STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165452	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wapello Specialty Care	601 Highway 61 South Wapello, IA 52653

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 - Minimal harm or potential for actual harm 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** 47336 Based on interviews, record review, and the facility policy, the facility failed to prevent abuse from occurring between residents for 3 of 7 residents reviewed for abuse (Resident #1, Resident #2, and Resident #7). The facility reported a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 00 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The Care Plan revealed a focus area initiated on 11/13/23 for resident displayed socially inappropriate sexual behavior and displayed untargeted touching at others. The interventions dated 11/13/23 revealed Resident #1 would be seated in the dining room away from female resident alleged incident. The interventions dated 11/14/23 revealed Resident #1 would eat meals in the lobby with male residents. The interventions dated 11/17/23 revealed resident had 1:1 supervision and the 1:1 supervision could be removed when no longer warranted due to resident not exhibiting untriggered behavior due to his confused/dementia state. The interventions dated 11/28/24 revealed placed on 1:1 and a pressure floor alarm in resident's room doorway to alert staff when exited the room. The Incident Report #1188 dated 11/12/23 at 11:20 AM revealed the following information: a. Nursing Description: The DON (Director of Nursing) became aware on 11/13 that there was an alleged resident to resident incident regarding Resident #1 and another female resident. The allegation was that Resident #1 touched a female resident's right breast. b. Resident Description: Resident Unable to give Description c. Immediate Action Taken: The residents separated, assessment of residents conducted today with no injuries. The residents will remain separated in the dining room for meals, as previously they were seated at the same dining room table. The Progress Note dated 11/13/23 at 6:33 PM revealed sexually inappropriate behavior observed and resident reassigned a new dining room seat due to alleged incident with female peer. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 11/16/23 at 4:18 PM revealed resident witnessed attempting to put hand up a female resident's shirt. The nurse educated resident that was inappropriate to touch other people and moved resident to a different area. The Self Report with submission date of 11/17/23 at 3:50 PM revealed the following information: a. Reporting type: Allegation of Abuse b. Approximate date time occurred: 11/17/23 at 3:40 PM c. Location occurred: lobby d. date aware: 11/17/23 e. Incident Summary: During investigation of a previous incident Resident #5 reported to staff that she witnessed Resident #1 rubbing Resident #2 with his hand up her shirt. She stated she notified the nurse but unable to identify the nurse or the time or date of the alleged incident. f. Corrective action description: Resident #1 placed on 1:1 at this time. The Self Report revealed the following information: a. Submission Date: 11/17/23 at 7:55 PM b. Approximate date time occurred: 11/16/23 at 4:20 PM c. location occurred: lobby of facility d. Date aware: 11/17/23 e. Incident summary: Staff C, LPN (Licensed Practical Nurse) reported that Resident #1 observed in an untargeted act and touched Resident #2 stomach on top of her shirt. Nurse moved resident to another area of the lobby away from others and in line of sight of nursing staff. Resident #1 experienced a change of behavior and MD (Medical Director) notified. The Progress Note dated 11/28/23 at 12:18 PM revealed a left a voice message with the provider regarding incident with resident and a female resident this morning. Requested a call back if Nurse Practitioner had any questions or would need any further information. The Incident Report #1209 dated 11/28/23 at 9:55 AM revealed the following information: a. Nursing Description: Resident #1 approached female peer in the hallway outside dining area and started to lift her shirt. b. Immediate Action Taken: Residents separated immediately (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #2 scored a 1 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS revealed medical diagnosis of non-Alzheimer's Disease. The Progress Note dated 11/17/23 at 8:14 PM, revealed phone call placed to resident's family to inform him of the alleged incident between his mother and a male peer. The resident's family member verbalized understanding of allegation and asked that his mother and the male peer stay separated. The Progress Note dated 11/28/23 at 10:47 AM revealed resident's son in the building. This writer spoke with him regarding the incident that occurred this morning between his mom and another resident. The son assured that staff will be within arm's reach of resident. The son will contact staff with any questions and or concerns. The Incident Report #1208 dated 11/28/23 at 7:45 AM revealed the following information: a. Nursing Description: Resident #2 sat in the hallway outside dining room waiting for breakfast when male peer approached her and started to lift up her shirt. b. Immediate Action Taken: Residents separated immediately c. Agencies/People Notified: Family member (son) and physician 3. The MDS assessment dated [DATE] revealed Resident #7 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The Care Plan revealed a focus area initiated on 11/13/23 for resident displayed socially inappropriate behavior. The interventions dated 11/13/23 revealed removing resident from public area's when behavior disruptive and unacceptable. The interventions dated 11/14/23 Resident #7 sat in the dining room away from the alleged resident incident. The Incident Report #1189 dated 11/12/23 at 11:20 AM revealed the following information: a. Nursing Description: DON notified 11/13/23 that on 11/12/23 at lunch a male resident touched Resident #7 right breast and she had her shirt up allegedly. b. Resident Description: Per Witness statement Resident #7 denied her shirt up, she said the male resident tried to get fresh with her, she denied that he actually touched her and denied that her shirt lifted up. c. Immediate Action Taken: The residents separated in the dining room, the dining room seating updated so they sat on the opposite areas of the dining room during meals. Resident #7 reported she wasn't upset regarding alleged incident as he didn't actually touch her. The Witness Statement for Resident #7 on 11/13/23 for incident that occurred 11/12/23 revealed the following statement: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Regional Director of Clinical Services (RDCS) asked Resident #7 what happened yesterday at breakfast with the gentleman and she stated he tried to get fresh with me. The RDCS said did he touch you, and she stated No, he tried to. The RDCS asked if he pulled up her shirt or if her shirt was up and she said no. The RDCS asked her if she was upset and she stated no. The Witness Statement from Staff A, CNA (Certified Nurse Aide) on 11/13/23 for incident that occurred on 11/12/23 revealed the following information: On 11/12/23 at lunchtime approximately noonish, turned around and saw Resident #7 shirt lifted up. Resident #7 wore a clothing protector, and from the side she could see her exposed skin/bra. Resident #1 touched her right side of her breast. Staff A went over and pulled her shirt down and moved his arm away. Went to the door to start serving and then he tried to touch Resident #7 again, he reached towards her but didn ' t touch her. Staff A went back over and separated and moved Resident #1 to the opposite side of the table. After lunch service Resident #1 started scooching towards Resident #7. Staff A had Staff D, Cook report to Staff B, LPN. When noticed Resident #1 moved closer to Resident #7, Staff A assisted him to the lobby in his wheelchair. Staff A hasn ' t noticed Resident #7 in any similar situations. Staff A stated her and Staff D were the only staff in the dining room at time of incident. During an interview on 4/10/24 at 1:48 PM, Staff A, CNA stated she tried to stop the incident between Resident #1 and Resident #7. She stated Resident #7 raised her shirt for Resident #1 to fondle her breast. During an interview on 4/10/24 at 3:09 PM, Staff E, CMA (Certified Medication Aide) stated Resident #1 reached under Resident #2 shirt in the common area in front of the nurse's station and she believed it happened a few times. During an interview on 4/11/24 at 9:00 AM, Staff C, LPN stated she recalled an incident with Resident #1 and Resident #2 sitting in the lobby and Resident #2 wheeled himself over to Resident #1 and she stopped him before he got his hand up Resident #2 shirt. Staff C stated she separated the residents but Resident #1 tried to go back to Resident #2 so she brought Resident #2 over by her side. During an interview on 4/11/24 at 1:55 PM, the ADON (Assistant Director of Nursing) stated when residents known to have this type of behavior, they needed monitored the whole time. During an interview on 4/11/24 at 2:00 PM, the RDCS stated Resident #1 was sexually inappropriate and touched the front of one of the resident's shirt. She stated she knew at least one of the times Resident #1 made skin contact. The Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy dated 4/21 revealed the following information: a. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to: 1. other residents b. Develop and implement policies and protocols to prevent and identify: (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Abuse and mistreatment of residents 2. Protect residents from any further harm during investigations.

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47336 Based on interview, record review, and the facility policy, the facility failed to report an allegation of abuse within 2 hours after the incident occurred for 3 of 7 residents reviewed for allegations of abuse (Resident #1, Resident #2, and Resident #7). The facility reported a census of 33 residents. Findings include: The Self Report revealed the following information: a. Submission Date 11/13/23 at 3:45 PM b. Approximate Date Time Occurred: 11/12/23 at 12:00 PM c. Location Occurred: Resident Dining Room d. Date Aware: 11/13/23 e. Incident Summary: Regional Services Clinical Director notified there was an alleged resident to resident incident in the dining room involving Resident #1 and Resident #7. The allegation was that Resident #1 touched Resident #7 right breast. Corrective Action Description: Internal investigation initiated. Local Law enforcement notified. Residents assessed no injuries. Responsible party/MD (Medical Director) notified of incident. Residents will be moved in the dining room as they were previously table mates. They are now assigned to different sides of the dining room. The Self Report revealed the following information: a. Submission Date of 11/17/23 at 7:55 PM b. Approximate date time occurred: 11/16/23 at 4:20 PM c. Location occurred: lobby of facility d. Date aware: 11/17/23 e. Law Enforcement notified f. Incident summary: Staff C, LPN (Licensed Practical Nurse) reported that Resident #1 observed in an untargeted act and touched on Resident #2 stomach on top of her shirt. Nurse moved resident to another area of the lobby away from others and in line of sight of nursing staff. Resident #1 experienced a change of behavior and MD notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 1:48 PM, Staff A, CNA (Certified Nurse Aide) stated she and the nurse didn't realize they needed to report the incident with Resident #1 and Resident #7 when it happened. During an interview on 4/11/24 at 8:35 AM, Staff B, LPN (Licensed Practical Nurse) stated she did not report the incident with Resident #1 and Resident #7 in the appropriate time frame. During an interview on 4/11/24 at 2:02 PM, the ADON (Assistant Director of Nursing) confirmed allegations of abuse needed reported within 2 hours of the incident. The Facility Recognizing Signs and Symptoms of Abuse/Neglect Policy dated 4/21 revealed the following information: a. All personnel expected to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. The Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy dated 4/21 revealed the following information: a. Investigate and report any allegations within the timeframe required by federal requirements.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on interviews, record review, and the facility policy, the facility failed to adequately supervise a resident after an allegation of abuse with another resident. This resulted in another occurrence with a resident to resident allegation of abuse for 2 of 7 residents reviewed for allegation of abuse (Resident #1 and Resident #2). The facility reported a census of 33 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 00 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The Care Plan revealed a focus area initiated on 11/13/23 for resident displayed socially inappropriate sexual behavior and displayed untargeted touching at others. The interventions dated 11/13/23 revealed Resident #1 would be seated in the dining room away from female resident alleged incident. The interventions dated 11/14/23 revealed Resident #1 would eat meals in the lobby with male residents. The interventions dated 11/17/23 revealed resident had 1:1 supervision and the 1:1 supervision could be removed when no longer warranted due to resident not exhibiting untriggered behavior due to his confused/dementia state. The interventions dated 11/28/24 revealed placed on 1:1 and a pressure floor alarm in resident's room doorway to alert staff when exited the room. The Self Report with submission date of 11/17/23 at 3:50 PM revealed the following information: a. Reporting type: Allegation of Abuse b. Approximate date time occurred: 11/17/23 at 3:40 PM c. Location occurred: lobby d. date aware: 11/17/23 e. Incident Summary: During investigation of a previous incident Resident #5 reported to staff that she witnessed Resident #1 rubbing Resident #2 with his hand up her shirt. She stated she notified the nurse but unable to identify the nurse or the time or date of the alleged incident. f. Corrective action description: Resident #1 placed on 1:1 at this time. The Self Report revealed the following information: a. Submission Date: 11/17/23 at 7:55 PM b. Approximate date time occurred: 11/16/23 at 4:20 PM c. location occurred: lobby of facility (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Date aware: 11/17/23 e. Incident summary: Staff C, LPN (Licensed Practical Nurse) reported that Resident #1 observed in an untargeted act and touched on Resident #2 stomach on top of her shirt. Nurse moved resident to another area of the lobby away from others and in line of sight of nursing staff. Resident #1 experienced a change of behavior and MD (Medical Director) notified. The Investigative Report for the incident that occurred on 11/28/23 revealed the following information: a. Date of Incident: 11/28/23 b. Date of Investigation: 11/28/23-12/1/23 Summary of alleged incident: c. Resident #2 sat in the hallway outside of dining room and waited for breakfast when Resident #1 approached her and started to lift Resident #2 shirt. He was stopped by staff and redirected back to male table for breakfast. Both assessed with no injuries. d. People interviewed Staff E, CMA (Certified Medication Aide) on 11/28/23 and Staff F, CNA (Certified Nurse Aide) on 11/28/23 e. Incident occurred at approximately 7:45 AM in the common area in front of the dining room doors f. Action taken during investigation: Residents separated immediately and male residents placed on 1:1 awaiting placement for male memory unit bed at [name redacted]. At this time will transfer to [name redacted] on Monday 12/4. e. Conclusion: Root cause analysis: Resident #1 observed starting to lift Resident #2 shirt. The self report completed, internal investigation completed. Resident had increased incidence of untargeted touch, care plan interventions have included: separation from previous female in the dining room, placement at a dining room table with males only, placement in the lobby eating table with males and supervision of staff, evaluated by provider for any acute infections, sertraline started, psych referral requested and made by facility, and placed on 1:1 with floor alarm in place to alert staff if he exited his room when he was previously in bed. Referral made to [name redacted]for male bed memory unit, planned transfer on 12/4. f. Conclusion: Resident #1 will be transferred to all male unit at the earliest opening. 1:1 continued until that time. The Progress Note dated 11/27/23 at 9:32 PM revealed the following information: a. Reason for Evaluation: Incident/Accident/Unusual Occurrence Follow-up Charting b. History of inappropriate behavior, resident a 1:1 while outside room, resident assisted with supper in his room as he refused to get up and go to the living room area to eat. Appetite good, no contact with other residents, resting at this time, no new concerns. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #2 scored a 1 out of 15 on the BIMS exam, which indicated cognition severely impaired. The MDS revealed medical diagnosis of non-Alzheimer's Disease. The Progress Note dated 11/17/23 at 8:14 PM, revealed phone call placed to resident's family to inform him of the alleged incident between his mother and a male peer. The resident's family member verbalized understanding of allegation and asked that his mother and the male peer stay separated. The Progress Note dated 11/28/23 at 10:47 AM revealed resident's son in the building. This writer spoke with him regarding the incident that occurred this morning between his mom and another resident. The son assured that staff will be within arm's reach of resident. The son will contact staff with any questions and or concerns. The Incident Report #1208 dated 11/28/23 at 7:45 AM revealed the following information: a. Nursing Description: Resident #2 sat in the hallway outside dining room waiting for breakfast when male peer approached her and started to lift up her shirt. b. Immediate Action Taken: Residents separated immediately c. Agencies/People Notified: Family member (son) and physician The Witness Statement on 11/28/24 from Staff E revealed the following information: a. Staff F yelled Staff E name and asked her to come quick. Staff E ran over to find Resident #1 sitting next to Resident #2 and pulling his hand back. Staff F then stated to Staff E what she saw. Staff E took Resident #1 to his room and reported to the DON (Director of Nursing). The Witness Statement on 11/28/24 from Staff F revealed the following information: a. Resident #1 lifted Resident #2 shirt, when Staff F saw what was happening, the shirt lifted to bottom breast and Resident #1 tried to get his hand up under her shirt. Staff F yelled for Staff E and she removed Resident #1 from the situation and took him to his room. During an interview on 4/10/24 at 1:32 PM, Staff G, CMA stated after Resident #1 and Resident #2 incident, staff needed to keep Resident #1 on a 1:1 until Resident #1 transferred to another facility. She stated Resident #1 always had someone outside his room and someone in the dining room. During an interview on 4/10/24 at 1:48 PM, Staff A, CNA stated they did 1:1 supervision with Resident #1 and put a pressure device in front of his door and they usually had a person who sat outside of his room until he transferred to another facility. During an interview on 4/10/24 at 1:58 PM, Staff H, CNA stated he worked third shift when the incidents occurred with Resident #1 and he stated if Resident #1 came out of his room he needed to be a 1:1 and to keep eyes on the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/24 at 3:09 PM, Staff E, CMA stated Resident #1 had 1:1 supervision but a lot of times the 1:1 staff disappeared or they didn't have the staff. Staff E stated they considered 1:1 supervision if the resident in the lobby area and staff at the nurse's station. She stated they preferred to sit at the table with him. During an interview on 4/11/24 at 1:55 PM, the ADON (Assistant Director of Nursing) queried on the expectation of 1:1 supervision and she stated staff to keep them in sight and not within reach of another resident. The Facility Safety and Supervision of Residents Policy dated July 2017 revealed the following information: a. Individualized, Resident-Centered Approach to Safety- Implementing interventions to reduce accident risks and hazards shall include 1. Communicating specific interventions to all relevant staff 2. Assigning responsibility for carrying out interventions 3. ensuring interventions implemented 4. documented interventions b. Systems's Approach to Safety 1. Resident supervision was a core component of the systems approach to safety. The type and frequency of residents supervision determined by the individual resident's assessed needs and identified hazards in the environment. The 1:1 Job Assignment Procedure (no date listed) revealed the following information: a. Goal: When assigned to 1:1 duty, the goal was to prevent the assigned resident access to strike out or engage in resident-to-resident behavior by staying between your assigned resident and other residents. b. Process: 1. Do not let assigned resident ambulate away from you. 2. Engage assigned resident in a 1:1 activity