STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265594	A. BUILDING 01 B. WING	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OZARKS METHODIST MANOR, THE	205 SOUTH COLLEGE, MARIONVILLE, MO 65705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Missouri, Department of Health and Senior Services on 01/15/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Missouri, Department of Health and Senior Services on 01/15/25 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancy. Ozark Methodist Manor is a one-story 78 bed building constructed with Type III (200) construction with concrete block bearing walls, concrete ceiling in two areas with concrete and unprotected steel (1 layer of ceiling drywall) in the newest section or Flossie Knight Hall. The facility has concrete flooring. The North Hall was completed in 1961, South Hall in 1970, Flossie Knight Hall in 1983, and the activity room in 2002. The facility has a 600-kilowatt (KW) diesel generator. The facility has 61 occupied beds.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wayne Carney | TITLE: Administrator | (X6) DATE: 2-7-25

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.

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	265594	A. BUILDING **01** B. WING _____	**01/15/2025**

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K 222	Continued From page 1 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors labeled with delayed egress signs to keep pushing were worked as signage directed. The deficient practice had the potential to affect all 22 residents. 1. Observation on 01/15/25, at 10:10 A.M., of the exit door near bedroom 10 and the activities room showed the door was labeled with signage of "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." Continued observation showed the door did not function as intended and it was not in the delayed egress locking mode. Further observation showed the Maintenance Director and the door contractor could not repair the door and return the door to lock mode. During an interview at the time of the observation, the Maintenance Director verified the door was not working properly and he could not put the	K 222		

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K 222	Continued From page 3 device into locking mode as intended. 2. Observation on 01/15/25, at 10:15 A.M., of the exit door inside the activities room showed the door was labeled with signage of "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." Continued observation showed the door did not function as intended and it was not in the delayed egress locking mode. Further observation showed the Maintenance Director and door contractor could not repair the door and return the door to lock mode. During an interview at the time of the observation, the Maintenance Director verified the door was not working properly and he could not put the device into locking mode as intended. 3. Observation on 01/15/25, at 10:25 A.M., of the exit door near room 25 showed the door was labeled with the signage "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." Continued observation showed the door did not function as intended and it was not in the delayed egress locking mode. Further observation showed the Maintenance Director and door contractor could not repair the door and return the door to lock mode. During an interview at the time of the observation, the Maintenance Director verified the door was not working properly and he could not put the device into locking mode as intended. 4. Observation on 01/15/25, at 10:35 A.M., of the exit door at the patio and activity room on the memory care unit showed the door was labeled with signage of "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS."	K 222		

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K 222	Continued From page 4 Continued observation showed the door did not function as intended and it was not in the delayed egress locking mode. Further observation showed the Maintenance Director and the door contractor could not repair the door and return the door to lock mode. During an interview at the time of the observation, the Maintenance Director verified the door was not working properly and he could not put the device into locking mode as intended.	K 222		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain exit directional signs in accordance with NFPA 101 (2012 edition) section 7.10.1.2.1. This had the potential to affect 15 residents on the Flossie Knight unit. 1. Observation on 01/15/25, at 11:05 A.M., showed an exit directional sign in the egress corridor near room 52 directing one to a door with a sign indicating "not an exit." During an interview at the time of the observation, the Maintenance Director verified the exit sign	K 293		

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K 293	Continued From page 5 was directing one to access an exit door that was not an exit.	K 293		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one hazardous area was	K 321		

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K 321	Continued From page 6 maintained with a one-hour fire barrier in accordance with NFPA 101 (2012 edition) section 8.7.1.1.(1). The deficient practice has the potential to affect the north and south units. 1. Observation on 01/15/25, at 10:00 A.M., showed a natural gas fuel fire boiler room near the nursing station-north hall that contained one large boiler. In the concrete wall, shared with the exit egress corridor, had a two-inch-by-two-inch hole in the concrete. The hole contained two, one-inch silver conduit that went through both sides of the wall. During an interview at the time of the observation, the Maintenance Director verified the presence of the hole.	K 321		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324		

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K 324	Continued From page 7 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the electric stove used for cooking was protected by a hood/exhaust system in accordance with NFPA 96 (2011 edition) section 4.1.1. and 4.1.6. The deficient practice has the potential to affect all residents. 1. Observation on 01/15/25, at 10:50 A.M., of the activity room on the memory care unit showed a four-burner electric stove lacked a hood grease vapor removal system. The stove was fully equipped with four burners and was available for use. During an interview at the time of the observation, the Maintenance Director verified the stove was used regularly. The Maintenance Director verified that animal fats were used in the cooking process.	K 324		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the	K 341		

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K 341	Continued From page 8 building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure two of 81 photoelectric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect the residents in one smoke zone. 1. Observation on 01/15/25, at 10:30 A.M., of a smoke detector in the corridor near room 38 showed the Maintenance Director measured the smoke detector to be 28" from an air diffuser. During an interview at the time of the observation, the Maintenance Director verified the smoke detector was only 28" from the air diffuser. 2. Observation on 01/15/25, at 10:55 A.M., of a smoke detector in the corridor near room 31 showed the Maintenance Director measured the smoke detector to be 15" from an air diffuser. During an interview at the time of the observation, the Maintenance Director verified the smoke	K 341		

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K 341	Continued From page 9 detector was only 15" from the air diffuser. 3. During interviews at the time of the observations, the Maintenance Director stated he had no specifications for the placement or use of the photo electric smoke detectors used in the facility.	K 341		
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure space heaters were not used in accordance with NFPA 101 (2012 edition) section 19.7.8. (2). The deficient practice has the potential to affect 10 residents in the smoke zone. 1. Observations on 01/15/25, at 10:05 A.M., of the Director of Nursing's (DON) office showed a space heater on the floor inside the opening of the desk. The space heater was within three feet of combustibles and had no markings of the maximum temperature for use in health care offices. The DON's office was in the main corridor in the same vicinity as residents' bedrooms. During an interview at the time of the observation, the Maintenance Director said the DON brought the device in from her home and he was not aware of the maximum temperature produced by	K 781		

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K 781	Continued From page 10 the device or if the maximum temperature exceeded 212 degrees Fahrenheit.	K 781		

PLAN OF CORRECTION

Provider/Supplier Name:	Ozarks Methodist Manor
Street Address, City, Zip:	205 S. College Avenue, Marionville, MO. 65705
Date of Survey:	January 15, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265594

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Credible Letter of Allegation. This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, directory, attorney of the Community.	

K 222 F	Egress Doors The facility failed to ensure doors labeled with delayed egress signs to keep pushing were worked as signage directed. The deficient practice to affect 22 residents. The following are plans to correct the deficiency: 1. The identified Egress Door will be repaired by a qualified door company. The egress doors with the 15 second signage by room #25 and memory care exit to the patio doors were unlocked and once locked are functioning correctly. 2. Other egress doors with the 15 second delay will be checked by maintenance person on a weekly basis and during monthly fire drills. 3. The plant operations manager will monitor the egress doors monthly. 4. Plant Ops. Director/maintenance designee will review the weekly checklist to ensure action on findings are repaired immediately. 5. Administrator will report to the QAPI Committee on the deficient practice until compliance is achieved and sustained.	2-20-25
K 293 E	Exit Signage The facility failed to maintain exit directional signs in accordance with NFRA 101(2012 edition) section 7.10.1.2.1. This had the potential to affect 15 residents. 1. Corrective action taken for the Exit Door Signage on Flossie Knight Wing is facing a direction of a door that is not an exit. The sign was removed 1-17-25. 2. The other remaining exit directional signage will be audited to ensure they are proper facing properly according to the stated rule. 3. Plant Ops. Director or maintenance designee will continue to complete weekly exit door signage checklist. 4. Plant Ops. Director or maintenance designee will review the Emergency Exit Door Signage checklist weekly to ensure action on findings are corrected immediately. 5. Administrator will report the deficient practice to the QAPI Committee until the compliance is achieved and sustained.	2-20-25
K 321 F	Hazardous Areas Facility failed to ensure one hazardous area was maintained with a one-hour fire barrier in accordance with NFRA 101 (2012 edition) section 8.7.1.1.(1). This had the potential to affect north/south units. 1. The unsealed penetration area at North Hall Furnace Room 2" X 2" hole with conduit feeding thru a concrete wall was sealed with an ABESCO FP 200 Fire Rated expanding 4hr rated foam. 2. All walls/ceilings have been audited to ensure there are no other	2-20-25

	penetrations checked by maintenance designee starting on 1-16-25. 3. Plant Ops. Director or maintenance designee will review the wall/ceiling penetration will use checklist weekly to ensure action on findings are repaired immediately. 4. Administrator will report to the QAPI Committee until compliance is achieved and sustained.	
K 324 F	Cooking Facilities The facility failed to ensure the electric stove used for cooking was protected by a hood/exhaust system in accordance with NFPA (2011 edition) section 4.1.1. and 4.1.6. The deficient practice has a potential to affect all residents. 1. The four-burner electric stove that lacked a hood grease vapor removal system was removed from the building. 2. The stoves have been removed from the building on January 20, 2025. These electric stoves will no longer be acceptable without a hood system. 3. No stoves will be permitted in activity areas without an approved hood system. Plant Ops. Director will monitor for compliance. 4. Administrator will report to the QAPI Committee until compliance is achieved and sustained.	2-20-25
K 341 E	Fire Alarm System-Installation The facility failed to ensure two of 81 photoelectric smoke detectors were greater than 36" from the ceiling air diffusers in accordance NFPA 72 (2010 edition) section 29.8.3.4.(6). This deficient practice has the potential to affect the residents in one smoke zone. 1. The two smoke detectors near room 31 and 38 will be moved by a qualified company away from an air diffuser of more than 36". 2. The entire building has been audited to ensure no other deficient practices are visualized. 3. Plant Ops. Director or designee will conduct weekly rounds in all hallways to ensure all smoke detectors are more than 36" away from an air diffuser. 4. Plant Op Director will monitor to ensure continued compliance. 5. Administrator will report to the QAPI Committee until compliance is achieved and sustained.	2-20-24
K 781 E	Portable Space Heaters The facility failed to ensure space heaters were not used in accordance with NFPA 101 (2012 edition) section 19.7.8. (2). The deficient practice has the potential to affect 10 residents in the smoke zone. 1. The space eaters were removed from the office of Director of Nursing Services. 2. All other offices/spaces were audited on 1-20-25 by Plant Ops. Director.	2-20-24

	3. The management team have been in-services on the dangers and risks to using space heaters. The space heaters are forbidden to use in any buildings housing residents. 4. Plant Ops. Director will monitor spaces to ensure compliance. 5. Administrator will report to the QAPI Committee until compliance is achieved and sustained.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.