STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165485	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Retirement Home	701 Ninth Street North Northwood, IA 50459

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, policy and procedure review, and staff interviews the facility failed to recognize a resident as a victim prior to transferring them to a different unit, instead of their alleged abuser for 1 of 5 residents reviewed (Resident #1). It can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm (e.g., embarrassment, punishment, humiliation, anxiety) as a result of having to move after getting violated by another resident. The facility identified a census of 36 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #1 required total assistance with toileting hygiene and transfers. Resident #1 didn't walk and used a wheelchair for mobility. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. The Communication - with Family Note dated 4/15/24 at 1:49 PM indicated the facility discussed the incident with Resident #1's son about a male resident touching her inappropriately. The staff explained they moved Resident #1 to a safe area and addressed all questions, who voiced no concerns. The staff planned to monitor and provide safe environment for Resident #2. The Social Services Note on 5/1/24 at 4:55 PM documented a discussion with Resident #1 that afternoon regarding the report of another male resident reaching down her shirt and touching her inappropriately. The staff reported they separated the residents immediately. The facility didn't observe any immediate changes in mood, anxiety, and affect (emotions). When inquired about Resident #1's feelings, she replied she had so much to do and expressed concern that she couldn't get all the work done. When asked if she specifically felt safe, Resident #1 responded she felt safe as she didn't worry about getting hurt, because she had just so much to do as it's a big event. The Social Services Note dated 5/1/24 at 5:05 PM indicated the facility called Resident #1's son regarding another male resident reached down his mother's shirt. The caller explained that the staff immediately separated the residents and started new intervention of frequent visual checks for the male resident. The call reviewed the comments with his mother as well as the staff observations. Informed the facility took the interactions seriously and they would maintain communication with him. The son reported he needed to think and would call with any questions or concerns. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Self-Report dated 5/7/24 at 4:12 PM documented an allegation of abuse. A CNA observed Resident #2 put his hands down Resident #1's shirt while in the lobby, as Resident #1 waited in the lounge/lobby area to go for supper. After redirecting Resident #2 to the dining room, the CNA checked to see if Resident #1 was ok and not exposed. The facility indicated the corrective action as the following: a. 5/7/24 Interventions: i. Education provided to Resident #2 on the importance of not touching other residents. ii. Education provided to the staff to keep Resident #2 away from other female residents. iii. 15-minute checks continued indefinitely on Resident #2. iv. Initiated 15-minute checks on Resident #1. v. The provider saw Resident #1 on rounds. vi. Resident #2 saw the provider on 5/7/24 and had an increase of his antidepressant medications. vii. Resident #2 scheduled to see the Psychiatry provider on 5/9/24. b. 5/8/24 Interventions: i. With the family's consent, the facility transferred Resident #1 to another area within the facility away from Resident #2, into a locked Alzheimer's wing. The Nurse Progress Note dated 5/7/24 at 7:25 PM reflected the facility called and spoke with Resident #1's son, about a male resident inappropriately touched his mother before supper that evening. When he asked the facility, what they planned to do about the male resident, the writer replied at the time they started interventions. The Director of Nursing (DON) planned a call to both families the next day. When the writer spoke with Resident #1 about the incident, she stated she didn't remember anything happening and felt fine. The staff ensured Resident #1 had her call light within reach. The facility placed Resident #1 on 15-minute checks at that time. The Care Plan dated 5/7/24 indicated Resident #1 had a potential for a psychosocial well being problem related to inappropriate touch by another male due to experienced inappropriate touch from another male resident. Interventions included: *15-minute checks initiated for safety. *Family notified of incident. *(5/8/24) moved to locked unit in The locked memory care unit for her safety until perpetrator's behaviors subside and/or discharges to another facility. The family okayed the room change and the facility notified them the room change is short term. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*(6/27/24) When conflict arises, remove resident to a calm safe environment and allow to vent/share feelings. The Social Services Note on 5/8/24 at 12:11 PM indicated the facility called Resident #1's son to discuss the on-going concern related to a male resident having inappropriate contact with his mother. The facility updated the other resident's family assisted relocating that resident. The facility inquired as to whether family would consider moving his mother to the locked memory care unit for the time being until situation can be resolved. Resident #1's son verbalized agreement with the plan. In addition, the staff initiated 15 minute checks for both residents, and provided staff supervision to his mother when she left her room. The facility's Self-Report submitted 5/8/24 at 3:40 PM reflected an allegation of abuse following a Certified Nurse Aide (CNA) reporting he saw Resident #2 put his hands down Resident #1's shirt while in the lobby of the facility. When the CNA told Resident #2 to keep his hands to himself, Resident #2 replied no. The CNA redirected Resident #2 from Resident #1 and started 15-minute checks for 24 hours. The facility notified the interim Director of Nursing (DON), Administrator, and Social Worker. In addition, they added Resident #2 to the nursing home rounds. The facility notified the staff to keep the 2 residents separated. The Social Services Note dated 5/8/24 at 4:51 PM reflected Resident #1 had a room change. Resident #1 moved to a room in The locked memory care unit for as a short-term safety precaution. Resident #1 continued with a pleasant demeanor, smiles and answered direct questions. When asked if she had anything on her mind, she replied it's beautiful, nice, and sunny. The staff noted her mood, behavior, and affect unchanged/stable. The facility called Resident #1's son to inform him of her new room. He reported he understood the reasons for the move and verbalized he appreciated the facility implemented strategies to maximize his mother's safety. On 8/14/24 at 12:30 PM, the facility's DON confirmed they expected the staff, residents, and visitors must always treat all residents with dignity and respect. The undated Resident Rights brochure directed resident's rights included *Being treated with respect and dignity *Being free from abuse *Making independent choices

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, staff interview, policy and procedure review, the facility failed to provide an environment free from sexual abuse for residents who didn't have the mental capacity to consent to sexual contact for 1 of 30 residents Resident #1). In addition, the facility failed to prevent a cognitive resident from having sexually aggressive behavior, such as inappropriate touching, grabbing, and fondling for 1 of 30 residents (Resident #2). On three separate occasions reflected Resident #2 fondled and touched Resident #1 underneath her clothes with the staff unaware of the situation. The facility failed to separate the 2 residents after the first and second incidents (4/15/24, and 5/1/24 in the common area). The facility failed to put in interventions in place until 4/15/24. The implemented interventions of continuous 15-minute checks lacked multiple areas of documentation following the 5/1/24 incident, reflecting the staff didn't monitor the residents' location as indicated. In addition, the facility failed to update Interventions on the Care Plan until 4/15/24. As the facility failed to ensure the safety interventions, this resulted in the likelihood of a serious adverse outcome to occur. It can be determined that the reasonable person in their position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation) as a result of the abuse. This resulted in an immediate need for the facility to take steps to ensure the protection for all residents from the risk of abuse. The facility reported a census of 36 residents. On 8/14/24 at 3:15 PM, the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on 8/15/24 after the facility staff completed the following: a. Education on the expected care for residents who have the tendency to show public displays of sexual behavior on 8/14/24 via text and on 8/15/24 at 10:00 AM at the all staff in-person in-service. b. Leadership staff understand the importance of completing an investigation regarding any resident on resident behaviors to include those sexual in nature. c. The staff intervened within 5 minutes after the incidents to ensure the safety of Resident #1. The staff talked with Resident #2 about his inappropriate behaviors. d. Implemented Inappropriate Behavior Protocol (to include sexual in nature behaviors) to aid staff in addressing any inappropriate behaviors. e. The facility updated both Care Plans. f. Resident #1 moved to the locked memory care unit on 5/8/24 g. The facility contacted other facilities for placement of Resident #2. h. Resident #2 discharged to another care facility in on 6/11/24. The facility lowered the Immediate Jeopardy to an E level deficiency prior to the survey exit. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #1 required total assistance with toileting hygiene and transfers. Resident #1 didn't walk and used a wheelchair for mobility. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. The Care Plan dated 5/7/24 indicated Resident #1 had a potential for a psychosocial well being problem related to inappropriate touch by another male due to experienced inappropriate touch from another male resident. Interventions included: *15-minute checks initiated for safety. *Family notified of incident. *(5/8/24) moved to locked unit in The locked memory care unit for her safety until perpetrator's behaviors subside and/or discharges to another facility. The family okayed the room change and the facility notified them the room change is short term. *(6/27/24) When conflict arises, remove resident to a calm safe environment and allow to vent/share feelings. The Communication with Family Note on 4/15/24 at 1:49 PM indicated the facility spoke with Resident #1's son about an incident of a male resident touching his mother inappropriately. The staff reported they removed her to a safe area. The facility planned to continue to monitor and provide safe environment for Resident #1. The Self-Report dated 5/1/24 at 12:34 PM, documented an allegation of abuse. A Certified Nurse Aide (CNA) reported to the charge nurse Resident #2 went to Resident #1 in the commons area and put his hand down her shirt. The CNA responded quickly and when they told him to keep his hands to himself, Resident #2 responded, no. The CNA redirected Resident #2 away from Resident #1 to the dining area. The facility started 15-minute checks for 24-hours and updated the Care Plan. The facility indicated the corrective action as 15 minutes checks indefinitely for the time being. Resident #2 added to the provider rounds on 5/7/24 and 5/9/24. The facility educated the staff to keep the residents apart. The Advanced Registered Nurse Practitioner returned the facility's notification fax with the response for the facility to supervise Resident #2 at all times around female residents. The Social Services Note on 5/1/24 at 4:55 PM documented a discussion with Resident #1 that afternoon regarding the report of another male resident reaching down her shirt and touching her inappropriately. The staff reported they separated the residents immediately. The facility didn't observe any immediate changes in mood, anxiety, and affect (emotions). When inquired about Resident #1's feelings, she replied she had so much to do and expressed concern that she couldn't get all the work done. When asked if she specifically felt safe, Resident #1 responded she felt safe as she didn't worry about getting hurt, because she had just so much to do as it's a big event. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Social Services Note dated 5/1/24 at 5:05 PM indicated the facility called Resident #1's son regarding another male resident reached down his mother's shirt. The caller explained that the staff immediately separated the residents and started new intervention of frequent visual checks for the male resident. The call reviewed the comments with his mother as well as the staff observations. Informed the facility took the interactions seriously and they would maintain communication with him. The son reported he needed to think and would call with any questions or concerns. The Self-Report dated 5/7/24 at 4:12 PM documented an allegation of abuse. A CNA observed Resident #2 put his hands down Resident #1's shirt while in the lobby, as Resident #1 waited in the lounge/lobby area to go for supper. The CNA redirected Resident #2 to the dining room and made sure Resident #1 was ok and not exposed. The facility indicated the corrective action as the following: a. 5/7/24 Interventions: i. Education provided to Resident #2 on the importance of not touching other residents. ii. Education provided to the staff to keep Resident #2 away from other female residents. iii. 15-minute checks continued indefinitely on Resident #2. iv. Initiated 15-minute checks on Resident #1. v. The provider saw Resident #1 on rounds. vi. Resident #2 saw the provider on 5/7/24 and had an increase of his antidepressant medications. vii. Resident #2 scheduled to see the Psychiatry provider on 5/9/24. b. 5/8/24 Interventions: i. The facility visited with Resident #2's son about his recurrent behaviors and new interventions. ii. The facility discussed referral options with Resident #2's son. iii. Son requested referral sent to previous facility. iv. Facility initiated referral. v. The facility transferred Resident #1 to another area within the facility away from Resident #2, a locked Alzheimer's wing. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The Nurse Progress Note dated 5/7/24 at 7:25 PM reflected the facility called and spoke with Resident #1's son, about a male resident inappropriately touched his mother before supper that evening. When he asked the facility, what they planned to do about the male resident, the writer replied at the time they started interventions. The Director of Nursing (DON) planned a call to both families the next day. When the writer spoke with Resident #1 about the incident, she stated she didn't remember anything happening and felt fine. The staff ensured Resident #1 had her call light within reach. The facility placed Resident #1 on 15-minute checks at that time. The Social Services Note on 5/8/24 at 12:11 PM indicated the facility called Resident #1's son to discuss the on-going concern related to a male resident having inappropriate contact with his mother. The facility updated the other resident's family assisted relocating that resident. The facility inquired as to whether family would consider moving his mother to the locked memory care unit for the time being until situation can be resolved. Resident #1's son verbalized agreement with the plan. In addition, the staff initiated 15 minute checks for both residents, and provided staff supervision to his mother when she left her room. The facility's Self-Report submitted 5/8/24 at 3:40 PM reflected an allegation of abuse following a Certified Nurse Aide (CNA) reporting he saw Resident #2 put his hands down Resident #1's shirt while in the lobby of the facility. When the CNA told Resident #2 to keep his hands to himself, Resident #2 replied no. The CNA redirected Resident #2 from Resident #1 and started 15-minute checks for 24 hours. The facility notified the interim Director of Nursing (DON), Administrator, and Social Worker. In addition, they added Resident #2 to the nursing home rounds. The facility notified the staff to keep the 2 residents separated. The Social Services Note dated 5/8/24 at 4:51 PM reflected Resident #1 had a room change. Resident #1 moved to a room in The locked memory care unit for as a short-term safety precaution. Resident #1 continued with a pleasant demeanor, smiles and answered direct questions. When asked if she had anything on her mind, she replied it's beautiful, nice, and sunny. The staff noted her mood, behavior, and affect unchanged/stable. The facility called Resident #1's son to inform him of her new room. He reported he understood the reasons for the move and verbalized he appreciated the facility implemented strategies to maximize his mother's safety. The facility and clinical record lacked documentation of any incident reports/investigations related to the incidents. 2. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS listed Resident #2 as independent with activities of daily living and used a walker for mobility. Resident #2 exhibited behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days in the lookback period. In addition, the MDS indicated he significantly intruded on the privacy or activity of others. The MDS included diagnoses of coronary artery disease (impaired arteries of the heart), heart failure, hypertension (high blood pressure), non Alzheimer's dementia and chronic kidney disease. The Care Plan initiated 4/16/24, identified Resident #2 as resident of the facility. The Care Plan included the following problems: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Hand-written documentation: 4/15/24 that he inappropriately touched a female resident. The staff intervened and redirected him. Provided education to Resident #2 on keeping his hands to himself. Educated the staff on resident not being around female residents. Monitor behaviors and added to the provider rounds. The goal reflected he would maintain his current level of function in all activities of daily living (ADLs) safety and thoroughly through the review date. The additional hand-written information indicated he saw the provider on rounds and started an antidepressant. b. Resident #2 attempted to touch female residents inappropriately at times. Additional hand-written documentation indicated 5/7/24: Inappropriate touching of a female resident. Education provided to Resident #2 and the staff. Provide direct supervision when out of his room. Continue 15-minute checks. Antidepressant increased. Added hand-written documentation 5/10/24: Current antidepressant discontinued and new antidepressant started with Depakote per the Psychiatric provider. The Goal reflected he would verbalize the need to control behavior through the review date. Hand-written documentation 5/8/24: Voluntary discharge process underway. Referral initiated to previous facility per son's request. 5/14/24: Previous facility completed their evaluation with a plan to transfer Resident #2 to new location beginning the next week. *(4/16/24) Monitor and document observed behaviors and attempted interventions in behavior log. *(4/16/24) Provide close supervision when Resident #2 is around female residents. *(5/2/24) Provide redirection as needed: Past Interests /Conversation Starters: Resident enjoys reading the newspaper, he used to work with scrap iron junking, and drove truck to the scrap yard. Favorite television shows include Gunsmoke and old westerns. *(5/2/24) Resident to be seen on Dr Rounds 5/7/24. Referral to Psychiatry as recommended. Referral for Talk Therapy as needed (PRN). *(5/2/24) Redirect when wandering, invading other resident's personal space, and monitor/report behaviors to charge nurse. *(5/9/24) Hand-written: Saw Psychiatry provider and recommendations sent to the ARNP. *(5/17/24) Hand-written: Facility visited with Resident #2's son and he didn't know when he would transfer to his previous facility. The family requested referrals sent to additional facilities. The Social Services Note dated 4/9/24 at 3:09 PM recorded a staff member notified the writer Resident #2 held another female resident's hand during the movie and popcorn activity. During this time, he attempted to take Resident #1's hand and place it on his chest underneath his denim bibs. The writer spoke with Resident #1 about inappropriate behavior and reminded him to respect peers and not to touch anyone inappropriately. The writer notified the Charge Nurse of the incident. The facility would continue to monitor for those types of behaviors. The Social Services Note dated 4/10/24 at 12:19 PM reflected the staff saw Resident #2 inappropriately touch another resident. After the staff moved Resident #2 to a safe place, they contacted the social worker and charge nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Nurse Progress Note dated 4/14/24 at 6:31 PM, labeled Late Entry reflected the writer saw Resident #2 outside of another resident's room. The writer redirected him to his room. The Nurse Progress Note dated 4/15/24 at 10:16 AM, indicated the staff found Resident #2 in the commons area visiting with another resident with his hand down the resident's shirt. The staff moved the resident to a safe area. The staff spoke to Resident #2 about his inappropriate behaviors and left a voicemail his son to call back at his convenience. The staff planned to continue watching for behaviors. The Nurse Progress Note dated 4/15/24 at 10:49 AM, recorded the nurse informed Resident #2's son of Resident #2's inappropriate behaviors when he returned the call. Resident #2's son stated he would have a face to face conversation with Resident #2 when he had time the next day. The Nurse Progress Note dated 4/15/24 at 3:35 PM, reflected the CNA's reported Resident #2 outside of another resident's room. He looked at the door, then he attempted to try and open the door. The staff redirected him. The Nurse Progress Note dated 4/15/24 at 8:30 PM indicated Resident #2 didn't have further attempts to enter the woman's room and no behaviors noted. The Nurse Progress Note dated 4/16/24 at 10:50 AM, reflected Resident #2 attempted to enter a female resident's room while she slept. The staff redirected him to the commons area. Resident #2 cooperated with the staff. The Nurse Progress Note dated 4/17/24 at 11:13 AM, documented after Resident #2 finished listening to the music, he left the chapel, and stood in the commons area. Resident #2 walked over to a female resident and started to rub her shoulder. The staff redirected Resident #2 immediately. Resident #2 requested to go to the dining room for lunch. The Social Services Note dated 4/17/24 at 3:27 PM recorded the writer spoke with Resident #2 about not invading the privacy of peers. Resident #2 voiced understanding. In addition, encouraged him to keep his hands to himself and not touch peers inappropriately. The Nurse Progress Note dated 4/18/24 at 1:19 PM reflected Resident #2 didn't make any inappropriate comments, inappropriate touching of any of the staff or residents at the facility, or wondering into any other rooms. The facility planned to monitor him. The Nurse Progress Note dated 5/1/24 at 12:34 PM, reflected a CNA reported to the charge nurse Resident #2 went up to a female resident in the commons area and put his hand down her shirt. The CNA responded quickly and when they told him to keep his hands to himself, Resident #2 responded, no. The CNA redirected Resident #2 away from Resident #1 to the dining area. The facility started 15-minute checks for 24-hours and updated the Care Plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Self-Report dated 5/1/24 at 12:34 PM, documented an allegation of abuse. A Certified Nurse Aide (CNA) reported to the charge nurse Resident #2 went to Resident #1 in the commons area and put his hand down her shirt. The CNA responded quickly and when they told him to keep his hands to himself, Resident #2 responded, no. The CNA redirected Resident #2 away from Resident #1 to the dining area. The facility started 15-minute checks for 24-hours and updated the Care Plan. The facility indicated the corrective action as 15 minutes checks indefinitely for the time being. Resident #2 added to the provider rounds on 5/7/24 and 5/9/24. The facility educated the staff to keep the residents apart. The Advanced Registered Nurse Practitioner returned the facility's notification fax with the response for the facility to supervise Resident #2 at all times around female residents. The Nurse Progress Note dated 5/1/24 at 1:47 PM indicated the facility updated the 15- minute checks to continue indefinitely for the time being and added to rounds. The staff educated to keep residents apart. The Nurse Progress Note dated 5/1/24 at 2:28 PM documented the staff reported Resident #2 touched another resident in an inappropriate manner. The staff visited with Resident #2 regarding the concern and explained he couldn't touch another resident in an inappropriate manner. In addition, the staff wrote the message on his whiteboard. Resident #2 voiced he understood he shouldn't touch and respect other residents. Staff initiated 15 minute checks indefinitely. The staff contacted Resident #2's son by telephone to update on the situation, the son voiced agreement with the plan of care. The Nurse Progress Note dated 5/7/24 at 4:12 PM indicated the staff observed Resident #2 putting his hand down another resident's shirt while in the lobby. The CNA redirected him to the dining room. The Self-Report dated 5/7/24 at 4:12 PM documented an allegation of abuse. A CNA observed Resident #2 put his hands down Resident #1's shirt while in the lobby, as Resident #1 waited in the lounge/lobby area to go for supper. After redirecting Resident #2 to the dining room, the CNA checked to see if Resident #1 was ok and not exposed. The facility indicated the corrective action as the following: a. 5/7/24 Interventions: i. Education provided to Resident #2 on the importance of not touching other residents. ii. Education provided to the staff to keep Resident #2 away from other female residents. iii. 15-minute checks continued indefinitely on Resident #2. iv. Initiated 15-minute checks on Resident #1. v. The provider saw Resident #1 on rounds. vi. Resident #2 saw the provider on 5/7/24 and had an increase of his antidepressant medications. vii. Resident #2 scheduled to see the Psychiatry provider on 5/9/24. b. 5/8/24 Interventions: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Retirement Home	701 Ninth Street North Northwood, IA 50459

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. With the family's consent, the facility transferred Resident #1 to another area within the facility away from Resident #2, into a locked Alzheimer's wing. The Communication with Family Note dated 5/7/24 at 4:20 PM documented the facility called Resident #2's son to update of him inappropriately touching another resident in the lobby. The Communication with Physician dated 5/7/24 at 4:26 PM labeled Late Entry reflected the CNA reported to the nurse that he observed Resident #2 touching another resident inappropriately in the lobby. The situation is recurrent behaviors of the same nature with these two residents. The CNA redirected Resident #2 to the dining room for the evening meal and educated him on the importance of not touching other residents. The facility placed both residents on 15-minute checks by staff again. The facility educated the staff to keep the two residents separated. The Nurse Progress Note dated 5/8/24 at 12:21 PM reflected a follow-up regarding the report of another incident of Resident #2 inappropriately touching another resident. Visited with Resident #2 who denied recollection of the incident from the day before. The author reiterated to Resident #2 that behavior is not acceptable. The facility called Resident #2's son and explained the facility couldn't tolerate Resident #2's behavior. The author informed him the facility had a goal to keep all residents safe. For that reason, they recommended he review relocating his father for his benefit as well as the benefit for the other resident. The 15 Minutes Resident Checks Form lacked documentation on the following dates and times of Resident #2's whereabouts: *5/1/24 from 8:30 PM 10:00 PM *5/2/24 from 7:00 AM 8:00 AM and 2:30 PM 3:30 PM *5/3/24 from 2:30 PM 10:00 PM *5/6/24 from 2:00 PM 10:00 PM *5/10/24 from 6:30 AM 10:00 PM Interview on 8/13/24 at 1:50 PM, Staff A, Social Worker/Admission Coordinator, said Resident #2 and Resident #1 knew each other from being neighbors in the community. They sat by each other at activities and in the dining room. They held hands and Resident #2 would rub Resident #1 shoulders. Staff A described the interactions as friendly gestures, then it escalated to inappropriate touching/behaviors with Resident #2. Staff A verified the incident on 4/9/24 as the same incident as 4/10/24. Staff A said after the first incident she didn't think anyone directed to watch Resident #2 and Resident #1. In addition, she didn't believe they put any interventions or instructions in place to prevent further incidents. Staff A said to her knowledge no other incidents happened to any other residents, only with Resident #1. Staff A said she didn't report the 4/9/24 incident to anyone due to it being a friendly gesture between two old friends. Now when she looked back at it, she should have separated them right away, and added interventions to the Care Plan. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/13/24 at 3:20 PM Staff B, Activity Director, said the incident on 4/9/24 happened in the chapel, during a movie Resident #2 and Resident #1 held hands. Then nonchalantly Resident #2 took Resident #1 hand and put it inside of Resident #2 bib overalls. She went to Resident #2 and told him that it was not appropriate for him to place Resident #1's hand inside of his bibs. Staff B, took Resident #1's hand out from under his bibs. Staff B said she didn't remember if anyone told the Administrator or Director of Nursing (DON) about the incident. Staff B, said she now knew any allegation of abuse needs reported right away. She verified the facility didn't report the incident to the DIAL and/or update the Care Plan. Interview on 8/13/24 at 3:50 PM, Staff C, Licensed Practical Nurse (LPN), said she didn't know of the incident on 4/9/24. Staff C said after the 4/15/24 incident, Staff D, Registered Nurse (RN), and Staff A told the staff to make sure and keep a closer eye on Resident #2 and Resident #1. In addition, make sure Resident #2 is nowhere near Resident #1. Staff C, said the 5/1/24 incident they started a directive to do 15-minute checks on Resident #2 and Resident #1. Staff C described the 5/7/24 incident as Resident #2 came out of the chapel and Resident #1 sat in the rock n go chair facing towards the television on the south wall. Resident #2 walked up to Resident #1 and put his hands down her shirt. The CNA, said he had his back towards Resident #1 talking with another staff member. When he turned around Resident #2 had his hand down her shirt. They went over right away, removed Resident #2 from the area, and told Resident #2 that was very inappropriate. Interview on 8/13/24 at 4:00 PM, Staff D, RN, said she spoke to Resident #2 about the incidents on 4/9/24 and 4/10/24. Staff D explained to Resident #2 the facility didn't allow inappropriate touching. They just told the staff to keep an eye on both residents when out of their rooms. Staff D confirmed she didn't put anything on the Care Plan about the incident. Interview on 8/14/24 at 9:30 AM, Staff E, RN, said that he didn't know about the 4/9/24 or 4/10/24 incident. The facility directed the staff on 4/15/24 to just keep Resident #1 and Resident #2 away from each other, they didn't get any other communication to prevent any further incidents from happening. Interview on 8/14/24 at 11:50 AM, Staff F, CNA, said didn't know about the incident between Resident #2 and Resident #1 until after she found Resident #2 with his hand down Resident #1's shirt on 5/1/24. Staff F said Resident #2 stood next to Resident #1 in the common area, with one hand down Resident #1's shirt. Staff F said the facility didn't give any directive on the 4/9/24 or 4/15/24 incident and they didn't have a communication book to look at. After the 5/1/24 incident the facility told them to keep a close eye on Resident #2. If he tried to go to Resident #1, they should redirect and navigate him to another area of the facility. The undated Abuse Prevention/Identification Policies and Procedure defined the purpose as to protect residents from other human beings (staff, visitors, family members or other residents) who may perpetrate verbal, sexual, physical, financial, and mental abuse, corporal punishment or involuntary seclusion. The Policy directed no resident is subjected to abuse through words of deeds of any person, from within or out of the facility. The facility will assure that all residents are free from neglect, mistreatment, and misappropriation of their property. The facility will do all within its control to prevent actions from occurring. That included doing whatever possible to control resident-on-resident altercations from occurring.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** 25858 Based on clinical record review, staff interview, and facility policy/procedure the facility failed to report an allegation of abuse to the Department of Inspections, Appeals, and Licensing (DIAL) following the observation of a male resident putting a female resident's hand inside his bib overalls or the continued instances of him putting his hand down the female resident's shirt for 2 of 5 residents reviewed (Residents #1 and #2). The failure to report the incident resulted in an immediate jeopardy situation. See citation F600 for additional information. The facility reported a census of 36 residents. On 8/14/24 at 3:15 PM, the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on 8/15/24 after the facility staff completed the following: a. Education on the expected care for residents who have the tendency to show public displays of sexual behavior, including reporting on 8/14/24 via text and on 8/15/24 at 10:00 AM at the all staff in-person in-service. b. Leadership staff understand the importance of completing an investigation regarding any resident on resident behaviors to include those sexual in nature. c. Implemented Inappropriate Behavior Protocol (to include sexual in nature behaviors) to aid staff in addressing any inappropriate behaviors. The facility lowered the Immediate Jeopardy to an E level deficiency prior to the survey exit. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #1 required total assistance with toileting hygiene and transfers. Resident #5 didn't walk and used a wheelchair for mobility. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. Resident #1's clinical record reflected a male resident (Resident #2) continued to make sexual advances to her on the following days: a. 5/1/24 b. 5/7/24 c. 5/8/24 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS listed Resident #2 as independent with activities of daily living and used a walker for mobility. Resident #2 exhibited behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days in the lookback period. In addition, the MDS indicated he significantly intruded on the privacy or activity of others. The MDS included diagnoses of coronary artery disease (impaired arteries of the heart), heart failure, hypertension (high blood pressure), non Alzheimer's dementia and chronic kidney disease. Resident #2's clinical record reflected he continued to touch a resident (Resident #1) with impaired cognition and without the ability to consent on the following days: a. 4/9/24: Resident #2 took Resident #1's hand and placed it inside his bib overalls. b. 4/10/24: Staff observed Resident #2 with his hand down Resident #1's shirt. c. 4/15/24: Staff observed Resident #2 with his hand down Resident #1's shirt. d. 5/1/24: Staff observed Resident #2 with his hand down Resident #1's shirt. e. 5/7/24: Staff observed Resident #2 with his hand down Resident #1's shirt. f. 5/8/24: Staff observed Resident #2 with his hand down Resident #1's shirt. The Self-Report dated 5/1/24 at 12:34 PM, documented an allegation of abuse. A Certified Nurse Aide (CNA) reported to the charge nurse Resident #2 went to Resident #1 in the commons area and put his hand down her shirt. The CNA responded quickly and when they told him to keep his hands to himself, Resident #2 responded, no. The CNA redirected Resident #2 away from Resident #1 to the dining area. The facility started 15-minute checks for 24-hours and updated the Care Plan. The facility indicated the corrective action as 15 minutes checks indefinitely for the time being. Resident #2 added to the provider rounds on 5/7/24 and 5/9/24. The facility educated the staff to keep the residents apart. The Advanced Registered Nurse Practitioner returned the facility's notification fax with the response for the facility to supervise Resident #2 at all times around female residents. The Self-Report dated 5/7/24 at 4:12 PM documented an allegation of abuse. A CNA observed Resident #2 put his hands down Resident #1's shirt while in the lobby, as Resident #1 waited in the lounge/lobby area to go for supper. The CNA redirected Resident #2 to the dining room and made sure Resident #1 was ok and not exposed. The facility indicated the corrective action as the following: a. 5/7/24 Interventions: i. Education provided to Resident #2 on the importance of not touching other residents. ii. Education provided to the staff to keep Resident #2 away from other female residents. iii. 15-minute checks continued indefinitely on Resident #2. iv. Initiated 15-minute checks on Resident #1. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	v. The provider saw Resident #1 on rounds. vi. Resident #2 saw the provider on 5/7/24 and had an increase of his antidepressant medications. vii. Resident #2 scheduled to see the Psychiatry provider on 5/9/24. b. 5/8/24 Interventions: i. The facility visited with Resident #2's son about his recurrent behaviors and new interventions. ii. The facility discussed referral options with Resident #2's son. iii. Son requested referral sent to previous facility. iv. Facility initiated referral. v. The facility transferred Resident #1 to another area within the facility away from Resident #2, a locked Alzheimer's wing. The facility, Resident #1, and Resident #2's clinical records lacked documentation of the facility reporting any incidents to the DIAL until 5/1/24 and then not again until 5/7/24. This reflected incidents not reported for the 4/9/24, 4/10/24, or the 4/15/24. Interview on 8/13/24 at 1:50 PM, Staff A, Social Worker/Admission Coordinator, said Resident #2 and Resident #1 knew each other from being neighbors in the community. They sat by each other at activities and in the dining room. They held hands and Resident #2 would rub Resident #1 shoulders. Staff A described the interactions as friendly gestures, then it escalated to inappropriate touching/behaviors with Resident #2. Staff A verified the incident on 4/9/24 as the same incident as 4/10/24. Staff A said she didn't report the 4/9/24 incident to anyone due to it being a friendly gesture between two old friends. Now when she looked back at it, she should have separated them right away, and added interventions to the Care Plan. Interview on 8/13/24 at 3:20 PM Staff B, Activity Director, said the incident on 4/9/24 happened in the chapel, during a movie Resident #2 and Resident #1 held hands. Then nonchalantly Resident #2 took Resident #1's hand and put it inside of his bib overalls. She went to Resident #2 and told him that it was not appropriate for him to place Resident #1's hand inside of his bibs. Staff B, took Resident #1's hand out from under his bibs. Staff B said she didn't remember if anyone told the Administrator or Director of Nursing (DON) about the incident. Staff B, said she now knew any allegation of abuse needs reported right away. She verified the facility didn't report the incident to the DIAL and/or update the Care Plan. Interview on 8/13/24 at 4:00 PM, Staff D, RN, said she spoke to Resident #2 about the incidents on 4/9/24 and 4/10/24. Staff D explained to Resident #2 the facility didn't allow inappropriate touching. Staff D said she didn't do an investigation on the incidents and/or didn't report it to DIAL. She added the 4/15/24 incident didn't get report to the DIAL either. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/13/24 at 4:45 PM, the Administrator said they expected the staff to start an investigation into any allegation of abuse. He verified no one told him of the 4/9/24, 4/10/24, and 4/15/24 incidents. The Administrator said the staff knew the policy to notify DIAL within a certain time frame, to start/initiate, and investigate. The facility went over the information during in-services, the new staff orientation policy, and procedures. The Administrator confirmed they expected the staff to follow the facility policy/procedures for reporting/investigating allegations. Interview on 8/14/24 at 11:50 AM, Staff F, CNA, said didn't know about the incident between Resident #2 and Resident #1 until after she found Resident #2 with his hand down Resident #1's shirt on 5/1/24. Staff F said Resident #2 stood next to Resident #1 in the common area, with one hand down Resident #1's shirt. Staff F said the facility didn't give any directive on the 4/9/24 or 4/15/24 incident and they didn't have a communication book to look at. After the 5/1/24 incident the facility told them to keep a close eye on Resident #2. If he tried to go to Resident #1, they should redirect and navigate him to another area of the facility. Staff F explained if they had an allegation of abuse, they are told to tell upper management. They will start an investigation, conduct interview, and notify the DIAL. The undated Abuse Prevention/Identification Policies and Procedure directed to report abuse allegations per Federal and State law. The facility will ensure that all alleged violations involving abuse are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the event that caused the allegation didn't involve abuse and didn't result in serious bodily injury. The staff must immediately report within 2 hours to the DON or Administrator or their designee any violations concerning mistreatment, neglect or abuse, including injuries of unknown source or misappropriation of resident property, no later than 24 hours if the events that cause the allegation didn't involve abuse or didn't result in serious bodily injury. The undated Abuse Investigation Policy instructed to assure all residents are protected from any form of abuse. To assure anyone committing any form of abuse is identified and removed from further opportunity to inflict. Any staff, who observes or are aware of an abuse situation occurring from staff and /or families, will report it immediately to the Administrator of Director of Nursing. In the event that the Administrator of Director of Nursing are not available staff should report any allegation to the Supervisor of duty. *When a report of suspected or alleged abuse is made to a supervisor, the person to whom it is reported will immediately begin the investigation process. *Staff will immediately report within 2 hours to the DON or Administrator or their designee any violations concerning mistreatment, neglect or abuse, including injuries or unknown source, or misappropriation of resident property or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, policy review, staff interview, the facility staff failed to thoroughly investigate all allegations of abuse, and separate a possible abuser from other residents. The facility lacked documentation of thorough investigations. In addition, the facility failed to conduct resident and staff interviews to determine the extent of the allegations, and if other residents were involved. The facility failed to separate the two residents until the incident occurred a third time and the family had to request something be done. After the facility added an intervention to monitor first Resident #2, then Resident #1's location, the facility failed to document as indicated. The facility's failure to investigate and separate the alleged abuser from the alleged victim resulted in an immediate jeopardy situation. It can be determined that the reasonable person in their position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation) as a result of the abuse. See citations F600 and F609 for additional information. The facility reported a census of 36 residents. On 8/14/24 at 3:15 PM, the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on 8/15/24 after the facility staff completed the following: a. Education on the expected care for residents who have the tendency to show public displays of sexual behavior on 8/14/24 via text and on 8/15/24 at 10:00 AM at the all staff in-person in-service. b. Leadership staff understand the importance of completing an investigation regarding any resident on resident behaviors to include those sexual in nature. c. Implemented Inappropriate Behavior Protocol (to include sexual in nature behaviors) to aid staff in addressing any inappropriate behaviors. d. Resident #1 moved to the locked memory care unit on 5/8/24 e. The facility contacted other facilities for placement of Resident #2. f. Resident #2 discharged to another care facility in on 6/11/24. The facility lowered the Immediate Jeopardy to an E level deficiency prior to the survey exit. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #1 required total assistance with toileting hygiene and transfers. Resident #1 didn't walk and used a wheelchair for mobility. The MDS included diagnoses of Alzheimer's disease, and non-Alzheimer's dementia. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Communication with Family/NOK/POA Note dated 4/15/24 at 1:49 PM reflected the facility contacted Resident #1's son to notify him a male resident touched his mother inappropriately. The facility told the son they moved Resident #1 to a safe area. The Care Plan dated 5/7/24 indicated Resident #1 had a potential for a psychosocial well being problem related to inappropriate touch by another male due to experienced inappropriate touch from another male resident. Interventions included: *15-minute checks initiated for safety. *Family notified of incident. *(5/8/24) moved to locked memory care unit for her safety until perpetrator's behaviors subside and/or discharges to another facility. The family okayed the room change and the facility notified them the room change is short term. *(6/27/24) When conflict arises, remove resident to a calm safe environment and allow to vent/share feelings. Resident #1's clinical record lacked documentation to keep the male resident away from her. The facility and clinical record lacked documentation of any incident reports/investigations related to the incidents. 2. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS listed Resident #2 as independent with activities of daily living and used a walker for mobility. Resident #2 exhibited behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days in the lookback period. In addition, the MDS indicated he significantly intruded on the privacy or activity of others. The MDS included diagnoses of coronary artery disease (impaired arteries of the heart), heart failure, hypertension (high blood pressure), non Alzheimer's dementia and chronic kidney disease. The Care Plan initiated 4/16/24, identified Resident #2 as resident of the facility. The Care Plan included the following problems: a. Hand-written documentation: 4/15/24 that he inappropriately touched a female resident. The staff intervened and redirected him. Provided education to Resident #2 on keeping his hands to himself. Educated the staff on resident not being around female residents. Monitor behaviors and added to the provider rounds. The goal reflected he would maintain his current level of function in all activities of daily living (ADLs) safety and thoroughly through the review date. The additional hand-written information indicated he saw the provider on rounds and started an antidepressant. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Resident #2 attempted to touch female residents inappropriately at times. Additional hand-written documentation indicated 5/7/24: Inappropriate touching of a female resident. Education provided to Resident #2 and the staff. Provide direct supervision when out of his room. Continue 15-minute checks. Antidepressant increased. Added hand-written documentation 5/10/24: Current antidepressant discontinued and new antidepressant started with Depakote per the Psychiatric provider. The Goal reflected he would verbalize the need to control behavior through the review date. Hand-written documentation 5/8/24: Voluntary discharge process underway. Referral initiated to previous facility per son's request. 5/14/24: Previous facility completed their evaluation with a plan to transfer Resident #2 to new location beginning the next week. *(4/16/24) Monitor and document observed behaviors and attempted interventions in behavior log. *(4/16/24) Provide close supervision when Resident #2 is around female residents. *(5/2/24) Provide redirection as needed: Past Interests /Conversation Starters: Resident enjoys reading the newspaper, he used to work with scrap iron junking, and drove truck to the scrap yard. Favorite television shows include Gunsmoke and old westerns. *(5/2/24) Resident to be seen on Dr Rounds 5/7/24. Referral to Psychiatry as recommended. Referral for Talk Therapy as needed (PRN). *(5/2/24) Redirect when wandering, invading other resident's personal space, and monitor/report behaviors to charge nurse. *(5/9/24) Hand-written: Saw Psychiatry provider and recommendations sent to the ARNP. *(5/17/24) Hand-written: Facility visited with Resident #2's son and he didn't know when he would transfer to his previous facility. The family requested referrals sent to additional facilities. Resident #2's son to update of him inappropriately touching another resident in the lobby. Resident #2's clinical record lacked direction to keep him separated from Resident #1 on the typed information of the Care Plan last revised 4/17/24. The facility added handwritten information for 4/15/24 on that same Care Plan. The 15 Minutes Resident Checks Form lacked documentation on the following dates and times of Resident #2's whereabouts: *5/1/24 from 8:30 PM 10:00 PM *5/2/24 from 7:00 AM 8:00 AM and 2:30 PM 3:30 PM *5/3/24 from 2:30 PM 10:00 PM *5/6/24 from 2:00 PM 10:00 PM *5/10/24 from 6:30 AM 10:00 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165485	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Retirement Home	701 Ninth Street North Northwood, IA 50459

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to keep Resident #1 safe from Resident #2 by failing to ensure he stayed away from Resident #1 following the first incident on 4/9/24 or the second incident on 4/15/24. Resident #2 continued to have access to Resident #1 before staff intervened on the following days: a. 4/9/24: Resident #2 took Resident #1's hand and placed it on his chest inside his bib overalls during an activity. b. 4/15/24: Resident #2 reached down Resident #1's shirt in commons area c. 4/17/24: After leaving the chapel, Resident #2 walked over to Resident #1 and started to rub her shoulder. d. 5/1/24: Resident #2 put his hand down Resident #1's shirt in the commons area. e. 5/7/24: Resident #2 observed putting his hand down Resident #1's shirt in the lobby. Interview on 8/13/24 at 1:50 PM, Staff A, Social Worker/Admission Coordinator, said after the first incident she didn't think anyone directed the staff to watch Resident #2 and Resident #1. In addition, she didn't believe they put any interventions or instructions in place to prevent further incidents. Staff A said to her knowledge no other incidents happened to any other residents, only with Resident #1. Staff A said she didn't report the 4/9/24 incident to anyone due to it being a friendly gesture between two old friends. Now when she looked back at it, she should have separated them right away, and added interventions to the Care Plan. Interview on 8/13/24 at 3:50 PM, Staff C, Licensed Practical Nurse (LPN), said she didn't know of the incident on 4/9/24. Staff C said after the 4/15/24 incident Staff D, Registered Nurse (RN), and Staff A told the staff to make sure and keep a closer eye on Resident #2 and Resident #1. In addition, make sure Resident #2 is nowhere near Resident #1. Staff C, said the 5/1/24 incident they started a directive to do 15-minute checks on Resident #2 and Resident #1. Staff C described the 5/7/24 incident as Resident #2 came out of the chapel and Resident #1 sat in the rock n go chair facing towards the television on the south wall. Resident #2 walked up to Resident #1 and put his hands down her shirt. The CNA, said he had his back towards Resident #1 talking with another staff member. When he turned around Resident #2 had his hand down her shirt. They went over right away, removed Resident #2 from the area, and told Resident #2 that was very inappropriate. Interview on 8/13/24 at 4:00 PM, Staff D, RN, said she spoke to Resident #2 about the incidents on 4/9/24 and 4/10/24. Staff D explained to Resident #2 the facility didn't allow inappropriate touching. Staff D said she didn't do an investigation on the incidents and/or didn't report it to DIAL. They implemented the intervention to redirect Resident #2 away from Resident #1. Staff D stated that she didn't do a thorough investigation on the incident, as she didn't interview staff or other residents. They just told the staff to keep an eye on both residents when out of their rooms. Staff D confirmed she didn't put anything on the Care Plan about the incident. She didn't think the facility had a paper incident/accident report made out. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/13/24 at 4:45 PM, the Administrator said they expected the staff to start an investigation into any allegation of abuse. He verified no one told him of the 4/9/24, 4/10/24, and 4/15/24 incidents. The administrator confirmed the facility didn't have, as he couldn't find, a completed thorough investigation with staff or resident interviews in the facility. The facility went over the information during in-services, the new staff orientation policy, and procedures. The Administrator confirmed they expected the staff to follow the facility policy/procedures for reporting/investigating allegations. Interview on 8/14/24 at 9:30 AM, Staff E, RN, said that he didn't know about the 4/9/24 or 4/10/24 incident. The facility directed the staff on 4/15/24 to just keep Resident #1 and Resident #2 away from each other, they didn't get any other communication to prevent any further incidents from happening. Interview on 8/14/24 at 11:50 AM, Staff F, CNA, said didn't know about the incident between Resident #2 and Resident #1 until after she found Resident #2 with his hand down Resident #1's shirt on 5/1/24. Staff F said Resident #2 stood next to Resident #1 in the common area, with one hand down Resident #1's shirt. Staff F said the facility didn't give any directive on the 4/9/24 or 4/15/24 incident and they didn't have a communication book to look at. After the 5/1/24 incident the facility told them to keep a close eye on Resident #2. If he tried to go to Resident #1, they should redirect and navigate him to another area of the facility. Staff F explained if they had an allegation of abuse, they are told to tell upper management. They will start an investigation, conduct interview, and notify the DIAL. The undated Abuse Prevention/Identification Policies and Procedure defined the purpose as to protect residents from other human beings (staff, visitors, family members or other residents) who may perpetrate verbal, sexual, physical, financial, and mental abuse, corporal punishment or involuntary seclusion. The facility will assure that all residents are free from neglect, mistreatment, and misappropriation of their property. The facility will do all within its control to prevent actions from occurring. That included doing whatever possible to control resident-on-resident altercations from occurring. The Procedure instructed the facility to take actions necessary to provide a safe, secure environment that will protect the right of all residents who reside in the facility. The facility will ensure staff, visitor, family members or other residents do not use verbal, mental, sexual, financial or physical abuse, corporal punishment or seclusion toward a resident. The facility supervisors will routinely monitor the facility staff to assure the delivery of resident care and services and to assure the potential for abuse or neglect is minimized.