

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Ozark Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1083 Ozark Care Drive, 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27152</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from sexual abuse when Resident #2 touched Resident #1's chest inappropriately. The facility census was 40.</p> <p>1. Review of the facility's Abuse Prevention Program, undated, showed the facility affirms the right of their residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents. Review showed:</p> <ul style="list-style-type: none"> -Abuse is defined as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility; - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish; -Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. <p>2. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 3/25/24, showed staff assessed the resident as cognitively intact.</p> <p>Review of the resident's plan of care, updated 5/01/23, showed staff were directed to provide the resident with privacy and dignity.</p> <p>Review of the facility investigation, dated 6/26/24, showed staff documented a staff member reported Resident #2 sat in a chair in the lobby and Resident #1 sat in a chair next to him/her. Resident #2 then reached over and grabbed Resident #1's chest and in turn Resident #1 closed fist struck Resident #2 in the chest.</p> <p>Review of the resident's nurse's notes, dated 6/26/24, showed staff documented Resident #2 grabbed Resident #1's chest and Resident #1 punched Resident #2. Staff documented the resident said he/she is ok, but pissed off about it.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/27/24 at 12:45 P.M., Resident #1 said Resident #2 pressed up on my chest, and I smacked him/her. He/She said Resident #2 knew what he/she was doing. The resident said he/she did not like it, when Resident #2 touched his/her chest inappropriately.</p> <p>2. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident with cognitive impairment, physical and verbal behaviors directed at others, and other behaviors not directed at others.</p> <p>Review of the residents hospital records, dated 1/11/24, showed the physician documented the resident has, continued to have sexual behaviors and inappropriate comments, although managed better with current medications.</p> <p>Review of hospital records, dated 3/21/24, showed the physician documented the resident has become more aggressive, and the facility licensed staff are, concerned that he/she does force things on his/her spouse, who he/she shares a room with. The physician documented the resident is easily aggravated, with abnormal sexual behavior.</p> <p>Review of the resident's plan of care, updated 6/27/24, showed staff were directed as follows:</p> <ul style="list-style-type: none"> -09/29/22 (revised 5/14/24)- Resident is known/has history of displaying inappropriate behavior. Specific behavior exhibited making inappropriate comments or making physical contact with staff or residents. Related diagnosis/condition Schizophrenia, Delirium (a serious change in mental abilities), personal history of other mental and behavioral conditions, altered mental state; -09/29/22- During episodes of inappropriate behavior, remove to a quiet environment; -09/29/22- Help resident understand why behavior is inappropriate/disruptive and the impact is has on personal well-being of others; -Initiate 15 minute checks for 72 hours; -Provide redirection/cueing as tolerated. <p>Review of the resident's Physician's Order Sheets, dated 6/01/24 to 6/30/24, showed the following orders:</p> <ul style="list-style-type: none"> -12/14/23- Estradiol (a hormone) one milligram (mg) one tablet daily for sexual behaviors, discontinued 6/21/24; -02/28/24- Progesterone (a steroid hormone) one capsule daily for sexual behaviors, discontinued 6/21/24; -03/01/24- Fluoxetine (an antidepressant) 40 mg two capsules once daily for depression with sexual behaviors, discontinued 6/21/24; -03/18/24- Naltrexone (an opioid analgesic) 50 mg one tablet daily for sexual behaviors; <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Review of the resident's nurse's notes, dated 6/26/24, showed staff documented the resident had abnormal behavior with another resident.</p> <p>Review of the resident's social service notes, dated 6/26/24, showed staff documented the resident grabbed a resident's breast.</p> <p>During an interview on 6/27/24 at 12:50P.M., Resident #3 said he/she saw Resident #2 grab Resident #1's chest.</p> <p>During an interview on 6/27/24 at 2:00 P.M., the Social Service Director (SSD) said he/she heard other people witnessed Resident #2 grab Resident #1's chest. He/She said staff are directed to redirect Resident #2 if the resident makes inappropriate comments.</p> <p>During an interview on 6/27/24 at 2:12 P.M., the Activities Director (AD) said he/she saw Resident #2 grab Resident #1's chest as he/she came out of the administrator's office. He/She said he/she reported the incident immediately to the administrator.</p> <p>During an interview on 6/27/24 at 2:55 P.M., the administrator said Resident #2 has a history of making inappropriate comments to female staff. He/She said Resident #1 has sat next to Resident #2 in the lobby of the facility on previous occasions, and did not have any issues.</p> <p>MO00238191</p>		