STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045414	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Health Nursing and Rehab Center	2500 Highway 65 South Clinton, AR 72031

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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review, and interview, it was determined that the facility failed to report to the Office of Long-Term Care (OLTC), an allegation of sexual abuse of one (Resident #46) by another (Resident #34) resident within two hours of the allegation being made. The findings are: 1. A review of an admission Record indicated Resident #34 was admitted to the facility with diagnoses that included: congestive heart failure, cognitive communication deficit, and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/15/2025, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment for daily decision making. Section E - Behaviors, indicated: Resident #34 did not have verbal, physical, or other behaviors symptoms directed toward others. Review of Resident #34's Care Plan initiated 08/25/2022, and revised on 01/16/2024, revealed the resident had a behavior problem related to being sexual with others. Interventions included: Resident currently taking [Name Brand Antidepressant] for depression, to encourage the resident to eat meals with spouse and to get out of the room more often. The resident is married and sometimes thinks another resident is spouse or reminds resident of spouse and resident may try to hold their hands or touch them inappropriately. The resident does not understand/remember that they have dementia or other residents do. (revised 08/10/2023). 2. A review of an admission Record indicated Resident #46 was admitted to the facility with diagnoses that included: neurocognitive disorder with Lewy bodies, vascular dementia with behavioral disturbances, and anxiety disorder. The admission MDS with an ARD of 01/22/2025, revealed Resident #46 had a BIMS score of 1, which indicated severe cognitive impairment for daily decision making. In Section E - Behaviors, indicated: Resident #46 had verbal and physical behaviors symptoms directed toward others, rejection of care and wondering. A review of Resident #46's Care Plan initiated 11/07/2023 and revised 02/09/2024, revealed the resident was at risk for elopement/wandering around building and getting turned around. Interventions included: Resident was not an exit seeker but had confusion related to dementia and wandered. The resident may get turned around and try to go through doors. The resident wore an elopement bracelet for safety. (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 - Some	A review of an OLTC Witness Statement Form, dated 08/30/2024 and completed by the Director of Nursing (DON), indicated the resident ' s family member had come to the DON ' s office and stated that another resident had alleged Resident #34 had placed a hand down Resident #46 ' s pants in the dining room. During a phone interview on 04/15/2025 at 10:47 AM, a family member of Resident #46 stated sometime last year during a visit with the resident, another resident approached them and told the family member that Resident #34 was observed seated in the dining room in a wheelchair beside Resident #46 and was touching Resident #46 inappropriately. The family member said it was after hours, so they reported it the following Monday. The family member was informed by the DON that an investigation would be conducted. The family member said the DON later contacted them and informed the family member the investigation was completed and it was determined it did not happen. During an interview on 04/17/2025 at 9:02 AM, the Administrator stated an internal investigation was completed and the allegation was unfounded, due to negative findings during the body audit and the interviews with the cognitive witnesses. The Administrator stated she felt the internal investigation was all that was needed and felt comfortable the incident did not happen. The Administrator stated there was no documentation for the internal investigation, and no documentation in (electronic charting program). The Administrator stated the internal investigation paperwork was on her desk, but after returning from vacation, she purged her office and accidentally threw the investigation paperwork away. During an interview on 04/17/2025 at 10:06 AM, Registered Nurse (RN) #5 was asked if the abuse allegation should have been reported. She said she thought it should have been. During a phone interview on 04/17/2025 at 10:14 AM, Licensed Practical Nurse (LPN) #7 was asked if the abuse allegation should have been reported. She said based on who said it happened, when, where, and having a witness around who really cared for Resident #46, I thought it was a lie from the start, so no. During an interview on 04/17/2025 at 10:38 AM, the DON stated on August 30th, Resident #46's family member came to the DON and stated a couple weeks before, a resident told her Resident #46 was raped, and Resident #34 touched Resident #46 inappropriately. The DON said she called the Administrator, interviewed the resident who made the accusation, and the residents who were sitting at the table with Resident #46. She asked two nurses to do an exam on Resident #46. Nothing was found during the body audit and the witnesses stated it never happened. The DON was informed Resident #34 was seated at the table in the big dining room, and Resident #46 was sitting at another table in the small dining room. She stated Resident #46 was acting normal after the body audit. The DON said she contacted Resident #46's family member, and the family member was good with the outcome of the investigation. The DON said the interventions placed were to ensure Resident #34 was in a separate dining room, and time checks were placed for staff to know where the resident was at all times. The DON said staff was able to interview everyone, complete a body examination, and there was nothing to report. A witness stated Resident #46 was seated next to them and did not see anything suspicious, so she felt an internal investigation was appropriate in this situation. The DON said, anytime an allegation is made, however, everyone complains so, that is where judgment comes into play. We used our experience, investigated in a timely manner, and presented it to the Administrator. She said there was not any documentation in PCC, because witness statements were made. During a phone interview on 04/17/2025 at 11:50 AM, the Medical Director said they should (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigate any allegation and come up with the conclusion to report or not.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that the facility failed to ensure evidence of an investigation for an allegation of sexual abuse was maintained after the investigation was conducted and failed to report to the Office of Long Term Care (OLTC) the results of the investigation to enable the state agency to provide the necessary oversight of the facility's efforts to investigate for two (Resident #34 and Resident #46) of two residents reviewed for abuse. The findings are: 1. A review of an admission Record indicated the facility admitted Resident #34 with diagnoses that included congestive heart failure, cognitive communication deficit, and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident # 34 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment for their daily decision making. In Section E - Behaviors, indicated: Resident #34 did not have verbal, physical or other behaviors symptoms directed toward others. Review of Resident #34's Care Plan initiated [DATE] and revised [DATE], revealed the resident had a behavior problem related to being sexual with others. Interventions included: Resident currently taking [name brand medication name] for depression, to encourage the resident to eat meals with spouse and to get out of the room more often. The resident is married and sometimes thinks another resident is spouse or reminds resident of spouse and resident may try to hold their hands or touch them inappropriately. The resident does not understand/remember that they have dementia or other residents do. (revised [DATE]). 2. A review of an admission Record indicated the facility admitted Resident #46 with diagnoses that included: neurocognitive disorder with Lewy bodies, vascular dementia with behavioral disturbances, and anxiety disorder. The admission MDS with an ARD of [DATE] revealed Resident #46 a BIMS score of 1 which indicated severe cognitive impairment for their daily decision making. In Section E - Behaviors, indicated: Resident #46 had verbal and physical behaviors symptoms directed toward others, rejection of care and wondering. A review of Resident # 46's Care Plan initiated [DATE] and revised [DATE], revealed the resident was at risk for an elopement/wandering around building and getting turned. Interventions included: Resident was not an exit seeker but had confusion related to dementia and wandered. The resident may get turned around and try to go through doors. The resident wore an elopement bracelet for safety. During a phone interview on [DATE] at 10:47 AM, a family member of Resident #46 said that sometime last year during a visit with Resident #46, another resident approached them and told the family member that Resident #34 was observed seated in the dining room in a wheelchair beside Resident #46 and was touching Resident #46 inappropriately. The family member said it was after hours, so they reported it the following Monday. The family member was informed by the Director of Nursing (DON), that an investigation would be conducted. The family member said the DON later contacted them and informed the family member that the investigation was completed and it was determined the incident did not (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happen. During an interview on [DATE] at 9:02 AM, the Administrator said she was familiar with the abuse allegation between Resident #34 and Resident #46. She was on vacation and was notified by the DON of the allegation that allegedly happened two weeks prior, from Resident #46 ' s family member. She informed the DON to start an investigation to find out what happened and complete a body audit on Resident # 46. She said that approximately 20 to 25 minutes later, she received a call back from the DON informing her that the DON had spoken with the resident who told the allegation to Resident #46's family member and that resident said they did not see anything. It had been told to that resident by another resident. The Administrator said it would be impossible for anyone to witness because Resident #46 sat in one dining room and Resident #34 sat on the opposite side of the dining room and there were two walls between each side. Resident #46 did not like to be touched and often rejected care and would scream, if touched. The Administrator said an internal investigation was completed and the allegation was unfounded, due to negative findings during the body audit and the interviews with the cognitive witnesses. She felt the internal investigation was all that was needed and felt comfortable the incident did not happen. The Administrator said there was no documentation for the internal investigation and no documentation in (electronic charting software name). The internal investigation paperwork was on her desk, and after returning from vacation, she purged her office and accidentally threw the investigation away. The Administrator said she had never seen or heard Resident #34 physically touch or verbally say anything inappropriate to another person, before or after the incident. She stated Resident #34 was friendly to others but never touched anyone in that way. [The reporting resident] dislikes Resident #34. During an interview on [DATE] at 8:48 AM, Registered Nurse (RN) #6 said she was working the day of the allegation. Around 4:30 PM the DON informed the RN of the situation and asked her to help the floor nurse complete a head-to-toe assessment, including a pubic area assessment. Resident #46 was combative during the assessment, which was normal because Resident #46 did not like to be touched. Resident #46 finally calmed down and RN #6 said the assessment was completed. No signs of abuse, scratches, bleeding or bruising were seen. RN #6 said that after the assessment, no behaviors were observed from Resident #46. RN #6 said that Resident #34 was a flirt , but she had never seen Resident #34 touch or say anything inappropriately to another resident, before or after the incident. RN #6 said some of the interventions in place were Resident #34 was to be in line of sight, and first to be served in the dining room, then moved to the resident's room. During a phone interview on [DATE] at 9:50 AM, the Ombudsman said that she was aware of one resident that touched another resident inappropriately, but that the resident no longer resided in the facility. During an interview on [DATE] at 10:06 AM, RN #5 said she was informed of the situation on that day. She spoke with a resident (who had since expired), and the resident stated it did not happen. RN #5 said the intervention was putting Resident #34 in an area where staff could always observe the resident. RN #5 said that she thought it should be reported to the OLTC. During a phone interview on [DATE] at 10:14 AM, Licensed Practical Nurse (LPN) #7 said she was working the South Hall at the time of the alleged incident and was informed to provide a witness statement. She witnessed the body audit performed on Resident #46. There were no findings, no bruising, redness, or scratches. LPN #7 said she had never seen Resident #34 inappropriately touch or say anything, before or after the incident. She stated, I would be surprised if Resident #34 did anything, due to failing health. The LPN said, checks were in place, but I am not sure if they were [DATE]-minute (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checks on Resident #34. LPN #7 said she thought the incident should have been a reportable to OLTC. She said based on who said it happened, when, where, and having a witness around who really cared for Resident #46, I thought it was a lie from the start. During an interview on [DATE] at 10:38 AM, the DON stated on [DATE], Resident #46's family member came to me and stated a couple weeks before, a resident told her that Resident #46 was raped, and that Resident #34 touched Resident #46 inappropriately. The DON said she called the administrator, interviewed the resident who made the accusation, and the residents who were sitting at the table with Resident #46. She asked two nurses to do an assessment on Resident #46. Nothing was found during the body audit and the witnesses stated it never happened. She was informed Resident #34 was seated at the table in the big dining room, and Resident #46 was sitting at another table in the small dining room. She stated Resident #46 was acting normal after the body audit. The DON said she contacted Resident #46's family member, and the family member was good with the outcome of the investigation. The DON said the interventions placed were to ensure Resident #34 was in a separate dining room, and time checks were placed for staff to know where resident was at all times. The DON said we were able to interview everyone, complete a body examination, and there was nothing to report. A witness stated Resident #46 was seated next to them and did not see anything suspicious, so she felt an internal investigation was appropriate in this situation. The DON said anytime an allegation is made, however, everyone complains so that is where judgment comes into play. We used our experience, investigated in a timely manner and presented it to the Administrator. She said there was not any documentation in PCC because witness statements were made. During a phone interview on [DATE] at 11:50 AM, the Medical Director said he was aware of the incident but could not remember the details. He said they should investigate any allegation and come up with the conclusion to report or not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review, it was determined that the facility failed to perform proper hand hygiene, don proper personal protective equipment (PPE), and follow standard infection control procedures for one (Resident #74) of three residents reviewed for isolation precautions. The findings are: A review of the admission Record noted Resident #74 was admitted to the facility on [DATE], for diagnoses which included aftercare following joint replacement surgery. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/2025 revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 14 (13-15 suggest cognitively intact). A review of the Physician Order Summary revealed Resident #74 was on enhanced barrier precautions (EBP), due to the peripherally inserted central catheter (PICC) line in their right arm and an order to receive antibiotics intravenously, via PICC line for a diagnosis of osteomyelitis (infection in the bone) of the hip. A review of the Transmission-Based Precautions (Isolation Precautions) policy, last revised 05/2024, noted For residents for whom EBP are indicated, EBP is employed, and gown and gloves should be worn when performing the following high-contact resident care activities. The policy noted Device care or use (PICC line is an indwelling device). A review of the undated Medication Administering policy, effective 09/2019, noted Staff shall follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) On 04/16/2025 at 8:00 AM, this surveyor observed Licensed Practical Nurse (LPN) #1 donning gloves in the medication room located on the 800 Hall, while she prepared the antibiotics for administration. LPN #1 retained the left glove on her hand and walked down the hall to Resident #74 ' s room, which was approximately 25 feet. LPN #1 did not perform hand hygiene and did not don a gown prior to entering Resident #74 ' s room. LPN #1 applied a glove to her right hand and cleaned the hub (the connection point where the end of the PICC line connects to the intravenous line [IV tubing] to deliver the medication) with an alcohol pad for approximately 10 seconds and allowed the hub to air dry, holding the end of the PICC line with her thumb and finger. LPN #1 then touched the hub with her left thumb multiple times. LPN #1 started to connect the IV tubing to the hub of the PICC line. LPN #1 was told she touched the hub so she cleaned the hub of the PICC line again and then connected the IV tubing to the hub of the PICC line and administered the medication. During an interview on 04/16/2025 at approximately 8:30 AM, LPN #1 stated, I was supposed to dress out for that, because the resident is on EBP. LPN #1 confirmed she wore the same glove on her left hand from the medication room to Resident #74's room and did not perform hand hygiene. LPN #1 also confirmed she did not don a gown to perform the medication administration. During an interview on 04/16/2025 at approximately 9:45 AM, the Director of Nursing (DON) confirmed Resident #74 was placed on EBP due to having a PICC line. She stated, It's especially important to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be cautious with PICC lines since they go straight to the heart. An infection would be dangerous. She also confirmed hand hygiene should be completed, new gloves applied, and a gown per the EBP for direct care or use of an indwelling device such as a PICC line.