STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	201 Alix Avenue Red Oak, IA 51566

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview, staff interviews and facility policy review, the facility failed to report an allegation of abuse to the appropriate entity for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 40 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS documented a diagnosis of Alzheimer's disease with early onset. Review of Resident #1's Electronic Health Record (EHR) titled, Progress Note entered by Staff A, Registered Nurse (RN) on 12/20/26 at 11:42 AM documented Staff H, Certified Nurse Assistant (CNA) reported she had observed Resident #1 and Resident #2 sitting at the nurses station with their hands down each other's pants. The residents were both separated. Resident #2 was taken to his room. Both Residents were assessed for trauma and none was observed. The Director of Nursing (DON), Staff G, Social Services Director, and the Administrator are aware of the incident. The Administrator stated the incident was not reportable because both residents had documented dementia.2. The MDS dated [DATE] documented Resident #2 had a BIMS of 03 indicating severe cognitive impairment. The MDS documented a diagnosis of vascular dementia, unspecified severity with other behavioral disturbance. Review of Resident #2's EHR titled, Progress Note entered by Staff A, Registered Nurse on 12/20/26 at 11:42 AM with effective date of 12/20/26 at 10:26 AM documented Staff H reported she had observed Resident #2 and Resident #1 sitting at the nurses station with their hands down each other's pants. The residents were separated and Resident #2 was assisted to his room. Both residents were assessed for trauma and none was observed. The DON, Staff G, and the Administrator are aware of the documented incident. The Administrator called the facility and stated the incident was not reportable because both residents had documented dementia.Review of Resident #2's EHR titled, Progress Note entered by Staff A, Registered Nurse on 12/20/26 at 12:35 PM with effective date of 12/20/26 at 12:16 PM documented Resident #2 observed reaching to touch another resident. Resident #2 was redirected by a CNA. Resident #2 hit the staff several times and told the staff to mind their business and leave him alone.On 2/18/26 at 9:15 AM Resident #1 stated she thought she had eaten breakfast but could not remember. Resident #1 acknowledged she did not know where this area was when asked if she grew up in the area of this facility. Resident #1 stated she kept to herself at the facility and was not friends with any of the residents at the facility. Resident #1 stated the staff treat her with dignity and respect at the facility. Resident #1 acknowledged she felt safe at the facility and was not scared of any of the residents or staff members. Resident #1 stated other residents had not attempted to touch her in any inappropriate ways.On 2/18/26 at 9:05 AM Resident #2 stated he had eaten breakfast that morning. Resident #2 explained that he had sausage, bacon, eggs and oatmeal. Resident #2 said the food was good. Resident #2 explained he did not have any friends that lived at the facility from his childhood. Resident #2 stated he had friends at the facility but could not remember any of their names or (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan - Red Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Alix Avenue Red Oak, IA 51566	

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(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	how he knew them. Resident #2 said he thought the staff treated him with dignity and respect. Resident #2 stated he felt safe at the facility. Resident #2 explained he had not touched any of the residents in any inappropriate way and none of the residents at the facility had touched him in any inappropriate way.On 2/17/26 at 5:30 PM Staff H, CNA acknowledged she had seen residents at the facility inappropriately touching each other. Staff H stated she had worked on a weekend and there were 2 residents sitting on the wall with their hands in each other's pants. Staff H acknowledged the incident occurred on 12/20/26. Staff H identified the 2 residents as Resident #1 and Resident #2. Staff H explained she did not see any movement in their pants but maybe Resident #1 was holding Resident #2's penis. Staff H said she stopped the 2 residents and assisted Resident #2 to his room. Staff H explained she told Staff A and Staff I, Licensed Practical Nurse (LPN). Staff H explained reported the incident to Staff A. Staff I acknowledged Staff A's Progress Notes entries regarding this incident for Resident #1 and Resident #2 was an accurate record of what happened. Staff H stated she did not see the nurses complete an assessment. Staff H stated she knew the incident had to be reported to the nurse for safety reasons because maybe Resident #2 would do it to someone else. Staff H stated she knew both residents had dementia. Staff H stated neither resident would remember what was discussed 15 minutes later. On 2/17/26 at 3:42 PM Staff G, Social Services Director stated she was informed of an incident where Resident #2 was reaching towards a resident. Staff G explained she called the DON and the DON called the Administrator. Staff G stated the incident was Resident #1 and Resident #2. Staff G stated during the incident Resident #2 was reaching towards Resident #1. Staff G stated she was unaware if the Administrator called the facility back after that. Staff G stated the incident she was talking about happened prior to Christmas of 2025 maybe around the 19th. Staff G explained Staff A did not report to her that the residents had each other's hands in their pants. Staff G said she notified the DON of the incident but she did not say there were hands in pants but could not remember exactly what was said. Staff G acknowledged she did not document the incident. Staff G stated she did not know if Staff A tried calling the DON first but she was not on call. Staff G explained typically those situations are brought to the DON or the Administrator. On 2/18/26 at 1:04 PM Resident #2's son stated his father was struggling with dementia and things have changed in his world with how he conducts himself. Resident #2's son stated he did not know exactly who reached out to talk to him about the incident. Resident #2's son explained he was out of town and the facility called his brother and then he followed up with the facility. Resident #2's son stated they had shared with him the concern of the 2 residents inappropriately touching each other. Resident #2's son explained they had come to a conclusion that it would have been better to have his dad stay in his room and move him to the nurses station to keep an eye on him. Resident #2's son stated he did feel it was inappropriate for the 2 residents but did not think there was any sort of abuse. On 2/18/26 at 1:25 PM Resident #1's daughter said she was only notified of one incident and that incident occurred back in December. Resident #1's daughter stated it was described to her as hands were being held. Resident #1's daughter said the staff described the residents having each other's hands in their waistband. Resident #1's daughter stated she did not remember who had notified her of the incident. On 2/17/26 at 2:38 PM the DON acknowledged there were no married residents living together at the facility. The DON acknowledged there are no residents involved in an intimate relationship with each other both living at the facility. The DON said there are no residents that inappropriately touch other residents. The DON stated she had not been made aware of Resident #2 inappropriately touching any residents of recent. The DON explained if the resident was inappropriately touching another resident such as putting his hands down their pants, up their shirt or touching their breast she would expect to be (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of those situations. The DON further explained once she was notified she would come into the facility and complete an investigation to determine if it was abuse and would have a 2 hour window to self report to the stated agency. The DON acknowledged she was not notified that Resident #2 had his hands down another resident's pants. The DON stated the facility had an algorithm to determine if the situation was reportable to the state or not. The DON stated she was not aware this incident that was documented to have occurred on 12/20/25 between Resident #1 and Resident #2. The DON stated the Administrator could determine if the incident was reportable to the state or not he also had access to the algorithm. The DON said she had not reported the incident to the state agency because she was unaware of the incident. On 2/18/26 at 10:13 AM the DON said Staff G called and said there was an incident. The DON said she called the Administrator and told him to call the facility. The DON stated there were no details provided about the incident to her. The DON explained that the Administrator handled the situation from there. The DON stated she was on vacation over Christmas at that time. The DON acknowledged the incident did not come back up and she had not returned until January. The DON stated she had talked to Staff H 2/18/26. The DON explained that Staff H stated she had walked up to the nursing station and said Resident #1 and Resident #2 had hands in each other's waistband. The DON stated Staff H had explained there was no movement with either resident's hands. The DON stated she asked if Staff H felt it was sexual. The DON said Staff H said no not really but knew she needed to separate them. The DON stated Staff H said she separated them and told Staff A. The DON stated having hands in each other's waistbands did not indicate the activity was sexual in nature but they do not want the residents doing that. The DON explained the residents were not moving their hands while in each other's waistbands. The DON stated Staff A had told the Administrator she had not seen anything. The DON explained if the residents truly just hands in each other's waistbands and nobody was moving or doing anything then no assessment would be required. On 2/18/26 at 9:28 AM the Administrator stated he had read the progress note from 12/20/25 yesterday. The Administrator stated he thought that the situation had occurred on a Saturday and Staff A had called Staff G and said it seemed like Resident #1 and Resident #2 had their hands in each other's pants. The Administrator explained the situation was reported to have happened out at the nurses station. The Administrator explained he called the building and talked to Staff A. The Administrator said Staff A explained that Staff H saw both the residents with their hands in each other's pants. The Administrator stated Staff A acknowledged she didn't see the situation Staff H did. The Administrator explained Staff A would talk to Staff H and after she found out more details she should call him back. The Administrator stated Staff H talked to Staff H and called back. The Administrator said Staff A explained that Staff H reported she was walking down the hallway and it looked like Resident #1 and Resident #2 had each other's hands in each other's pants but the 2 residents were actually holding each other's hands. The Administrator stated Staff A said Staff H thought that was different and she said she separated them. The Administrator stated Staff A explained the 2 residents were not out by the nurses station very long. The Administrator explained he asked Staff A did Staff H actually see hands in the pants. The Administrator stated Staff A had just jumped to that conclusion. The Administrator stated Staff A asked do we need to report this. The Administrator said he told Staff A he would talk to the DON and decide. The Administrator explained what they knew was the 2 residents were holding hands and he was holding her hand in his lap. The Administrator explained Staff A said Staff H had separated the 2 residents and Staff A was going to complete an assessment. The Administrator stated the DON and he had talked and the Progress Note did not seem to add up to what was initially presented. The Administrator stated he called Staff A back at the facility and said they were not going to report it. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator said Staff A kind of argued with him a little. The Administrator stated he explained to Staff A nothing was seen that indicated hands in the pants. The Administrator explained the staff just had to do a better job keeping the two of them separated. The Administrator stated he thought it was Staff H that had reported the situation. The Administrator stated when returned to work on Monday he did not think that he had talked to the nurse or the CNA about the incident. The Administrator explained the facility did have cameras in the front lobby but the DON attempted to look yesterday but the review was short of that date. The Administrator stated they were unable to go back that far in the video footage. The Administrator stated talking to Staff A on Saturday he felt the situation did not warrant an investigation. The Administrator said they did not look at the cameras or talk to the staff about the incident. The Administrator explained if the residents did indeed have each other's hands down each other's pants it would have been a totally different story. The Administrator acknowledged there was only one witness and it went from hands in the pants to hands in the lap during his discussion.Review of policy revised 7/6/23 titled Abuse and Neglect documented the purpose was to ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location, to ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect, exploitation and abuse of residents and misappropriation of their property, to ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals, to ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated and to ensure a complete review of existing incidents by the investigation team to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation. The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends or other individuals. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services. These designated individuals are delegated the authority by the administrator to: Intervene in any situation in order to protect residents. Remove any individual from the location if necessary for the protection of residents or employees, including but not limited to employees, visitors, contractors or family members. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The charge nurse also will ensure that any potential for further abuse is eliminated. Notification procedures: Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.). Document this notification in the Risk Management module of PCC. Designated agencies will be notified (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported no later than 24 hours after the allegation is made. If the designated agency(ies) requests a written report, notify the social worker and administrator. Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that an investigation is in progress. Record this notification. The investigation team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident.

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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** Based on clinical record review, family interviews, staff interviews and policy review, the facility failed to complete a comprehensive investigation immediately when an allegation of abuse was reported for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 40 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS documented a diagnosis of Alzheimer's disease with early onset. Review of Resident #1's EHR titled, Progress Note entered by Staff A, Registered Nurse (RN) on 12/20/26 at 11:42 AM documented Staff H, Certified Nurse Assistant (CNA) reported she had observed Resident #1 and Resident #2 sitting at the nurses station with their hands down each other's pants. The residents were both separated. Resident #2 was taken to his room. Both Residents were assessed for trauma and none was observed. The Director of Nursing (DON), Staff G, Social Services Director, and the Administrator were aware of the incident. The Administrator stated the incident was not reportable because both residents had documented dementia.2. The MDS dated [DATE] documented Resident #2 had a BIMS of 03 indicating severe cognitive impairment. The MDS documented a diagnosis of vascular dementia, unspecified severity with other behavioral disturbance. Review of Resident #2's EHR titled, Progress Note entered by Staff A, Registered Nurse on 12/20/26 at 11:42 AM with effective date of 12/20/26 at 10:26 AM documented Staff H reported she had observed Resident #2 and Resident #1 sitting at the nurses station with their hands down each other's pants. The residents were separated and Resident #2 was assisted to his room. Both residents were assessed for trauma and none was observed. The DON, Staff G, and the Administrator are aware of the documented incident. The Administrator called the facility and stated the incident was not reportable because both residents had documented dementia.Review of Resident #2's EHR titled, Progress Note entered by Staff A, Registered Nurse on 12/20/26 at 12:35 PM with effective date of 12/20/26 at 12:16 PM documented Resident #2 observed reaching to touch another resident. Resident #2 was redirected by a CNA. Resident #2 hit the staff several times and told the staff to mind their business and leave him alone.On 2/18/26 at 9:15 AM Resident #1 stated she thought she had eaten breakfast but could not remember. Resident #1 acknowledged she did not know where this area was when asked if she grew up in the area of this facility. Resident #1 stated she kept to herself at the facility and was not friends with any of the residents at the facility. Resident #1 stated the staff treat her with dignity and respect at the facility. Resident #1 acknowledged she felt safe at the facility and was not scared of any of the residents or staff members. Resident #1 stated other residents had not attempted to touch her in any inappropriate ways.On 2/18/26 at 9:05 AM Resident #2 stated he had eaten breakfast that morning. Resident #2 explained that he had sausage, bacon, eggs and oatmeal. Resident #2 said the food was good. Resident #2 explained he did not have any friends that lived at the facility from his childhood. Resident #2 stated he had friends at the facility but could not remember any of their names or how he knew them. Resident #2 said he thought the staff treated him with dignity and respect. Resident #2 stated he felt safe at the facility. Resident #2 explained he had not touched any of the residents in any inappropriate way and none of the residents at the facility had touched him in any inappropriate way.On 2/17/26 at 5:30 PM Staff H, CNA acknowledged she had seen residents at the facility inappropriately touching each other. Staff H stated she had worked on a weekend and there were 2 residents sitting on the wall with their hands in each other's pants. Staff H acknowledged the incident occurred on 12/20/26. Staff H identified the 2 residents as Resident #1 and Resident #2. Staff H explained she did not see any movement in their pants but maybe Resident #1 was holding Resident #2's penis. Staff H said she stopped the 2 residents and assisted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 to his room. Staff H explained she told Staff A and Staff I, Licensed Practical Nurse (LPN). Staff H explained reported the incident to Staff A. Staff I acknowledged Staff A's Progress Notes entries regarding this incident for Resident #1 and Resident #2 was an accurate record of what happened. Staff H stated she did not see the nurses complete an assessment. Staff H stated she knew the incident had to be reported to the nurse for safety reasons because maybe Resident #2 would do it to someone else. Staff H stated she knew both residents had dementia. Staff H stated neither resident would remember what was discussed 15 minutes later. On 2/17/26 at 3:42 PM Staff G, Social Services Director stated she was informed of an incident where Resident #2 was reaching towards a resident. Staff G explained she called the DON and the DON called the Administrator. Staff G stated the incident she was Resident #1 and Resident #2. Staff G stated during the incident Resident #2 was reaching towards Resident #1. Staff G stated she was unaware if the Administrator called the facility back after that. Staff G stated the incident she was talking about happened prior to Christmas of 2025 maybe around the 19th. Staff G explained Staff A did not report to her that the residents had each other's hands in their pants. Staff G said she notified the DON of the incident but she did not say there were hands in pants but could not remember exactly what was said. Staff G acknowledged she did not document the incident. Staff G stated she did not know if Staff A tried calling the DON first but she was not on call. Staff G explained typically those situations are brought to the DON or the Administrator. On 2/18/26 at 1:04 PM Resident #2's son stated his father was struggling with dementia and things have changed in his world with how he conducts himself. Resident #2's son stated he did not know exactly who reached out to talk to him about the incident. Resident #2's son explained he was out of town and the facility called his brother and then he followed up with the facility. Resident #2's son stated they had shared with him the concern of the 2 residents inappropriately touching each other. Resident #2's son explained they had come to a conclusion that it would have been better to have his dad stay in his room and move him to the nurses station to keep an eye on him. Resident #2's son stated he did feel it was inappropriate for the 2 residents but did not think there was any sort of abuse. On 2/18/26 at 1:25 PM Resident #1's daughter said she was only notified of one incident and that incident occurred back in December. Resident #1's daughter stated it was described to her as hands were being held. Resident #1's daughter said the staff described the residents having each other's hands in their waistband. Resident #1's daughter stated she did not remember who had notified her of the incident. On 2/17/26 at 2:38 PM the DON acknowledged there were no married residents living together at the facility. The DON acknowledged there are no residents involved in an intimate relationship with each other both living at the facility. The DON said there are no residents that inappropriately touch other residents. The DON stated she had not been made aware of Resident #2 inappropriately touching any residents of recent. The DON explained if the resident was inappropriately touching another resident such as putting his hands down their pants, up their shirt or touching their breast she would expect to be notified of those situations. The DON further explained once she was notified she would come into the facility and complete an investigation to determine if it was abuse. The DON explained she would talk to the residents and talk to the staff as part of the investigation. The DON acknowledged she was not notified that Resident #2 had his hands down another resident's pants. The DON said she should have been informed and started an investigation if an incident like that occurred. The DON stated she was not aware this incident that was documented to have occurred on 12/20/25 between Resident #1 and Resident #2. The DON acknowledged she had not completed an investigation into the report that Resident #2 had his hands down another resident's pants. On 2/18/26 at 10:13 AM the DON said Staff G called and said there was an incident. The DON said she called (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator and told him to call the facility. The DON stated there were no details provided about the incident to her. The DON explained that the Administrator handled the situation from there. The DON stated she was on vacation over Christmas at that time. The DON acknowledged the incident did not come back up and she had not returned until January. The DON stated she had talked to Staff H 2/18/26. The DON explained that Staff H stated she had walked up to the nursing station and said Resident #1 and Resident #2 had hands in each other's waistband. The DON stated Staff H had explained there was no movement with either resident's hands. The DON stated she asked if Staff H felt it was sexual. The DON said Staff H said no not really but knew she needed to separate them. The DON stated Staff H said she separated them and told Staff A. The DON stated having hands in each other's waistbands did not indicate the activity was sexual in nature but they do not want the residents doing that. The DON explained the residents were not moving their hands while in each other's waistbands. The DON stated Staff A had told the Administrator she had not seen anything. The DON explained if the residents truly just hands in each other's waistbands and nobody was moving or doing anything then no assessment would be required. On 2/18/26 at 9:28 AM the Administrator stated he had read the progress note from 12/20/25 yesterday. The Administrator stated he thought that the situation had occurred on a Saturday and Staff A had called Staff G and said it seemed like Resident #1 and Resident #2 had their hands in each other's pants. The Administrator explained the situation was reported to have happened out at the nurses station. The Administrator explained he called the building and talked to Staff A. The Administrator said Staff A explained that Staff H saw both the residents with their hands in each other's pants. The Administrator stated Staff A acknowledged she didn't see the situation Staff H did. The Administrator explained Staff A would talk to Staff H and after she found out more details she should call him back. The Administrator stated Staff A talked to Staff H and called back. The Administrator said Staff A explained that Staff H reported she was walking down the hallway and it looked like Resident #1 and Resident #2 had each other's hands in each other's pants but the 2 residents were actually holding each other's hands. The Administrator stated Staff A said Staff H thought that was different and she said she separated them. The Administrator stated Staff A explained the 2 residents were not out by the nurses station very long. The Administrator explained he asked Staff A did Staff H actually see hands in the pants. The Administrator stated Staff A had just jumped to that conclusion. The Administrator stated Staff A asked do we need to report this. The Administrator said he told Staff A he would talk to the DON and decide. The Administrator explained what they knew was the 2 residents were holding hands and he was holding her hand in his lap. The Administrator explained Staff A said Staff H had separated the 2 residents and Staff A was going to complete an assessment. The Administrator stated the DON and he had talked and the Progress Note did not seem to add up to what was initially presented. The Administrator stated he called Staff A back at the facility and said they were not going to report it. The Administrator said Staff A kind of argued with him a little. The Administrator stated he explained to Staff A nothing was seen that indicated hands in the pants. The Administrator explained the staff just had to do a better job keeping the two of them separated. The Administrator stated he thought it was Staff H that had reported the situation. The Administrator stated when returned to work on Monday he did not think that he had talked to the nurse or the CNA about the incident. The Administrator explained the facility did have cameras in the front lobby but the DON attempted to look yesterday but the review was short of that date. The Administrator stated they were unable to go back that far in the video footage. The Administrator stated talking to Staff A on Saturday he felt the situation did not warrant an investigation. The Administrator said they did not look at the cameras or talk to the staff about the incident. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan - Red Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Alix Avenue Red Oak, IA 51566	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator explained if the residents did indeed have each other's hands down each other's pants it would have been a totally different story. The Administrator acknowledged there was only one witness and it went from hands in the pants to hands in the lap during his discussion.Review of policy revised 7/6/23 titled Abuse and Neglect documented the purpose was to ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location, to ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect, exploitation and abuse of residents and misappropriation of their property, to ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals, to ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated and to ensure a complete review of existing incidents by the investigation team to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation. The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends or other individuals. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services. These designated individuals are delegated the authority by the administrator to: Intervene in any situation in order to protect residents. Remove any individual from the location if necessary for the protection of residents or employees, including but not limited to employees, visitors, contractors or family members. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The charge nurse also will ensure that any potential for further abuse is eliminated. Notification procedures: Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.). Document this notification in the Risk Management module of PCC. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported no later than 24 hours after the allegation is made. If the designated agency(ies) requests a written report, notify the social worker and administrator. Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or an injury of unknown origin, inform them that (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	201 Alix Avenue Red Oak, IA 51566

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an investigation is in progress. Record this notification. The investigation team (social worker, administrator and director of nursing services) will review all incidents no later than the next working day following the incident.