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	03/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents remained free of accident hazards and received adequate assistance with assistive devices to prevent further accidents when the facility failed to ensure staff were trained on and operated mechanical lifts (Hoyer - a mobile, mechanical device designed to safety lift and transfer patients with limited mobility between beds, wheelchairs, toilets, or baths) in a safe manner by standards of practice resulting one resident (Resident # 2) falling from the lift and suffering lacerations and continued numbness in chine. The facility census was 81.Review of the facility policy titled Fall Protocol, undated, showed the following:-Immediately do a physical assessment of the resident who has fallen to include vital signs and neurological assessments. Measure any bruising or impaired skin;-Investigate the incident;-Notify the on-call nurse, if significant injury occurs notify the physician;-Notify the responsible party;-Fill out a fall incident report;-Definition of fall is any unintentional change in position coming to rest on the floor or ground.1.Review of the Resident #2's face sheet showed the following information:-admission date of 02/15/23;-Diagnoses included heart failure, chronic pain, high blood pressure, and diabetes.Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 02/21/26 showed the following information:-Cognitively intact-Dependent on assistance from staff for toileting, dressing, and mobility.Review of the resident's care plan, dated 10/18/24, showed the resident required the use of a Hoyer lift and assistance from two staff members for transfers.Observation and interview on 02/27/26, at 10:19 A.M., showed the following: -The resident laid in his/her bed with bruising around both eyes and a healed scar from his/her bottom lip to the underside of his/her chin;-The staff had been telling him/her and others that the manual Hoyer lift was not steady and could break or turn over;-He/she was in his/her wheelchair and the staff were going to transfer him/her to his/her bed;-During the transfer, while he/she was in the sling, in the air, the Hoyer seemed to get stuck on something and was hard to move across the floor. The aides had given the lift a big slam/push forward and the lift suddenly tipped over and landed on top of him/her;-After the fall, Certified Nursing Assistant (CNA) D ran out of the room to get help, and CNA E stayed beside him/her;-He/she does not remember much other than looking up and seeing several staff members standing around him/her;-He/she continued to have decreased sensation and numbness to the bottom half of his/her face, causing issues with eating and talking;-The staff don't use the manual Hoyer lift on him/her anymore due to fear. They now use another resident's Hoyer that was provided by hospice.Review of the facility's Event Report, dated 01/23/26, showed the following information:-The resident fell from the Hoyer lift and suffered from a laceration. The laceration required direct pressure to the wound to stop the bleeding;-No interventions used;-Two staff in the resident's room were assisting with a Hoyer transfer. Staff applied Hoyer straps and mechanically raised the resident up. In transition in the air, two staff rolled the Hoyer to the bed to release the resident onto the bed. When the resident's body was close to the edge of the bed the staff reported that the [NAME] lift tipped to the left resulting in the resident falling to the ground from the highest position on the lift. The resident hit (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 0689 Level of Harm - Actual harm Residents Affected - Few	his/her head and suffered from a laceration to his/her chin, and the back of his/her head. The Administrator called the hospital a day later and was told the resident received sutures to his/her chin, but did not require stitches to the back of his/her head.Observation and interview on 02/27/26, at 10:53 A.M., showed the following:-Certified Medication Technician (CMT) F, CMT A, and CNA G entered the resident's room;-CMT F said they would be using the hospice Hoyer for a safer transfer of the resident from the bed to the wheelchair;-The Hoyer sling was under the resident and positioned above the resident's head;-CMT F and CMT A hooked up the straps from the Hoyer sling to the Hoyer lift;-CMT F questioned what color sling straps to use and rather or not the middle strap should be attached;-CMT A instructed CMT F to attach all straps for safety;-CMT F operated the Hoyer lift and lifted the resident into the air, while CMT A and CNA G guided and supported the resident;-The resident was seen to be leaning toward his/her right and his/her neck was crooked due to Hoyer sling placement being above his/her head;-CMT F guided the Hoyer lift toward the resident's wheelchair with the legs to the Hoyer lift in the open position;-Once arriving above the resident's wheelchair, CNA G and CMT A obtained the sling and resident and guided and positioned the resident into proper placement;-CMT F began lowering the Hoyer lift without locking the wheels.During an interview on 02/27/26, at 11:30 A.M., CNA G said the following:-He/she was told that the resident was a three-person transfer;-He/she was new at the facility and was told the resident had fallen out of the manual Hoyer lift and was instructed to use the hospice lift, as it was safer;-The facility Hoyer lifts don't seem stable and he/she was afraid to put people in them;-He/she knows how to operate a Hoyer lift, but did not have any specific training on that;-Hoyer lifts should be locked when staff are putting the sling straps on/off, when lifting the resident, and again when lowering the resident onto the desired location; -He/she was told that the facility was going to order some newer, sturdier Hoyer lifts but he/she had not seen them yet. During an interview on 02/27/26, at 12:20 P.M. and 2:10 P.M., CNA D said the following:-He/she was not aware of any unsafe medical equipment;-He/she was present during the incident with the resident, and had never had an issue with transferring the resident with the manual Hoyer lift before;-No one was operating the Hoyer lift when the Hoyer lift tipped over;-He/she was on the left side of the resident, CNA E was on the right side of the resident, and both were pulling on the sling to try to get the Hoyer lift to move. That was when the Hoyer lift flipped over;-There should be one staff member operating the Hoyer lift, and one staff member guiding and positioning the resident;-He/she thought the maintenance department would inspect and repair any broken equipment.During an interview on 02/27/26, at 2:15 P.M., CMT A said the following:-When operating a Hoyer lift, the legs must be open, and there must always be two staff members. One staff member should operate the Hoyer lift while the other staff member guides and positions the resident;-If staff members were holding onto the Hoyer sling and attempting to operate the lift by pulling on the sling, that would cause an accident.During an interview on 02/27/26, at 2:31 P.M., Licensed Practical Nurse (LPN) B said the following:-When operating a Hoyer lift, the legs must be open, there must be two staff members, and the legs must be locked with raising or lowering the resident;-One staff member should operate the Hoyer lift, and one staff member should be guiding and positioning the resident;-It would not be acceptable for staff members to operate the lift by pulling on the Hoyer sling;-The maintenance department would inspect and repair any broken equipment if there were a need.During an interview on 02/27/26, at 2:54 P.M., CNA E said the following:-He/she was present at the time of the incident;-When operating a Hoyer lift, the legs must be open, there must be two staff members, and the legs must be locked when raising or lowering the resident;-One staff member should operate the Hoyer lift, and one staff member should be guiding and positioning the resident;-On the day of the incident, CNA D was operating the Hoyer lift and moving the lift toward the resident's bed when the lift just tipped over on top of the resident;-He/she was on the other side of the resident's bed and was not guiding the resident or lift;-If the lift had not had someone operating it and the staff pulled on the sling versus the lift, he/she did not think that could cause the lift to tip over;-This is not the first incident that he/she has had with someone falling out of a Hoyer lift;-The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility Hoyer lifts are in working order, they're just old.During an interview on 03/02/26, at 2:13 P.M., the Medical Director said the following:-He did not recall being notified of the incident with the resident, but could have been via fax;-He expected two staff members to operate a Hoyer lift;-Pulling on the Hoyer lift by the Hoyer sling could cause a balance concern and cause an accident;-He did not recall what the ultimate cause of the fall was. According to his notes, the facility said the lift broke;-He has continued to see the resident and is aware of his/her lasting lack of sensation to the lower portion of his/her face.During an interview on 03/02/26, at 2:30 P.M., the Maintenance Director said the following:-It was the maintenance departments responsibility to perform inspections and maintenance on facility owned Hoyer lifts;-He completed safety checks on the Hoyer lifts once a month. He had not done this monthly check yet;-The staff have not told him of any concerns on any broken Hoyer lifts. If that were the case the lift would be tagged for non-use until it was operable again.During an interview on 03/02/26, at 3:42 P.M., the Assistant Director of Nursing (ADON) said the following:-She expected two staff to operate a Hoyer lift;-One staff member should be operating the Hoyer lift and the other staff should be guiding and positioning the resident;-The Hoyer lift legs should be open during movement. The Hoyer lift legs should be locked with lifting or lowering a resident.During an interview on 03/02/26, at 4:35 P.M., the Administrator said the following:-She expected two staff to operate the Hoyer lift;-One staff member should be operating the Hoyer lift, and the other staff should be guiding and positioning the resident;-She was called down to the resident's room directly after the incident. She did not make any observations of the Hoyer lift being broken, or see any reason to believe the Hoyer lift malfunctioned;-The involved staff did not indicate to her that they were pulling on the Hoyer sling. If that was the case, that would not be an acceptable transfer;-Her conclusion of the incident was that the Hoyer lift just tipped over during use;-It took seven staff members to get the Hoyer lift off of the resident the day of the incident;-Staff are to continue using the Hoyer lift, as there is nothing wrong with it;-She was aware that the resident has a lasting lack of sensation in his/her lower portion of the face.Complaints 2724937 and 2725032

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed provide pharmaceutical services that included accurate documentation and safe administering of all medications when staff failed to obtain a physician's order before leaving one resident's (Resident #1) medications at bedside and when the staff that signed off on the medication administration was not the staff member who administered the medication. The facility census was 81.Review of the facility policy titled Medication Administration Policy and Safety Tips, undated, showed the following:-Nurses must use acceptable nursing practices when administering medications;-Never leave medications in a resident's room, unless there is an order from a physician stating may leave at bedside;-stay with resident until resident has taken medication. If the resident refuses, then take the medication with you when leaving the room period do not leave the medication in the room. 1. Review of the Resident #1's face sheet (a brief profile) showed the following:-admission date of 05/01/19;-Diagnoses included chronic obstructive pulmonary disease (COPD- a progressive incurable lung disease), Parkinson's disease (a movement disorder of the nervous system that worsens over time), type II diabetes mellitus (a chronic condition where the body resists insulin and fails to maintain healthy blood sugar levels), borderline personality disorder (a serious, long-term mental health condition marked by extreme instability in moods, self-image, behavior, and relationships), high blood pressure, post-traumatic stress disorder (PTSD -a treatable mental health condition triggered by experiencing or witnessing terrifying, life-threatening events like combat, abuse or disasters), attention deficit hyperactivity disorder (ADHD - persistent patterns of inattention, hyperactivity, and impulsivity that interfere with daily functioning) and bipolar disorder (a chronic mental health condition characterized by intense mood swings ranging from mania to depression).Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool administered by staff), dated 11/13/25, showed the resident was cognitively intact.Review of the resident's care plan, last revised 02/27/26, showed the following:-At risk for adverse side effects from the use of psychotropic drugs;-Goal for relief without adverse effects, and monitoring for gradual dose reductions and lowest effective dose.Review of the resident's current Physician Order Sheet (POS) showed the following:-An order, dated 11/01/23, for pantoprazole (used to treat reflux) tablet, delayed release 40 milligram (mg), give one tablet once a morning during morning med pass;-An order, dated 07/02/24, for Mag 64 (magnesium chloride - supplement) tablet, delayed release, 64 mg, one tablet twice a day, morning med pass and night med pass;-An order, dated 06/16/25, for ondansetron HCl (anti-nausea medication) tablet 8 mg, one tablet once a morning at morning med pass;-An order, dated 11/01/23, for multivitamin tablet one tablet once a morning at morning med pass;-An order, dated 11/14/25, for Lipitor (used to lower cholesterol) tablet 20 mg, one tablet once a morning at morning med pass;-An order, dated 12/10/25, for bethanechol chloride (used to treat bladder dysfunction) tablet 10 mg, one tablet three times a day morning med pass, mid-day med pass, and night med pass;-An order, dated 11/01/23, for aspirin tablet 81 mg, one tablet once a morning at morning med pass;-An order, dated 01/30/26, for amlodipine (used to treat high blood pressure) tablet 2.5 mg, one tablet once a morning at morning med pass.Review of the resident's progress note dated 02/27/26, at 9:35 A.M., showed the following:-Certified Medication Technician (CMT) A requested this nurse to deliver medication to the resident;-LPN B entered the room, woke the resident up, and reported he/she had the resident's medications. The resident told LPN B to put the medications on the table, and he/she would take them if LPN B would get him/her milk. LPN B went to get a carton of milk for the resident, returned, and placed a straw in the milk carton. LPN B left the room;-The resident advised after the trays were passed his/her medication was missing. LPN B went to talk with the resident about missing medication. The resident had his/her breakfast and reported the pills were missing. Resident wanted to speak to the Administrator, but the Administrator was not in the building at that time.Review of the resident's progress note for 02/27/26, at 11:58 A.M., (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed LPN B noted the resident had located the missing pills next to him/her and apologized to LPN B.Review of the resident's February 2026 Medication Administration Record (MAR) for the morning medication pass on 02/27/26, showed staff documented administration of the resident's pantoprazole, Mag 64, ondansetron HCl, multivitamin, Lipitor, bethanechol chloride, aspirin, and amlodipine.During an interview on 03/02/26, at 11:01 A.M., the resident said the following:-He/she tells staff to stay and observe him/her taking medications, but they will not;-On 02/27/26, the resident woke up and realized he/she had not taken morning medications. LPN B came in and said he/she had taken the medications. The resident did not remember and then found the medications next to him/her in the bed and notified LPN B.During an interview on 03/02/26, at 2:04 P.M., Certified Nurse Assistant (CNA) C said the following:-Staff should not leave medications at bed side with a resident. It was not safe;-On 2/27/26, he/she answered the resident's call light. The resident advised medications had been delivered while he/she was awake. He/she then fell asleep, woke up to eat breakfast, and the medications were missing;-CNA C notified LPN B about the alleged missing medications. During an interview on 03/05/26, at 8:19 A.M., CMT A said the following:-Medications were not to be left at the bedside without a physician's order;-The only medications the resident has physician's order to be left bedside are eye drops, nasal spray, and ointments;-He/she signed the medications out on the MAR but asked LPN B to deliver them to the resident. During an interview on 03/02/26, at 3:00 P.M., LPN B said the following:-On 02/27/26, CMT A requested he/she deliver the resident's morning medication pass;-He/she delivered the medications to the resident;-The resident said he/she would take the medications if LPN B would get the resident milk;-LPN B left the room and brought back a carton of milk, put a straw in the carton and left the room without observing the resident take the medications;-Staff should not leave a resident's medications bedside without a physician's order. He/she should have watched the resident take the medications. During an interview on 03/02/26, at 3:42 P.M., the Assistant Director of Nursing (ADON) said the following:-CMT's generally pass medications at the facility unless the nurse needs to cover or during the night shift;-Staff should not leave medications at bedside unless there is a physician's order to do so. During an interview on 03/02/26, at 4:36 P.M., the Administrator said the following:-CMT's pass medications at the facility unless the nurse is covering or during the night shift;-Staff should not leave medications at bedside unless there is a physician's order to do so;-To her knowledge, the resident does not have a physician's order to leave his/her medication pass bedside. Complaint 2733413