

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2025
NAME OF PROVIDER OR SUPPLIER Bethany Life		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Lafayette Street Story City, IA 50248	

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 - Minimal harm or potential for 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** Based on observation, clinical record review, resident and staff interviews, family interviews, facility policy/procedure reviews, the facility failed to adequately supervise 1 of 2 residents (Resident #1) This lack of supervision resulted in Resident #2 going to Resident #1 room, and Resident #1 was in a compromising position in bed. Resident #1 has a history of sexual advances towards other residents including Resident #2. The facility reported a census of 121 residents.</p> <p>Finding include:</p> <ol style="list-style-type: none"> 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] reflected they usually made themselves understood and understood others. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS listed Resident #1 required supervision or touching assistance with ambulation and a walker as the mobility device. The MDS included diagnoses of non-Alzheimer's dementia, anxiety and depression. <p>The Care Plan Focus revised 5/1/25 reflected Resident #1 had a behavior problem regarding being sexually inappropriate and went in others' rooms at times. The Interventions directed the following:</p> <ol style="list-style-type: none"> i. Observe body language and facial expressions closely for clues about her needs. ii. Supervision at all times to ensure her well-being. iii. 11/2/23: Assist the resident to develop more appropriate methods of coping and interacting with her peers. Encourage the resident to express feelings appropriately. iv. 11/2/23: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. v. Incident 4/14/25: Resident separated entities notified head to toe assessment physician notification. vi. Resident to resident 4/20/25: Order change for Seroquel (a medication which plays a role in regulating mood, thoughts, and behaviors) 25 milligrams (mg) at noon. vii. 5/1/25: If reasonable, discuss Resident #1's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. <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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Unusual Event dated 4/20/25 at 3:45 PM, documented the staff found Resident #1 in her room with a male resident (Resident #2). When a Certified Nursing Assistant (CNA) entered the room, they found Resident #1 lying on her bed with her pants and underwear around her knees with Resident #2 laying on top of her. The staff noted Resident #2 had his pants down around his knees, with his underwear still in place. He had an erect penis, lying motionless. Approximately 5 minutes before the incident, the staff saw both residents in the living room. Resident #1 told the CNA who entered her room, You have no business being in here, got out now! When interviewing Resident #1 about the situation that occurred, she stated, Oh yes, I heard about that terrible accident and the hospital people were involved, so sad for his wife. The staff immediately separated the residents, and the nurse completed a head-to-toe assessment. The staff assisted Resident #1 to another unit in the facility.</p> <p>On 6/12/25 at 3:55 PM, observed Resident #1 sitting on the couch in the unit with her eyes closed and walker in front of her.</p> <p>On 6/16/25 at 12:40 PM, when attempted to interview Resident #1, she couldn't recall an incident that happened between her and a male resident.</p> <p>The Orders Administration Note dated 3/24/25 at 1:34 PM, identified a staff member observed Resident #1 put her hand on another male resident's thigh and kept trying to hold his hand. The staff intervened quickly and separated the residents but she kept asking the male resident to sit next to her on the couch.</p> <p>The Nursing Progress Note dated 3/25/25 at 5:42 PM, indicated Resident #1 consistently tried to get a male resident to go in her room to shut the door and watch a movie together. The nurse explained they could watch the movie in the living room. Resident #1 told the other resident once that lady leaves we can go in my room. The nurse observed Resident #1 and Resident #2 hold hands and separated them.</p> <p>The Nursing Progress Note dated 3/26/25 at 5:42 PM, reflected Resident #1 constantly tried touching a male residents' thigh/leg that night. She tried to get in his face to talk to him, no matter how many times the staff separated her from him. She always tried to touch him and constantly tried to call him over to hold hands or sit next to him.</p> <p>The Advanced Registered Nurse Practitioner (ARNP) Progress Notes dated 3/27/25 indicated they saw Resident #1 at the request of staff for an evaluation of her behaviors. The staff reported Resident acting overly friendly with males on her unit with borderline inappropriate touching. The staff reported she had her hand high on their thighs and attempted to follow them into their rooms. In addition, the staff reported Resident #1 acted overly friendly with females on the unit. The facility transferred Resident #1 from one locked unit to the current locked unit for similar behaviors.</p> <p>The Nursing Progress Notes dated 4/2/25 at 1:16 PM, indicated the staff found Resident #1 holding hands with a male resident. When the staff intervened, Resident #1 got upset. When the staff move the male resident, she continued to call him over and tried to hold his hands again.</p> <p>The Nursing Progress Notes dated 4/4/25 at 2:58 PM, identified Resident #1 tried to go into a male's room and closed the doors. The staff witnessed them holding hands, Resident #1 felt his cheeks, and tried to sneak around staff to be next to each other. The staff provided supervision.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nursing Progress Notes dated 4/6/25 at 1:16 PM, Resident #1 tried to hold hands with multiple residents. She tried to get male residents to sit next to her on couch while making comments about going to her room together and shutting the door.</p> <p>The Nursing Progress Notes dated 4/7/25 at 9:51 PM, a CNA reported Resident #1 asked if she could give her roommate a kiss. The CNA told Resident #1 she couldn't as it was inappropriate. Resident #1 replied One little kiss won't hurt anyone, if you won't tell then I won't tell. The CNA once again told her she couldn't kiss her roommate. Resident #1 went to bed and the CNA did frequent checks.</p> <p>The Nursing Progress Notes dated 4/13/25 at 12:02 PM, identified a CNA reported Resident #1 inappropriately touched another resident. Once witnessed, the staff separated the 2 parties to different units. The nurse completed a head-to-toe assessment without irregularities then notified management and other pertinent parties. The note reflected the staff would continue to separate the residents until they could evaluate their plan of action. The facility collected a witness statement For the CNA, relayed to management. The note reflected they informed all staff.</p> <p>The Nursing Progress Notes dated 4/14/25 at 11:09 AM, indicated as the nurse gave Resident #1 her medications that morning, the nurse observed Resident #1 rubbing another resident's arm and wanting to hold her hand. The nurse told Resident #1 they couldn't hold hands with other residents. Resident #1 responded, oh we can't touch over here too. The nurse reported the incident to the Nurse Manager.</p> <p>The Nursing Progress Notes dated 4/16/25 at 9:50 PM, Resident #1 attempted to persuade a male resident in to her room. Staff intervened before the residents made physical contact and separated them. Resident #1 didn't have further contact with the male resident.</p> <p>The Nursing Progress Notes dated 4/20/25 at 2:00 PM, described Resident #1 as anxious and agitated most of the shift. Resident #1 tried to touch a male resident's shoulder and arm. In addition, she attempted to follow him into his room when he used the bathroom. Resident #1 again tried to sit next to him on the couch. Other residents told Resident #1 to leave them alone due to her constantly trying to help them or ask them the same questions over and over. This made another resident yell at her and get agitated as well.</p> <p>The Nursing Progress Notes dated 4/20/25 at 3:45 PM, as a CNA entered Resident #1's room, they found Resident #1 laying on her bed with her pants and underwear around her knees. Resident #2 laid on top of her with his pants down around his knees, he had his underwear in place. Resident #2 had an erect penis, as he laid still motionless. Resident #1 told the CNA who entered her room, You have no business being in here, get out now! When the nurse interviewed Resident #1 about the situation that occurred, she replied, Oh, yes, I heard about that terrible accident and the hospital people were involved, so sad for his wife. The staff immediately separated the residents and the nurse completed a head-to-toe assessment with no injuries noted. The facility moved Resident #1 was assisted to another unit until further notice.</p> <p>2. Resident #2's MDS assessment dated [DATE] reflected they could make themselves understood and understood others. The MDS identified a BIMS score of 3, indicating severe cognitive impairment. The MDS listed Resident #2 required supervision or touching assistance and didn't use a mobility device for ambulation. The MDS included diagnoses of non-Alzheimer dementia, vascular dementia (general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), and depression.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan Focus initiated 8/6/24 indicated Resident #2 had a behavior problem related to being touchy at times. He always looked for his girlfriend. In addition, he attempted to kiss and grabbed the staff. Resident #2 could be sexually inappropriate, as he went in to others' rooms at times and restless. The Interventions directed the following:</p> <ul style="list-style-type: none"> i. If reasonable, discuss his behavior, explain and reinforce why the behaviors are inappropriate and/or unacceptable. ii. Incident 4/14/25: The facility separated Resident #2 from another resident. The nurse completed a head-to-toe assessment and notified the physician. iii. Intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. iv. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. v. Resident encounter 4/20/25. Medication review. <p>On 6/16/25 at 1:35 PM, Resident #2's Representative (RR2) reported they didn't have any issues or concerns with staffing on the day of the incident. RR2 stated an incident happened and they hoped another incident didn't happen again.</p> <p>The Unusual Event dated 4/20/25 at 3:45 PM identified a CNA entered Resident #1's room and found Resident #2 laying on top of Resident #1. Resident #1 had her pants and underwear around her knees. Resident #2 had his pants down with his underwear still in place. The staff noted Resident #2 had an erect penis, lying motionless on top of Resident #1. The staff witnessed both residents in the living room approximately 5 minutes before the situation. When interviewed, Resident #2 couldn't describe the event that occurred. Resident #2 responded, Where are my parents. The staff immediately separated the residents and the nurse completed a head-to-toe assessment. The facility notified RR2, who voiced understanding. The facility assigned Resident #1 to another unit until further notice.</p> <p>The General Note dated 3/25/25 at 2:28 AM, reflected the facility had Resident #2 as a one-to-one (1:1) due to his anxiety, pacing, and going into others room. The note described Resident #2 as sexually inappropriate. The staff provided redirection, snacks, drinks and offered the use of the toilet as well.</p> <p>The Nursing Progress Note dated 4/4/25 at 2:56 PM indicated the staff saw Resident #2 attempt to go into a female's room, close the door, hold hands, rubbed her leg, and tried to sneak around staff to be next to each other. The staff provided supervision.</p> <p>The Nursing Progress Note dated 4/6/25 at 1:59 AM identified staff reported on the previous shift, Resident #2 went from behind a young CNA and put his hand on her breast. The staff redirected Resident #2. During the shift, as the CNA assisted Resident #2 to bed, and turned to cover him up, he had his pants down and stated aren't you going to get on this? The CNA redirected Resident #2 again, and asked him to pull up his pants. After a few minutes as the CNA sat in the den, Resident #2 came in and pulled his pants down again. The staff asked Resident #2 to pull up his pants and go lay down in bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nursing Progress Note dated 4/6/25 at 5:14 AM, reflected a CNA reported Resident #2 came out of his room, into the den where she sat quietly with another male resident, and proceeded to pull down his pants again. The other resident sitting with the CNA became upset at Resident #2's actions. The CNA asked Resident #2 to pull up his pants. Resident #2 pulled up his pants and returned to his room.</p> <p>The Nursing Progress Note dated 4/7/25 at 8:19 AM, documented Resident #2 went into the hallway naked where a female resident tried to grab him and take him into the dining room with her. The CNA immediately separated them.</p> <p>The Nursing Progress Note dated 4/8/25 at 3:19 AM, reflected Resident #2 pulled his pants down twice (twice in his room and twice outside of his room) and attempted another 2 times. The CNA intervened and redirected but this didn't decrease his behavior.</p> <p>The ARNP Progress Note dated 4/10/25 indicated they saw Resident #2 due to his increase with agitation, pacing, and erratic behaviors. In addition, he had some sexual behaviors and urinating in inappropriate locations.</p> <p>The Nursing Progress Note dated 4/13/25 at 12:02 PM, identified a CNA reported Resident #2 touched another patient inappropriately. After the staff witnessed the 2 parties, they separated them to different units. The staff notified management and pertinent parties. They planned to continue to separate patients until they could evaluate a plan of action. The facility collected a Witness Statement from the CNA and submitted to management.</p> <p>The Nursing Progress Note dated 4/14/25 at 10:32 PM, identified a CNA called the nurse and reported when they did walk rounds, they found Resident #2 in a female resident's room. The CNA's immediately separated them and the nurse informed the Nurse Manager.</p> <p>The Nursing Progress Note dated 4/20/25 at 3:45 PM, identified a CNA entered Resident #1's room and found Resident #2 laying on top of Resident #1. Resident #1 had her pants and underwear around her knees. Resident #2 had his pants down with his underwear still in place. The staff noted Resident #2 had an erect penis, lying motionless on top of Resident #1. The staff witnessed both residents in the living room approximately 5 minutes before the situation. When interviewed, Resident #2 couldn't describe the event that occurred. Resident #2 responded, Where are my parents. The staff immediately separated the residents and the nurse completed a head-to-toe assessment. The facility notified RR2, who voiced understanding. The facility assigned Resident #1 to another unit until further notice.</p> <p>The Nursing Progress Note dated 4/21/25 at 8:53 PM, indicated a CNA reported Resident #2 rubbed the back up and down of a female resident. The staff immediately separated them and they had no further behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The ARNP Progress Note dated 4/21/25 reflected the ARNP saw Resident #2 because the staff requested them to evaluate his behaviors. Resident #1 involved in a sexual encounter with another resident at facility. They increased his Zolofit (a medication that helps in the brain that plays a role in mood regulation) on 4/10/25 following the initial encounter with the other resident. The ARNP instructed the staff to separate Resident #2 from the other resident. The staff attempted however the 2 residents managed to get together in one of their rooms. The staff separated the 2 residents prior to any sexual activity. The ARNP recommended to continue separation of Resident #2 from the other resident and to continue monitoring for behaviors.</p> <p>The ARNP Progress Note dated 5/5/25 identified having Resident #2 separated from the other resident that who caused his anxiety, his behaviors returned to baseline.</p> <p>On 6/12/25 at 2:00 PM, Staff A, CNA, explained they worked on 4/20/25, when the incident happened between Resident #1 and Resident #2. Staff A sat on the couch in the living area visiting with another resident. Staff A had her back towards Resident #1 and Resident #2, they didn't see them leave the living room area until Staff B, CNA, asked if she saw the 2 residents leave the living room area. Staff A reported they had difficulty keeping close supervision on Resident #1 and Resident #2, as they both moved independently and described them as very quick. Staff A stated Resident #1 liked to flirt with Resident #2 and attempt to get him in her room. Staff A, said Resident #1 transferred to that unit as she had sexual advances and behaviors in another unit. Staff A verified the facility failed to give directives except to try and keep the 2 residents apart. Staff A, reported the difficulty to keep them apart with only 2 staff working on the unit.</p> <p>On 6/12/25 at 3:30 PM, Staff B, explained she worked on 4/20/25 when the incident occurred between Resident #1 and Resident #2. Staff B sat on the couch doing their charting for the day. When Staff B looked up, they didn't see the 2 residents in the living area. When Staff B, asked Staff A, if she saw the 2 residents, Staff A, replied no. Staff B, said she went looking for the 2 residents. She found Resident #2 in Resident #1's room with her pants and underwear down to her knees and Resident #2 on top of her with his pants down but he still had his underwear on with an erect penis. Staff B said she told Resident #2 to come with her and she took him out to Staff A to watch him, as she called the charge nurse. Staff B went back into Resident #1's room to assist getting her dressed. Staff B, explained Resident #1 had the same type of behaviors in another unit, when they transferred her to that unit. Staff B stated Resident #2 liked to flirt with the men on the unit. Staff B, verified the facility didn't give any directives except to attempt to keep the 2 residents apart and give them closer supervision. Staff B explained having difficulty providing close supervision when they only had 2 staff on the unit at times.</p> <p>On 6/16/25 at 9:00 AM, Staff C, Registered Nurse (RN), stated she worked on 4/20/25 when the incident between Resident #1 and Resident #2 happened. Staff C, explained at the time, she took care of another resident on a different unit when she received a phone call that she needed to go to the unit for an incident. Staff C, stated when she got to the unit the staff had the 2 residents separated and she assessed them. Staff C, explained Resident #1 acted flirty towards Resident #2 and did sexual innuendos for Resident #2 to go to her room. Staff C verified the facility failed to give any extra directives on the 2 resident except to attempt to keep them separated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/16/25 at 3:55 PM, Staff D, CNA, explained Resident #1 liked to flirt with Resident #2. They added it was just a matter of time when the 2 residents would be in the same room together. Staff D verified the facility failed to give any extra directives with the 2 residents except to try and keep them separated as much as they could. Staff D explained the facility transferred Resident #1 to that unit due to having sexual advances on another unit. Since Resident #1 transferred off the unit, Resident #2 didn't have any sexual advances towards staff or other residents.</p> <p>On 6/16/25 at 4:00 PM, Staff E, CNA, verified that the facility did not give any extra directives except to attempt to keep Resident #1 and Resident #2 apart. Staff E, said since both residents moved independently, this made it difficult to supervise them both at all times. Staff E, described Resident #1 as flirtatious with Resident #2 for a while prior to the incident. Staff E added that management knew about the sexual advances but didn't do anything until the incident and then they transferred Resident #1 to another unit. Since Resident #1 transferred, Resident #2 didn't have any sexual advances towards staff or any other residents.</p> <p>On 6/17/25 at 8:30 AM, the Director of Nursing (DON) and Administrator, verified they expected the staff to keep the 2 residents separated at all times and the facility failed to keep close supervision on Resident #1 knowing she had a history of sexual innuendos and being flirtatious to other residents, especially men. They verified the facility failed to give adequate nursing supervision with these 2 residents.</p> <p>The undated Resident Rights pamphlet, directed the resident had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident including abuse: the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion (separation from others by someone other than themselves).</p>		