STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265753	A. Building B. Wing	01/22/2026

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. Based on observations, interviews and record review, the facility failed to ensure all allegations of possible abuse were reported within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when staff failed to report an allegation of staff to resident abuse alleged by one resident (Resident #1) to DHSS. The facility census was 82.Review of the facility's policy titled Abuse and Neglect Policy and Procedure, revised 03/20/25, showed the following:-It is the policy and the right of each resident to be free from abuse, neglect, misappropriation of property and exploitation;-All reports of resident abuse will be reported to the local, state, and federal agencies and thoroughly investigated by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or designee. Findings of all investigations are documented and reported;-If resident abuse is suspected, the suspicion must be reported immediately to the Administrator, DON, and/or their designee and to other officials according to state law;-The Administrator, DON, or the individual making the allegation immediately report his or her suspicion to the state licensing agency responsible for surveying/licensing the facility; the resident's representative; the facility medical director and/or resident's physician; and law enforcement, when appropriate;-Immediately is defined as within two hours of an allegation of abuse or allegation resulting in serious bodily injury and within 24 hours for allegations not involving abuse or resulting in serious bodily injury.1.Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 11/08/22;-Diagnoses included vascular dementia (damaged blood vessels that reduce the amount of oxygen to the brain and cause a decline in thinking skills), diabetes mellitus (chronic disease in which blood sugar levels are too high), and high blood pressure.Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/31/25, showed the following:-Moderate cognitive impairment;-Rejection of care occurred 4 to 6 days a week; -Resident used a wheelchair and required staff assistance with transfers and mobility.Review of a facility statement written by Certified Medication Tech (CMT) B, dated 01/17/26, showed the following: -At 11:37 A.M., on 01/17/26, CMT B entered resident's room to administer scheduled medications, check blood sugar, and administer insulin;-The resident became irate after administration and claimed injury to his/her hand;-The resident then began swatting and throwing water;-The nurse was called to the room to inspect the alleged injuries to the resident and found none to be present.During an interview on 01/22/26, at 11:24 A.M., CMT B said the following:-Management should be notified immediately of any abuse and state within 2 hours;-The resident said CMT B hurt his/her hand after insulin was administered;-He/she informed LPN A of the resident accusing him/her of hitting them;-The ADON was also informed of the accusation;-It would be considered abuse if a staff hit a resident's hand.Review of a facility statement written by LPN A, dated 01/17/26, showed the following: -CMT B called him/her to the resident's room;-He/she noted CMT B had wet hair and water on his/her shirt;-CMT B stated he/she gave the resident insulin and medications, and the resident (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	became agitated and threw water on him/her;-The resident was yelling and saying CMT B had hurt his/her hand;-The resident had a couple light bruises on both hands as usual;-The nurse noted no new injury and reported the incident to the ADON.During an interview on 01/22/26, at 10:40 A.M., LPN A said the following:-He/she would notify the administration immediately of any abuse;-Abuse should be reported to the state within two hours;-The resident said CMT B hurt his/her hand, but no injuries were noted;-The resident getting his/her hand hit would be abuse so he/she reported to the ADON right away.Review of a facility statement written by Certified Nurse Assistant (CNA) C, dated 01/17/26, showed the following:-He/she heard the resident hollering;-Staff went to the resident's room, and the resident said staff hurt his/her hand.During an interview on 01/22/26, at 12:05 P.M., CNA D said the following:-He/she would report abuse immediately to the nurse;-Abuse allegations should be reported to the state within two hours;-On 01/17/25, about 12:00 P.M., CMT B came to the nurses' station and reported the resident was arguing with him about medication;-He/she went to the resident's room with another staff to get the resident up for lunch;-The resident said, He gave me that bruise, and pointed at CMT B;-He/she immediately told the ADON and LPN A;-He would consider it abuse if a resident accused staff of giving them a bruise.Review of the resident's progress note dated 01/17/26, at 11:32 A.M., showed Licensed Practical Nurse (LPN) A documented the certified medication technician (CMT) gave the resident his/her medications, completed a blood sugar check, and administered insulin. The resident got upset and threw water on the CMT. Resident educated that staff were here to help him/her and staff would not tolerate this kind of behavior. Resident yelled at this nurse to get out of his/her room. Nurse left resident in the recliner with the call light in reach. (The LPN did not document the resident's allegation of injury to hand caused by staff.) Review of DHSS records showed the facility did not report the allegation of possible abuse on 01/17/26. Review of an undated facility statement written by ADON showed the following:-On 01/17/26, he/she was at the nurses' station desk when CMT B stated, I took a shower;-CMT B and LPN A told him/her how the resident became upset while CMT B was obtaining a blood sugar and administering insulin;-The resident threw a cup of water at CMT B;-While talking to CMT B and LPN A, he/she observed CNA D talking with the resident, but could not hear what they were saying;-His/her understanding of the situation was that the resident had said CMT B had hurt his/her finger during the finger stick which he/she says often after having fingerstick completed;-He/she assessed the resident and noted old bruising on top of both hands but there was no new bruising to his/her hands or fingers.Review of a facility statement written by the Administrator, dated 01/17/26, showed the following: -The Administrator was working as a charge nurse on another unit when he/she was notified someone hurt the resident's hand;-The Administrator asked the resident if someone hurt him/her today and he/she responded, the man that got me out of bed grabbed my hand too tight;-The Administrator asked the resident if the employee giving the medication hurt him/her and the resident responded no; -CMT B was who he/she stated to the previous staff that had hurt him/her. CMT B did not get the resident out of bed that morning. During an interview on 01/22/26, at 10:20 A.M., the Administrator said the following:-Staff heard the resident yelling and CMT B asked for assistance while passing medications;-The resident said CMT B hurt him/her and pointed to his/her stomach;-The resident then reported CMT B hurt his/her finger;-LPN A and the ADON assessed the resident and then reported the incident to the Administrator;-Resident was noted to have bruising on the top of both hands and some bruising to the stomach;-The hand bruising possibly related to lab draws and the bruising to stomach was due to insulin injections.Interview and observation of the resident on 01/22/26, at 3:00 P.M., showed the following:-The resident sat in a recliner in his/her room;-The ADON observed and measured bruises on the resident's hands;-The resident's right hand showed a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	circular reddish purple colored bruise on top of the hand measuring 6.3 centimeters (cm) by 4.7 cm and a lighter purple colored bruise measuring 3.8 cm by 3 cm;-The resident's left hand had a 2 cm by 2 cm purple bruise located on the inner wrist with 4 circular purple bruises approximately 1 cm by 1 cm scattered on the top of the resident's hand;-The resident reported he/she obtained the bruising to hands when staff helped him/her out of bed.During an interview on 01/22/26, at 10:52 A.M., CNA E said the following:-He/she would report abuse to the charge nurse as soon as possible;-Abuse should be reported to the state as fast as possible.During an interview on 01/22/26, at 12:02 P.M., CMT G said the following:-He/she would report abuse to the nurse as soon as possible;-Abuse should be reported to the state within 24 hours;-Hitting or hurting a resident's hand would be abuse.During an interview on 01/22/26, at 11:57 A.M. LPN F said the following:-He/she would notify the supervisor immediately of an allegation of abuse;-The state should be notified of any abuse allegations within 2 hours;-Hitting a resident's hand was considered abuse.During an interview on 01/22/26, at 12:55 P.M., Registered Nurse (RN) H said the following:-He/she would report abuse to the supervisor immediately;-The state should be notified of abuse within two hours;-Hitting a resident's hand would be considered abuse.During an interview on 01/22/26, at 1:05 P.M., the ADON said the following:-The state should be notified of abuse within two hours;-LPN A and CMT B reported the resident was upset at CMT B during the medication pass and threw water on him/her;-He/she did not hear about any possible abuse until after leaving the facility for the day;-He/she was not sure if the abuse allegation should have been reported due to the resident having dementia.During interviews on 01/22/26, at 1:50 P.M. and 2:55 P.M., the Administrator said the following:-Staff should report abuse to the administration as soon as possible;-An abuse allegation should be reported to the state within two hours;-He/she received the report someone hurt the resident from CNA D sometime after lunch;-LPN A reported the ADON;-He/she should have reported and followed policy in relation to the initial abuse report on 01/17/26.Complaint #2719718

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interviews and record review, the facility failed to ensure all allegations of possible abuse were investigated immediately and steps were taken to protect all residents during the investigation when staff failed to be begin an immediate full and documented investigation and allowed the alleged staff member continue to work independently when one resident (Resident #1) made an allegation of staff to resident abuse. The facility census was 82.Review of the facility's policy titled Abuse and Neglect Policy and Procedure, revised 03/20/25, showed the following:-It is the policy and the right of each resident to be free from abuse, neglect, misappropriation of property and exploitation;-All reports of resident abuse will be reported to the local, state, and federal agencies and thoroughly investigated by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or designee. Findings of all investigations are documented and reported;-All investigations will be thoroughly investigated. The Administrator, DON and/or designee shall initiate the investigation;-The administrator, DON and/or designee shall ensure that the resident and the person reporting the suspected violation are protected from retaliation;-Any employee who has been accused of resident abuse is placed on leave at the time of the allegation;-The individual conducting the investigation at a minimum reviews the documentation and the evidence; interviews and obtains statements from the person reporting the incident; interviews the resident or the resident's representative; interviews and obtains statements from staff members who had contact with the resident during the alleged incident; interviews no less than ten residents with whom the accused employee provides care or services; reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly;-Within five working days of the incident, the Administrator will provide a follow up investigation report to the state surveying agency;-The investigation report will provide sufficient information to describe the results of the investigation and indicate any corrective action taken;-The follow up investigation report will provide as much information as possible.1. Review of Resident #1"s face sheet (admission data) showed the following:-admission date of 11/08/22;-Diagnoses included vascular dementia (damaged blood vessels that reduce the amount of oxygen to the brain and cause a decline in thinking skills), diabetes mellitus (chronic disease in which blood sugar levels are too high), and high blood pressure.Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 12/31/25, showed the following:-Moderate cognitive impairment;-Rejection of care occurred 4 to 6 days a week; -Resident used a wheelchair and required staff assistance with transfers and mobility.Review of a facility statement written by Certified Medication Tech (CMT) B, dated 01/17/26, showed the following: -At 11:37 A.M., on 01/17/26, CMT B entered resident's room to administer scheduled medications, check blood sugar, and administer insulin;-The resident became irate after administration and claimed injury to his/her hand;-The resident then began swatting and throwing water;-The nurse was called to the room to inspect the alleged injuries to the resident and found none to be present.During an interview on 01/22/26, at 11:24 A.M., CMT B said the following:-The resident said CMT B hurt his/her hand after insulin was administered;-He/she informed Licensed Practical Nurse (LPN) A of the resident accusing him/her of hitting them;-The ADON was also informed of the accusation;-He/she was told to continue passing medications and left the room;-He/she worked the next day and was placed on the locked unit away from the resident;-He/she had not been suspended from work;-It would be considered abuse if a staff hit a resident's hand.Review of facility staffing sheets showed CMT B worked after the allegation of abuse was made on 01/17/26 and on 01/18/26.Review of a facility statement written by LPN A, dated 01/17/26, showed the following: -CMT B called him/her to the resident's room;-He/she noted CMT B had wet hair and water on his/her (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shirt;-CMT B stated he/she gave the resident insulin and medications, and the resident became agitated and threw water on him/her;-The resident was yelling and saying CMT B had hurt his/her hand;-The resident had a couple light bruises on both hands as usual. The nurse noted no new injury and reported incident to the ADON.During interviews on 01/22/26, at 10:40 A.M. and 12:50 P.M., LPN A said the following:-The resident said CMT B hurt his/her hand, but no injuries were noted;-The resident getting his/her hand hit would be abuse so he/she reported to the ADON right away;-He/she should have made a progress regarding the allegation;-The progress note should include the event, any notifications, and a resident assessment.Review of a facility statement written by Certified Nurse Assistant (CNA) C, dated 01/17/26, showed the following: -He/she heard resident hollering.;-Staff went to the resident's room, and the resident said staff hurt his/her hand.During an interview on 01/22/26, at 12:05 P.M., CNA D said the following:-On 01/17/25, about 12:00 P.M., CMT B came to the nurses' station and reported the resident was arguing with him about medication;-He/she went to the resident's room with another staff to get the resident up for lunch;-The resident said, He gave me that bruise, and pointed at CMT B;-He/she immediately told the ADON and LPN A;-The ADON and LPN A told him/her that CMT B needed to stay away from the resident;-CMT B should not have continued working after abuse allegation;-He would consider it possible abuse if a resident accused staff of giving them a bruise.Review of a facility statement written by ADON, undated, showed the following: -On 01/17/16, he/she was at the nurses' station desk when CMT B stated, I took a shower;-CMT B and LPN A told him/her how the resident became upset while CMT B was obtaining a blood sugar and administering insulin;-The resident threw a cup of water at CMT B;-His/her understanding of the situation was that the resident had said CMT B had hurt her finger during the finger stick which he/she says often after having fingerstick completed;-He/she assessed the resident and noted old bruising on top of both hands but there was no new bruising to his/her hands or fingers. Review of a facility statement written by the Administrator, dated 01/17/26, showed the following: -The Administrator was working as a charge nurse on another unit when he/she was notified someone hurt the resident's hand;-The Administrator asked the resident if someone hurt him/her today and he/she responded, the man that got me out of bed grabbed my hand too tight. Review of the resident's progress note dated 01/17/26, at 11:32 A.M., showed Licensed Practical Nurse (LPN) A documented the Certified Medication Technician (CMT) gave the resident his/her medications, completed a blood sugar check, and administered insulin. The resident got upset and threw water on the CMT. Resident educated that staff are here to help him/her and staff will not tolerate this kind of behavior. Resident yelled at this nurse to get out of his/her room. Nurse left resident in the recliner with the call light in reach. (The LPN did not document the resident's allegation of possible abuse, notifications, or resident assessment) Review of the resident's electronic medical record showed no entries related to an assessment, notifications, or further information related to the abuse allegation.Review showed the facility did not provide full completed investigation upon request.Review of DHSS records on 01/22/26 showed the facility had not submitted an investigation into the allegation of abuse. Interview and observation of the resident on 01/22/26, at 3:00 P.M., showed the following:-Resident sat in a recliner in his/her room;-The ADON observed and measured bruises on the resident's hands. The resident's right hand showed a circular reddish purple colored bruise on top of the hand measuring 6.3 centimeters (cm) by 4.7 cm and a lighter purple colored bruise measuring 3.8 cm by 3 cm;-The resident's left hand had a 2 cm by 2 cm purple bruise located on the inner wrist with 4 circular purple bruises approximately 1 cm by 1 cm scattered on the top of the resident's hand;-The resident's abdomen did not show any visible discolorations;-The resident reported he/she obtained the bruising to hands when staff helped him/her out of bed.During an (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 01/22/26, at 12:02 P.M., CMT G said hitting or hurting a resident's hand would be abuse.During an interview on 01/22/26, at 11:57 A.M. LPN F said the following:-A progress note should be entered to include a resident assessment and notification to the physician and family;-Hitting a resident's hand was considered abuse.During an interview on 01/22/26, at 12:55 P.M., Registered Nurse (RN) H said the following:-Hitting a resident's hand would be considered abuse;-A resident should be assessed after an allegation of abuse and checked for bruises or marks;-A progress note should be entered and include notifications to physician and administration, resident assessment, and what was reported.During an interview on 01/22/26, at 1:05 P.M., the ADON said the following:-If he she received an allegation of abuse, he/she would make sure the resident was safe and immediately contact the Administrator;-The state should be notified of abuse within two hours;- LPN A and CMT B reported the resident was upset at CMT B during the medication pass and threw water on him/her;-LPN A reported he/she would provide medications and blood glucose checks for the resident instead of CMT B;-The ADON heard CNA D report bruising to LPN A as he/she was leaving the nurses' station;-He/she checked the resident and noted older bruising on both hands, but it did not appear suspicious;-He/she did not hear about any possible abuse until after leaving the facility for the day;-A progress report should be completed and include what happened, notifications to the physician, management, and family, and a skin assessment;-The resident should be monitored to assess for any new bruising.During interviews on 01/22/26, at 10:20 A.M., and on 01/22/26, at 1:50 P.M. and 2:55 P.M., the Administrator said the following:-Staff heard the resident yelling and CMT B asked for assistance while passing medications;-The resident said CMT B hurt him/her and pointed to his/her stomach. The resident then reported CMT B hurt his/her finger;-LPN A and the ADON assessed the resident and then reported the incident to the Administrator;-Resident was noted to have bruising on the top of both hands and some bruising to the stomach;-The hand bruising was possibly related to lab draws and the bruising to stomach was due to insulin injections;-CMT B continued to work on the resident's hall after the incident but did not care for the resident;-CMT B was not suspended pending an investigation;-He/she had staff statements and was investigating;-He/she received the report someone hurt the resident from CNA D sometime after lunch;-LPN A reported the ADON and him/her investigated the report and there was no new bruising;-A progress report should be made and include a resident statement, family and physician notifications, and a resident assessment;-The ADON completed a skin assessment on paper, but it should be on a skin assessment tool;-CMT B should have been suspended after the abuse allegation.#2719718