names and signature of both nurses disposing of the medication, and the method of disposition;-Documentation on the Medication Disposal Log will include the resident name, medication name, prescription number, disposal date, disposal amount, reason for disposal, and method of disposal. 1. Observation on 10/31/25, at 10:00 A.M., in the DON/ADON's office showed the following:-A locked 4 drawer metal file cabinet;-The top drawer contained bubble packs, pill packs, vials, and bottles containing liquid medication of discontinued controlled substances for approximately 34 different residents. Not all medications contained the individual narcotic sheet;-The second, third, and fourth drawers contained discontinued albuterol Sulfate inhalation solution (used to treat breathing difficulties), various cough suppressants, boxes of lidocaine patches (used to treat pain), Pepto-Bismol, and over the counter vitamins. 2. Review of Resident #1's medical record showed the resident expired on 10/20/25. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-Three full bottles containing 100 milligrams (mg) per 5 milliliters (ml) of morphine sol (used to treat pain), 20 mg/ml, dated of 10/13/25, with the resident's name;-A medication card with 30 tablets of temazepam (used to treat insomnia), 15 milligrams (mg), dated 10/13/25, with the resident's name;-Three full bottles containing 30 ml of lorazepam sol (used to treat anxiety), 2mg/ml, dated 10/13/25, with the resident's name. 3. Review of Resident #2's medical record showed the resident expired on 10/04/25. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-A medication card with 30 tablets of lorazepam (used to treat anxiety), 0.5 mg, dated 10/01/25, with the resident's name and no controlled substance accountability sheet. 4. Review of Resident #3's medical record showed the resident currently admitted to the facility. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-A medication card with 11 tablets of Tramadol (used to treat pain), 50 mg, dated 01/09/25, with the resident's name and no controlled substance accountability sheet. 5. Review of Resident #4's medical record showed the resident currently admitted to the facility. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-Three boxes containing 5 patches per box of Fentanyl (used to treat pain), 25 microgram (mcg) per hour (hr), dated 06/23/25, with the resident's name and no controlled substance accountability sheet;-Two medication cards with 20 tablets per card (40 tablets total) of pregabalin (used to treat pain and anxiety), 25 mg, dated 10/07/25, with resident's name and no controlled substance accountability sheet. 6. Review of Resident #5's medical record showed the resident currently admitted to the facility. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-Two full bottles containing 20 milliliters (ml) of morphine sol (used to treat pain), dated of 09/10/25, with the resident's name and no controlled substance accountability sheet. 7. Review of Resident #6's medical record showed the resident currently admitted to the facility. Observation on 10/31/25, at 11:45 A.M., in the DON's office showed the following medication in a metal file cabinet:-One full bottle containing 30 ml of lorazepam sol (used to treat</p>		