STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Immediate jeopardy to resident health or safety 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** 21382 Based on policy review, record review, review of the State Survey Agency's Long Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to ensure residents were free from abuse. This was true for 1 of 12 residents (Resident #25) reviewed for abuse. This deficient practice placed Resident #25 in immediate jeopardy of serious harm, impairment, or death when the facility did not protect him from physical and sexual abuse from Resident #52. Findings include: The facility's Freedom from Resident Abuse, Neglect, Mistreatment & Exploitation Policy, and Procedure, dated 6/2021 documented each resident has the right to be free from verbal, sexual, physical, and mental abuse; neglect, exploitation, mistreatment, including injuries of unknown source misappropriation of resident's property, involuntary seclusion, and crime against a resident. The policy defined the following: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse - is non-consensual sexual contact of any type with a resident. The facility's Social Services Procedure Manual, revised 10/2016, defined sexual abuse as, but not limited to, sexual harassment, sexual coercion, or sexual assault. The manual stated Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the residents. Findings of the examination must be recorded in the resident's medical record. (Note: If sexual abuse is suspected, DO NOT bathe the resident, or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately.) - Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including dementia, right hemiplegia, and hemiparesis (paralysis or weakness on one side of the body), neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well), and chronic kidney disease. An annual MDS assessment, dated 4/30/24, documented Resident #25 had moderately impaired cognition and was rarely or never understood. The assessment also documented Resident #25 had a short term and long-term memory problem. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including dementia with Lewy bodies (protein deposits develop in nerve cells in the brain causing a decline in mental abilities that gradually gets worse over time) and Parkinson's disease. A quarterly MDS assessment, dated 2/6/24, documented Resident #52 was moderately cognitively impaired. Resident #52's care plan, initiated 4/19/24, documented he had sexually inappropriate behaviors as evidenced by disrobing, fondling himself, making sexually explicit comments and inappropriately touching himself. Resident #25 and Resident #52 were roommates. a. An Investigation Report, dated 5/5/24, documented CNA #1 stated she entered Resident #25 and Resident #52's room to answer their call light. CNA #1 saw Resident #52 on top of Resident #25's bed. Resident #52 was on all fours straddling Resident #25. CNA #1 stated she saw Resident #25's brief on the floor and his catheter had been pulled out. Resident #52 had nothing on from his waist down. CNA #1 stated she did not see Resident #52 pull Resident #25's catheter out, but she knew Resident #25 did not have the strength to remove his own brief or catheter. The report documented CNA #1 reasoned based on the position Resident #52 was in, he had done it to [Resident #25]. CNA #1 reported Resident #25 did not say anything, but he looked wide-eyed and scared. The report documented [Resident #25] had BM [bowel movement] on him from his brief and [Resident #52] had it all over him. After being cleaned up, Resident #52 was moved to another room. The report documented CNA #2 went to Resident #25's room on 5/5/24 at 8:12 AM to get his lunch order. Resident #25 told CNA #2 he wished he was here last night. When Resident #25 was asked why by CNA #2, Resident #25 told him he was molested last night. b. A Late Entry Incident Note, dated 5/5/24 at 2:50 AM, documented Resident #25's roommate had pulled his catheter out. The nurse grabbed the catheter supplies and went to the room. Resident #52 was on his side of the room being cleaned up by staff and Resident #25 was also being cleaned up. The note documented This LN replaced his catheter. The note did not document Resident #25 was assessed for trauma when his indwelling catheter was traumatically removed. c. An Alert Charting Progress Note, dated 5/5/24 at 10:50 AM, documented Resident #25 had blood on his adult brief that was coming from the head of his penis. A Nursing Note, dated 5/5/24 at 11:00 AM, documented a skin check was completed for Resident #25. An abrasion to the tip of his penis was noted, and frank blood (fresh blood) was present. d. A Notice of Emergency Discharge, dated 5/6/24, documented on 5/5/24 Resident #52 was found in state of undress on top of Resident #25. The Notice documented Resident #52 had removed Resident #25's adult brief and forcefully removed Resident #25's catheter causing visible physical harm to Resident #25 as well as psychosocial harm associated with the assault. e. A Progress Note, date 5/6/24 at 9:47 PM, documented Resident #25 had Small amount of frank blood from penis still present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #25's record did not include documentation the physician was notified of the blood on his adult brief that was coming from the head of his penis or presence of the abrasion to the tip of his penis. On 6/25/24 at 2:20 PM, SW #2 stated on the night of 5/5/24, Resident #52 was found on his hands and knees over Resident #25. Resident #25 and Resident #52 were both naked from their waist down. SW #2 stated Resident #52 was moved to a private room that night and placed on a 1:1 supervision. SW #2 stated the facility did not consider Resident #25 was sexually abused by Resident #52 as Resident #52 could not have done anything sexual in the position they were found in. On 6/26/24 at 10:16 AM, Resident #25 stated he remembered an incident with Resident #52. When asked if Resident #52 physically touched him in any other way than removing his brief and indwelling catheter, he shook his head. When asked if he was afraid of anyone in the building, Resident #25 shook his head to indicate no. When asked if he consented to the incident, Resident #25 shook his head. Resident #25 stated he did not want what Resident #52 did to happen. On 6/26/24 at 2:05 PM, during a follow-up interview, Resident #25 stated he had pain when his indwelling catheter was pulled out by Resident #52. On 6/26/24 at 4:05 PM, during a telephone interview, RN #1 stated she was on the other side of the facility with another resident when she was called to Resident #25 and Resident #52's room. RN #1 stated when she entered their room, Resident #25 and Resident #52 were both seated on their side of the room being cleaned by two CNAs. CNA #1 explained to her how she found Resident #25 and Resident #52. RN #1 stated she assessed Resident #25 and re-inserted his indwelling catheter. RN #1 stated I thought the incident was sexual. RN #1 stated there was an abrasion to the groin of Resident #25. On 6/26/24 at 5:50 PM, CNA #1 stated when she entered Resident #25 and Resident #52's room to answer their call light, she saw Resident #52 on top of Resident #25 straddling him. Resident #52 was holding himself up on his hands and knees over Resident #25. CNA #1 stated Resident #25's indwelling catheter and his adult brief were on the floor with bowel excrement (stool). Resident #25 and Resident #52 had stool all over them. CNA #1 stated she told Resident #52 to get off Resident #25, but Resident #52 did not move. CNA #1 stated she stepped to the door and yelled for help then returned to the bedside where Resident #25 and Resident #52 were and asked Resident #52 to get off Resident #25 again, Resident #52 then moved. When CNA #1 was asked what she thought was happening, CNA #1 stated it appeared to be sexual abuse as the residents did not have anything on from their waist down. CNA #1 stated Resident #52 had stool on his hands and Resident #25 had stool all over him. On 6/26/24 at 3:35 PM, when asked what a reasonable person would think if she found the men in the position they were, the DON replied, Some sort of assault had happened or was about to happen. On 6/26/24 at 3:45 PM, the Administrator stated he did not feel this was sexual abuse. On 6/26/24 at 5:05 PM, the Medical Director stated he had been the facility's medical director for [AGE] years. When asked about Resident #25 and Resident #52's incident, the Medical Director stated his gut feeling was more sexual. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/27/24 at 4:00 PM, SW #2 stated in regard to interviewing other residents about Resident #52's inappropriate sexual behavior, no, I didn't think it was necessary and didn't think other residents would have anything to contribute. When asked if they might have had something pertinent to share, he stated, I didn't feel they did. Resident #25 was not sent out for a sexual assault examination by a medical provider. There was no documentation in Resident #25's record action was taken to prevent an incident of sexual abuse from happening to other residents. No other residents were interviewed to ensure they were not victims of sexual assault. This failure put all residents in immediate jeopardy for abuse. On 6/26/24 at 8:18 PM, the Administrator and DON were notified of an Immediate Jeopardy (IJ) at F600 related to the facility's failure to ensure Resident #25 was free from sexual abuse. On 6/27/24 at 2:43 PM, the facility provided a plan to remove the immediacy which was accepted. On 6/28/24 at 10:30 AM, the Administrator was notified that the immediacy was removed following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a G scope and severity following the removal of the immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 21382 Based on policy review, record review, review of the the State Agency's Long Term Care Reporting Portal, and staff interview, it was determined the facility failed to ensure an allegation of resident abuse was reported to the State Survey Agency within 2 hours. This affected 1 of 12 residents (Resident #25) who were reviewed for abuse. This failure created the potential for residents to be subjected to ongoing abuse without detection and protective measures implemented by the facility. Findings include: The facility's policy titled, Abuse and Neglect Signs and Symptoms of Abuse/Neglect, revised 6/2021, stated The Idaho State Veteran's Home will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. The policy further stated once the allegation was deemed to be reportable by the Abuse Response Team, the social worker reported the alleged violation to the State Long Term Care Agency. The reporting requirement must be met immediately but no later than 2 hours after the allegation is made if the allegation involves actual harm or serious bodily injury. The policy stated if the alleged violation meets the definition of abuse, neglect, exploitation, or mistreatment, the facility should not make an initial determination whether the allegation is credible before reporting the allegation. The State Operations Manual Appendix PP, revised 2/3/23, states In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: -Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made . a. A Facility Reported Incident documented a CNA called this LN to let me know that resident's roommate was naked on top of him in his bed. [Resident #25's] roommate had pulled off [Resident #25's] brief and pulled his catheter out. Staff told his roommate to get off of him. Resident complied within a few minutes. This LN grabbed catheter supplies and went to the room. At this time [Resident #25's] roommate was on his side of the room being assisted/cleaned up by staff. [Resident #25] was also being assisted/cleaned up. This LN replaced his catheter. Residents' roommate was moved to a single room near the nurse's station. The report documented the incident occurred on 5/5/24 at 2:50 AM. The report was submitted to the State Agency's Long Term Care Reporting Portal on 5/5/24 at 11:23 AM, more than 8 hours after the incident occurred. b. A Facility Investigation Summary, dated 5/5/24, documented CNA #2 went to Resident #25's room on 5/5/24 at 8:12 AM to get his lunch order. Resident #25 told CNA #2 he wished CNA #2 was there [at the facility] last night. When Resident #25 was asked why by CNA #2, Resident #25 told him he was molested last night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 - Few	c. A Notice of Emergency Discharge, dated 5/6/24, documented on 5/5/24 Resident #52 was found in state of undress on top of Resident #25. The Notice documented Resident #52 had removed Resident #25's adult brief and forcefully removed Resident #25's catheter causing visible physical harm to Resident #25 as well as psychosocial harm associated with the assault. d. A fax coversheet, dated 5/5/24, sent by Social Worker SW #2 at 10:30 AM to the local Police Department, included a form titled, Reasonable Suspicion of a Crime Against a Resident Reporting Form. The instructions on the form stated, Contact and submit this completed form to the [State Long Term Care Agency] and local Police Department within 2 hours (if there is serious bodily injury) or 24 hours (if there is not serious bodily injury) of forming a reasonable suspicion that a crime may have been committed against any individual who is a resident of the [facility]. The form included both residents' names and a description of the incident. The form asked, Was there serious bodily injury as a result of the incident? SW #2 marked no in response to the question. A Facility Investigation Summary, dated 5/5/24, and submitted to the State Agency's Long Term Care Reporting portal on 5/8/24, documented 5/5/24 incident between Resident #25 and Resident #52 was described as . resident's roommate was naked on top of him in his bed.roommate had pulled off.brief and pulled.catheter out. The facility's findings were, Information gathered from [Resident #52] along with staff provide clear evidence [Resident #25] was physically abused by his roommate [Resident #52]. [Resident #25's] own statements provide clarity to what [CNA #1] had witnessed and reported. During an interview with SW #2 on 6/25/24 at 1:56 PM, he confirmed he conducted the investigation of the incident on 5/5/24 that occurred between Resident #25 and Resident #52. He stated he did not recollect the events and would need to review his notes of the incident in his own time. When asked about the incident, SW #2 stated, If we knew at the time that it was abuse it might have been a two-hour report. He stated he and the Administrator did not feel the incident resulted in serious bodily injury to Resident #25 and therefore did not have to be reported within two hours but instead within 24 hours. During an interview on 6/25/24 at 2:42 PM, SW #2 and the Administrator stated they (the facility) did not report the allegation withing two hours since there was no serious bodily injury. The Administrator and SW #2 both stated the reporting requirement was 24-hours for abuse when there was no serious bodily injury. When the language in the regulation was explained to state abuse, neglect, misappropriation, or serious bodily harm they both focused on serious bodily harm for reporting in two hours. During an interview with the Administrator on 6/26/24 at 3:45 PM, he stated he did not feel the incident was sexual abuse but could not speak for staff. However, the Administrator stated he felt that there was physical contact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on policy review, record review, review of the State Survey Agency's Long Term Care Reporting Portal, and staff interview, it was determined the facility failed to ensure allegations of abuse were thoroughly investigated. This was true for 1 of 12 residents (Resident #25) reviewed for abuse. This failure placed Resident #25 at risk for the potential of more than minimal harm when the facility did not protect him from physical and sexual abuse from Resident #52. This deficiency also created the potential for all residents residing in the facility to be subjected to ongoing abuse without detection and protective measures implemented by the facility. Findings include: The facility policy titled, Abuse and Neglect Signs and Symptoms of Abuse/Neglect, revised 6/2021, stated Regardless of whether an allegation requires federal or state reporting.all allegations related to abuse (physical, mental, sexual, and verbal), neglect mistreatment, injuries of unknown source.must be thoroughly investigated by the facility under the direction and oversight of the Abuse Response Team, and in accordance with state and federal law. The policy defined the following: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse - is non-consensual sexual contact of any type with a resident. Serious bodily injury - an injury involving extreme physical pain . or an injury resulting from criminal sexual abuse. The policy stated further stated, .steps will be utilized to assist in ensuring a proper, thorough, and impartial investigation is completed timely related to any alleged violation .the allegation is related to abuse, neglect, mistreatment.then Social Services or designee .will take the lead . The policy also stated, 'Any persons who have first-hand knowledge of the incident must submit a signed and dated written statement to the Principal Investigator before they leave the premises at the end of their shift. All statements must include specific times, places, staff/residents, what was said and by whom, and what was seen, in chronological order. - Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including dementia, right hemiplegia, and hemiparesis (paralysis or weakness on one side of the body), neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well), and chronic kidney disease. An annual MDS assessment, dated 4/30/24, documented Resident #25 had moderately impaired cognition and was rarely or never understood. The assessment also documented Resident #25 had a short term and long-term memory problem. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Idaho State Veterans Home - Lewiston	821 21st Avenue Lewiston, ID 83501

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #52 was admitted to the facility on [DATE], with multiple diagnoses including dementia with Lewy bodies (protein deposits develop in nerve cells in the brain causing a decline in mental abilities that gradually gets worse over time) and Parkinson's disease. Resident #52's care plan for behaviors, initiated on 4/19/24, documented Resident #52 had a history of behaviors socially and sexually inappropriate related to dementia and neurocognitive disorder with Lewy bodies. Goals included were to not have Resident #52 harm himself or others and he would have fewer episodes of exposing himself. Interventions also were initiated on 4/19/24 and included anticipating Resident #52's needs, reapproach him if resistive to care, include Resident #52 in an activity program, monitor the number of behavioral episodes. and try to determine the root cause. A second care plan, initiated on 4/19/24, related to Resident #52's sexually inappropriate behaviors. The focus of Resident #52's behaviors was disrobing, fondling himself, sexually explicit comments, and inappropriate touching of himself. The goal was for the behaviors to lessen. The interventions included distraction with activities of preference, offer food or drink, staff were to tell him when his behaviors affected others, monitor, and identify triggers, and staff were to walk away if the behavior persisted. A Facility Reported Incident Summary, dated 5/5/24, did not include times for any the interviews for statements that SW #2 conducted, as directed by the facility policy. The summary documented SW #2 interviewed Resident #25 and Resident #52 on 5/5/24. On 5/7/24 at an unspecified time, SW #2 asked Resident #25 to walk him through what happened on 5/5/24. Resident #25 stated he woke up to a man standing over him handling his indwelling catheter. Resident #25 stated he used his call light for assistance and wished he had something to hit him [Resident #52] with, and that he was afraid. Resident #25 stated he felt unsafe when it happened but after being told Resident #52 was no longer in the facility and would not return, he stated he said good. The summary documented Resident #52 was discharged to the hospital. SW #2 interviewed staff, Resident #25, and Resident #52 as part of his investigation. The investigation did not include interviews with other residents to rule out further allegations and that residents felt safe. During an interview with SW #2 on 6/27/24 at 4:00 PM, he stated he did not think it was necessary to interview other residents and did not think other residents would have anything to contribute. When asked if the residents might have had something pertinent to share, he stated, I didn't feel they did. During an interview with the Administrator on 6/26/24 at 3:45 PM, he stated he did not feel the incident was a sexual incident but could not speak for staff. However, he stated he felt there was physical contact, and staff made Resident #25 and Resident #52 safe, and followed facility policy.