STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265171	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Osage Beach Rehabilitation and Health Care Center	844 Passover Road Osage Beach, MO 65065

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure one resident (Resident #2) remained free from sexual abuse, when a resident (Resident #1) entered Resident #2's room and touched his/her chest. The facility census was 81.The administrator was notified on 06/22/26 of Past Non-Compliance which occurred on 06/17/26. The Administrator and Director investigated, notified the residents' responsible parties, and in-serviced staff regarding abuse, sent Resident #1 to the hospital for evaluation, and initiated one on one monitoring. Resident #2 had additional therapy services initiated as a result of this. Staff corrected the deficient practice on 06/18/26. 1.Review of the facility's Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, revised 2/1/23, showed Sexual Abuse is defined as non-consensual sexual contact of any type with a patient that includes but is not limited to, sexual harassment, sexual coercion, or sexual assault. 2.Review of the facility's internal investigation report, dated 6/17/26, showed staff documented Resident #1 came into Resident #2's room and placed his/her hand down Resident #2's shirt, touched Resident #2's chest. Resident #2 said Resident #1's hands were cold. Resident #2 said it caused him/her to have childhood memories of being molested. Staff documented 15-minute checks were initiated.3.Review of Resident #1's face sheet showed the resident admitted on [DATE] with diagnoses of vascular dementia with psychotic disturbance, delusional disorders and anxiety disorder. Review of the resident's plan of care, dated 6/18/26, showed staff assessed the resident with inappropriate sexual behaviors and wanders into other residents' rooms. Staff were directed to administer medications as ordered, monitor and observe for change in and behavior, be direct and prompt when telling the resident his behavior is inappropriate and restrict harmful physical action in a cautious non harmful manor.Review of the resident's nurse's notes, dated 6/10/26, showed staff documented the resident was in another residents room and kissed the resident on the cheek. The resident was redirected. Resident prior to incident was wandering the halls and was redirected from other rooms. During an interview on 6/22/26 at 8:26 A.M., the Director of Nursing (DON) said the facility sent Resident #1 to the hospital but there were no open beds available. He/She said Resident #1s medication had previously been changed but did not have time to take effect. He/She said Resident #1 needs a locked unit.4.Review of Resident #2's quarterly MDS, 4/3/26, showed facility staff assessed the resident as cognitively intact, rejects care and diagnoses of seizures and anxiety disorder. Review of the resident's nurses notes, dated 6/17/26, showed staff documented they responded to a resident shouting help, upon entering room, the resident said there was a resident in his/her room going through his/her things and he/she asked the other resident to stop then the resident came over to him/her and reached over the walker and stuck his/her hand in his/her shirt and groped his/her chest. The resident yelled stop and help and pressed the call light. During an interview on 6/22/26 at 8:26 A.M., The DON said Resident #2 has a history of being sexual assault by his/her family members. He/She said Resident #2 has stayed in his/her room since the incident because he/she does not want to interact with Resident #1. During an interview on 6/22/26 at 9:07 A.M., the administrator said Resident #2 has a history of being sexually (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 0600 Level of Harm - Actual harm Residents Affected - Few	abuse from his/her family. He/She said Resident #2 has seen his/her therapist since the incident to help him/her transition. During an interview on 6/22/26 at 9:15 A.M., Resident #2 said Resident #1 entered his/her room and started to go through his/her stuff. He/She said the resident then put his/her hand down his/her shirt and touched his/her chest. He/She said he/she was molested as a child, and this brought it all back. He/She said if he/she had a belt he/she would have beat the resident with it. He/She said he/she does not want to face the resident, never wants to see him/her again. During an interview on 6/22/26 at 9:35 A.M., Graduate Registered Nurse (GRN) said he/she heard Resident #2 yell from his/her room for help. He/She entered the room and Resident #2 said Resident #1 had come into his/her room and touched his/her chest. He/She said he/she went to find Resident #1 to ensure he/she was not in another resident's room and had another nurse sit with Resident #2 while he/she went to report the allegations. During an interview on 6/22/26 at 8:26 A.M., the DON said all staff were educated for Resident #1 to be on one on ones and then 15-minute checks when in room, but if up and wandering he/she is always with a staff. Complaint # 3047620