STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165235	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenox Care Center	111 East Van Buren Lenox, IA 50851

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. 47079 Based on facility document review, family interview, staff interviews, personnel file review and policy review, the facility staff failed to report suspected abuse between a staff member and a resident (#15) within two (2) hours after the observed behavior. The facility reported a census of 24. Findings include: On 2/24/25, a facility-reported incident indicated Staff K, Certified Nurse Aide (CNA) witnessed Staff L, CNA tickle Resident #15's nipple while they helped the resident get dressed. On 2/24/25 at 12:32 PM, Resident #15's relative stated Staff M, Licensed Practical Nurse (LPN) notified him on 2/23/25 at 4:46 PM that Resident #15 was inappropriately touched just before lunch. On 2/25/25 at 1:17 PM, Staff K stated she witnessed the incident at 12:30 PM on 2/23/25 and notified Staff N, CNA around 2:50 PM of the incident. She also stated she waited until after 3:10 PM to notify the Assistant Director of Nursing (ADON). At 2:46 PM, the Director of Nursing (DON) verified the ADON was the on-call leadership staff on 2/23/25. She also stated all staff receive online abuse prevention training upon hire. At 3:21 PM, the ADON verified Staff K notified her of the suspected abuse on 2/23/25 at 3:40 PM. She also stated she notified the Administrator at 3:45 PM. On 2/27/25 at 11:53 AM, staff file reviews revealed Staff K completed a 3-year valid Dependent Adult Abuse training on 3/11/22. On 2/27/25 at 3:18 PM, the Administrator stated the staff should've called the Administrator immediately after the observed behavior. A policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy revised 4/2023 indicated all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the Administrator. It also indicated all allegations of resident abuse shall be reported to the appropriate state entity not later than two (2) hours after the allegation is made.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47673 Based on Electronic Health Records (EHR) review, staff interviews, and policy review the facility failed to provide an opportunity for bath or shower and reposition 1 of 12 residents reviewed (Resident #5). The facility reported a census of 24 residents. Finding include: The Minimum Data Set (MDS) for Resident #5, dated 12/27/24 did not document a Brief Interview for Mental Status (BIMS) score. The MDS documented Resident #5 was rarely/never understood. The MDS documented Resident #5 required the use of an enteral tube, tracheostomy tube, and a suprapubic catheter. The MDS also documented diagnoses of athetoid cerebral palsy, abnormal posture, contracture of right hand, contracture of left hand, contracture unspecified ankle, contracture unspecified knee, contracture unspecified hip, unspecified quadriplegia, and unspecified dystonia. Review of Resident #5's Care Plan documented Resident #5 had a self-care deficit and required assistance with Activities of Daily Living (ADLs). Resident #5 required 2 people to assist and encourage bathing 2 x weekly. Resident #5 required 2 person assistance with bed mobility. Resident #5 mobility was described as bed bound. The Care Plan documented Resident #5 was at risk for pain/discomfort and increased risk for injury from decreased function related to dx of cerebral palsy. The Care Plan also documented to attempt and document any of non-pharmacological interventions used as appropriate such as repositioning, heat pack, and massage. Encourage Resident #5 to shift weight, if able, every 2 hours to assist with skin integrity. On 2/25/25 at 1:55 PM Staff Q, Certified Nursing Assistant (CNA) stated Resident #5 does not get repositioned. Staff Q stated Resident #5 only had stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 1:55 PM Staff A, CNA stated Resident #5 does not get repositioned. Staff A stated Resident #5 only stuffed animals under his arm. Staff Q stated Resident #5 laid only on his back in bed. Staff Q stated Resident #5 would grimace when repositioned. On 2/25/25 at 2:10 PM the Director of Nursing (DON) stated Resident #5 did not get repositioned from side to side. The DON stated Resident #5 only laid on his back while in bed. The DON stated the air flow mattress provided enough change in position that Resident #5 did not need repositioning. On 2/26/25 at 9:40 AM the Administrator stated it was the facility's expectation that staff would reposition Resident #5. On 2/26/25 at 10:06 AM Staff R, Certified Occupational Therapy Assistant (COTA) / Director of Rehab stated he was familiar with Resident #5. Staff R stated the pressure relief mattress would be enough to prevent breakdown. Staff R stated the pressure relief mattress was to offload weight. Staff R stated he did not think repositioning would benefit the resident. Staff R stated there was a current order to evaluate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 5:49 PM the DON stated that Resident #5 was repositioned when care was completed. The DON stated that personal cares were Resident #5's repositioning. Review of documents titled, Bathing Records for the last 90 days revealed 24 opportunities for baths. The clinical record lacked documentation of baths being given on 12/20, 12/13, and 11/29/24. Bathing records revealed Resident #5 received only one bath a week for 3 out of 4 weeks and was not given a bath on Friday 3 out of 4 of the same weeks. The weeks were 11/24/24 - 12/21/24. On 2/27/25 at 9:06 AM the DON stated the facility's expectation for baths was Resident #5 would have received 2 baths a week on Tuesday and Friday and made up if the bath was missed. The DON acknowledged baths were missed on 12/20, 12/13, and 11/29/24. The DON acknowledged Resident #5 did not get a bath 3 out of 4 weeks on Fridays. Review of policy dated 5/13 titled, Repositioning documented the purpose of this procedure was to provide guidelines for the evaluation of the residents repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Residents who are in bed should be on at least an every 2 hour repositioning schedule. Review of policy revised 3/18 titled, Activities of Daily Living (ADL), documented that residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain food nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care including appropriate support and assistance with bathing and mobility. Care and services to prevent and or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. The resident's ability to perform ADL's will be measured using clinical tools, including the MDS. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.