

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  12/12/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</b></p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were not left at bedside for a resident that was not assessed to self-administer medications for one resident (Resident #36) out of 21 residents in the sample.</p> <p>Review of the facility's policy titled, Medication Administration undated, showed the following regarding self-administration of medication by residents:</p> <ul style="list-style-type: none"> <li>-The resident must be alert and oriented and be familiar with taking his/her own medication. The medication must be kept in a locked box or locked drawer.</li> <li>-The resident must have a physician's order for self-administration.</li> <li>-A list of the medication was kept in the resident's MAR and his/her medical record. This list was monitored by the charge nurse every month and when there was any change of orders.</li> <li>-The charge nurse will also check the lock box periodically, but at least weekly.</li> <li>-The resident had a medication administration sheet that he/she kept to document when he/she took any medication.</li> </ul> <p>1. Review of Resident #62's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included tobacco use.</li> </ul> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 09/15/24, and located in the resident's EMR under the MDS tab, showed the resident had no cognitive impairment.</p> <p>Observations on 12/10/24, at 2:05 P.M., on 12/11/24, at 10:36 A.M., and 12/12/24, at 9:06 A.M., showed the resident had an inhaler inside a blue sleeve lying on the bedside table next to his/her recliner.</p> <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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Care Plan, dated 05/16/24, and located in the resident's EMR under the Care Plan tab, showed staff did not care plan self-administration of medications.</p> <p>During an observation and interview on 12/12/24, at 9:06 A.M., Licensed Practical Nurse (LPN) 2 said the resident was not assessed to self-administer any medications. He/she observed the inhaler lying on the bedside table next to the resident's recliner and said he/she was not aware the resident had it. The inhaler should not be in the resident's room.</p> <p>During an interview on 12/12/24, at 12:22 P.M., the Nurse Practitioner (NP) said there should be no medications at a resident's bedside unless they have been assessed to self-administer.</p> <p>During an interview on 12/12/24, at 2:19 P.M., the Director of Nursing (DON) said no medications should be at a resident's bedside.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39411</p> <p>40902</p> <p>Based on record review and interview, the facility failed to develop and implement a complete care plan for each resident when staff failed to care plan smoking on the facility's property for two residents (Resident #12 and #62) of two residents reviewed for smoking.</p> <p>Review of the facility's policy titled, Care Plan Policy, dated 03/23/18, showed initial care plans are written shortly after admission (or re-admission) and are reviewed every three months so new problems can be dealt with at the time.</p> <p>1. Review of Resident #12's Face Sheet tab of the electronic medical record (EMR) showed the following:</p> <p>-admitted on 01/31/24;</p> <p>-Diagnoses included nicotine dependence.</p> <p>Review of the resident's Care Plan, dated 03/21/24 and located in the Care Plan tab of the EMR, showed the staff did not care plan related to the resident's nicotine dependence and smoking.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 08/14/24, and located in the Resident Assessment Instrument (RAI) tab of the EMR, showed the resident was cognitively intact.</p> <p>During an interview on 12/09/24, at 2:13 PM, the resident said he/she can only smoke when his/her family member comes to visit.</p> <p>During an interview on 12/11/24, at 11:00 A.M., Family Member (FM) 1 said he/she comes to the facility three times a week and sits with the resident as he/she smokes. The resident can smoke safely, but does not light his/her own cigarettes or dispose of them without help.</p> <p>2. Review of Resident #62's Face Sheet, located in the EMR under the Profile tab, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included tobacco use.</p> <p>Review of the resident's Care Plan, dated 05/16/24 and located in the resident's EMR under the Care Plan tab,s showed staff did not care plan related to tobacco use or smoking.</p> <p>Review of the resident's significant change MDS, with an ARD of 09/15/24, located in the resident's EMR under the MDS tab, showed resident had no cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24, at 1:57 P.M., the Director of Nursing (DON) said the resident did not have a care plan for smoking.</p> <p>3. During an interview on 12/12/24, at 1:18 P.M., the MDS Coordinator (MDSC) said if a resident did smoke, it should be documented and care planned for nicotine use.</p> <p>4. During an interview on 12/11/24, at 12:16 P.M., the Director of Nursing (DON) said only family members may assist residents who smoke and staff may not assist residents with smoking. Smoking is discussed during the care plan meeting and should be care planned.</p> <p>5. During an interview on 12/11/24, at 1:34 P.M., the Administrator said smoking should be on the care plan upon admission and updated as needed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39857</p> <p>40902</p> <p>Based on observation, record review, and interview, the facility failed to provide respiratory care per standard of practice for all residents when staff failed to administer oxygen as ordered for one resident (Resident #62) and when staff failed to ensure oxygen supplies were stored and changed appropriately when not in use for two residents (Resident #37 and #55).</p> <p>Review of the facility's policy titled Ozark Nursing and Care Center, undated, showed all oxygen tubing must be kept in a baggie when not in use.</p> <p>1. Review of Resident #62's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included tobacco use, shortness of breath, and chronic obstructive pulmonary disease (COPD - an ongoing lung condition caused by damage to the lungs).</p> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 09/15/24, located in the resident's EMR under the MDS tab, showed the resident had no cognitive impairment.</p> <p>Review of the resident's Care Plan, dated 10/14/24, located in the EMR under the Care Plan tab showed the resident was at risk for ineffective breathing patterns related to shortness of breath and COPD. Interventions in place were to administer oxygen at two liters per minute (LPM) via nasal cannula continuously.</p> <p>Review of the resident's Physician Orders, dated 10/14/24, located in the EMR under the Orders tab, showed staff to administer oxygen 2 LPM via nasal cannula continuously.</p> <p>Observations on 12/10/24, at 2:05 P.M., on 12/11/24, at 10:36 A.M., and on 12/12/24, at 9:06 A.M., showed the resident was seated in a recliner using a nasal cannula and the oxygen canister was set at four LPM.</p> <p>During an observation and interview on 12/12/24, at 9:06 AM, Licensed Practical Nurse (LPN) 2 said the resident should be on 2 LPM. He looked at the resident's oxygen canister and stated it was set at 4 LPM. He/she did sign off on the Medication Administration Record (MAR) today that the resident was receiving 2 liters, but he/she did not actually look at the liters at that time, but should have.</p> <p>During an interview on 12/12/24, at 12:22 P.M., the Nurse Practitioner (NP) said he/she expected staff to follow physician orders for oxygen administration and administer the correct LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/12/24, at 2:19 P.M., the Director of Nursing (DON) said he/she expected staff to administer oxygen according to physician orders.</p> <p>2. Review of Resident #37's Admission Record, undated, located under the Profile tab of the electronic medical record (EMR), showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included COPD with (acute) exacerbation.</p> <p>Review of the resident's annual MDS, with an ARD of 11/03/24, located in the EMR under the MDS tab, showed the resident was cognitively intact.</p> <p>Review of the resident's Care Plan, dated 10/14/24, located in the EMR under the MDS tab revealed, showed resident at risk for ineffective breathing patterns related to shortness of breath due to COPD. Intervention included change oxygen tubing weekly on Wednesday nights and date the new tubing.</p> <p>During an observation 12/09/24, at 12:44 P.M., the resident's updraft apparatus lay on the bedside table and was not dated or stored in a plastic bag.</p> <p>During an observation 12/10/24, at 2:30 P.M., the resident's updraft apparatus was laying on the bedside table and was not dated or stored in a plastic bag.</p> <p>During an observation on 12/11/24, at 11:58 P.M., the resident received an updraft treatment and the apparatus was dated 12/04/24.</p> <p>3. Review of Resident #55's undated Admission Record, located under the Profile tab of the EMR, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included of chronic respiratory failure with hypoxia (low levels of oxygen in body tissues).</p> <p>Review of the resident's Care Plan, dated 10/14/24, located in the EMR under the MDS tab revealed, showed resident at risk for ineffective breathing patterns related to shortness of breath due to COPD. Intervention included change oxygen tubing and humidifier weekly on Wednesday nights and date the new tubing and humidifier.</p> <p>Review of the resident's quarterly MDS, with an ARD of 11/02/24, located in the EMR under the MDS tab, showed the resident was cognitively intact.</p> <p>During an observation 12/09/24, at 1:44 P.M., the resident's nasal cannula was draped over the over bed table and no date on tubing.</p> <p>During an observation 12/10/24, at 4:30 P.M., the resident's oxygen was in use and the tubing was not dated.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/11/24, at 10:45 A.M., the resident was using the oxygen and the tubing was dated 12/04/24.</p> <p>4. During an interview on 12/12/24 at 1:45 P.M., LPN 2 said the oxygen nasal cannulas and updraft apparatus should be stored in a bag, and the tubing and bag should be dated.</p> <p>During an interview on 12/12/24, at 1:57 P.M., LPN 1 said the oxygen nasal cannulas and updraft apparatus should be stored in a bag, and the tubing and bag should be dated.</p> <p>During an interview on 12/12/24, at 2:45 P.M., the DON said the oxygen nasal cannulas and updraft apparatus would be stored in a clean clear plastic bag dated and initialed, along with dating and initialing the oxygen tubing.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</b></p> <p>Based on observation, record review, and interview, the facility failed to ensure effective pain management was provided for every resident when staff failed to keep pain medication in stock and failed to follow-up on pain relief after administering as needed pain medication for one resident (Resident #14) reviewed for pain of 21 sampled residents.</p> <p>1. Review of Resident #14's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included multiple sclerosis (MS - a chronic autoimmune disease that affects the central nervous system, which includes the brain, spinal cord, and optic nerves) and lower back pain.</p> <p>Review of the resident's Care Plan, dated 10/30/20, located in the resident's EMR under the Care Plan tab, showed the resident had had chronic pain. Interventions included for staff to address complaints of pain promptly and administer as needed (PRN) medication for breakthrough pain.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 10/08/24, located in the EMR under the MDS tab , showed the following:</p> <p>-No cognitive impairment;</p> <p>-Frequent pain that occasionally interfered with day-to-day activities.</p> <p>Review of the resident's Physician Orders, dated 12/12/24, located in the EMR under the Orders tab, showed the following:</p> <p>-An order, dated 09/26/23, for oxycodone (used to treat moderate to severe pain) 10 milligram (mg), PRN, every four hours for breakthrough pain.</p> <p>-An order, dated 12/09/24, for lidocaine (topical pain medication) adhesive patch, medicated 5%, topical, apply patch to lower back in morning (AM), leave on for 12 hours, and remove.</p> <p>Review of the resident's Medication Administration Report (MAR), dated December 2024, located under the Reports tab, showed on 12/09/24, 12/10/24, and 12/11/24, staff did not administer the resident's lidocaine medication due to medication being unavailable.</p> <p>Review of the resident's Controlled Drug Record/Disposition Form, dated November 2024 and December 2024, located on the medication cart, showed the resident oxycodone 10mg was administered on 12/11/24, at 8:48 AM.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 12/11/24, at 11:50 A.M., the resident approached Certified Medication Technician (CMT) 1, who was standing at the medication cart, and stated his/her back hurts like hell. CMT 1 told the resident they were still waiting on the pharmacy to fill the lidocaine order and get the patches to the facility. CMT 1 did not alert or report anything to the nurse on duty about the resident's pain. The resident said he/she had been administered oxycodone, but it was no longer effective.</p> <p>During an interview on 12/11/24, at 2:28 P.M., CMT 1 said when a resident stated they had a pain scale of 5 or higher he/she would ask if they want something for pain and she would administer the medication and then go back within about 30 minutes to an hour to reassess. When a resident reported the medication was not effective he/she would report that to the nurse, and they would document that in a progress note. He/she administered the resident's an oxycodone, but did not document that on the MAR and did not go back to reassess if it was effective or not. He/she did not report to the nurse that the resident said the oxycodone was not effective.</p> <p>During an interview on 12/12/24, at 1:57 P.M., the Director of Nursing (DON) said he/she was unaware the resident was complaining of pain and that his/her PRN oxycodone was not effective. He/she takes pain very seriously and that any complaint by a resident about pain should be addressed. Anytime a resident stated they were in pain she expected staff to administer pain medication and that should be a priority. He/she expected nursing staff to reach out to the physician if what the facility was doing was not enough to relieve pain.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39411</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all food stored in the main kitchen was free from possible contamination when staff failed ensure food was appropriately labeled and dated, and not expired or past used by date. The failure had the potential to increase the prevalence and spread of food borne illnesses and infection for all 68 facility residents.</p> <p>Review of the facility's policy titled, Cold Food Storage Chart, undated, indicated that opened foods must be dated with the open date and leftovers must be labeled with the date it was made and what it is.</p> <p>1. During an observation on [DATE], at 10:42 A.M., the following was observed in the reach-in refrigerator and verified by the Dietary Manager (DM) during the initial kitchen tour:</p> <ul style="list-style-type: none"> <li>-Opened 5-pound (lb.) container of cottage cheese with no date of opening, with a Styrofoam cup inside the container.</li> <li>-One-gallon mayonnaise open with used date [DATE];</li> <li>-One-gallon BBQ sauce open and dated [DATE];</li> <li>-One-gallon Honey Mustard dated [DATE];</li> <li>-One-gallon Pimento Spread opened with used by date of [DATE];</li> <li>-A squeezed bottle of white sauce dressing which the DM identified as Ranch dressing, with no date and no identifying label;</li> <li>-One-gallon freezer bag with shredded meat which the DM identified as turkey. The DM did know how long the turkey was in the refrigerator;</li> <li>-An opened five lb. bag of shredded cheddar cheese. The bag was left open exposed to air. There was no date of opening or use by date;</li> <li>-An open undated five lb. bag of parmesan cheese that was left open and exposed to air;</li> <li>-An one-gallon bag of sliced cheese with no date;</li> <li>-Three undated storage bags of cooked biscuits.</li> <li>-One-gallon bag of cooked pancakes with no date,</li> <li>-One-gallon bag of chopped celery brown in color with slimy substance in the bag with no date;</li> <li>-Aluminum pan of cooked green peppers with no use by date;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-An open one-quart carton of almond milk with manufacturer's instructions to use within seven to ten days.</p> <p>During an interview on [DATE], at 10:42 A.M., the DM said these items should have been dated correctly with an open date and a use-by date. Leftovers should only be kept for three days.</p> <p>Observation of the walk-in refrigerator on [DATE], at 11:13 A.M., showed a crate of 36 undated thawed Mighty Shakes. Review of the manufacturer's instructions indicated thawed shakes should be consumed within 10 days after thawed.</p> <p>During an interview on [DATE], at 4:24 P.M., the Administrator said his/her expectation was that the dietary staff follow the policy for labeling of food and disposing of food appropriately to ensure the residents are served safe and quality food.</p>