STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165219	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurens Care Center	304 EAST VETERANS ROAD , LAURENS, Iowa, 50554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 x DC	INITIAL COMMENTS Correction date 10/9/25 Investigation of self reports #1790449-I, #1791472-I, #2629625-I and complaint #2625437-C conducted 10/6/25 to 10/8/25 resulted in the following deficiencies.	F0000	**F 0561** It is the intent of Laurens Care Center to ensure that residents are provided the right to use their pharmacy of choice. Specifically in this instance, the right for resident #4 to obtain medications through the VA as part of their VA benefit. Effective October 20, 2025, Resident #4 transitioned to receiving medications through the VA. On October 9, 2025, VA medication status for new admissions was added to the facility admission checklist, which is now a part of our admission packet. This new process will identify new admits who choose to receive their prescriptions from the VA pharmacy. All identified concerns regarding residents receiving medications through the VA will be presented to the QAPI Committee for feedback and resolution, quarterly or on an as needed basis.	
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the	F0561		

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 reverse for further 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
Julie Nold LWHA	Administrator	11/24/2025

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F0561 SS = D	Continued from page 1 facility failed to ensure residents and/or their representatives had the right choose a pharmacy for 1 of 3 resident's reviewed (Resident #4). The facility reported a census of 27 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 7/23/25, Resident #4 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included diabetes, Alzheimer's disease, anxiety disorder, restlessness and agitation. The resident's drug regimen included antianxiety, antiplatelet, and hypoglycemic medications. The Care Plan identified the resident on Antiplatelet therapy (Aspirin) revised 4/7/25, antianxiety medication (lorazepam) initiated 5/7/25, and antidepressant medication (Trazadone) initiated 9/23/25. An Admission Information form dated 3/28/25 documented yes for Resident #4 being a veteran and yes for Veterans Administration (VA) meds.	F0561		
	The Progress Notes documented the following: On 7/23/25 at 1:38 p.m. the Social Services Coordinator (SSC) received a phone call from the Clinic on behalf of Resident #4's spouse requesting his VA benefits be reviewed. The caller shared the resident paid full price for multiple medications, and the spouse questioned if VA insurance would cover the cost of the medications. The SSC shared the inquiry with the administrator and Director of Nursing (DON). The SSC would follow up as needed. On 7/30/25 at 12:39 a.m. call placed to pharmacy, and they were unable to find prescriptions with VA for Resident #4. He was seen on 6/12/25 and had advanced dementia - Dr through Veteran Affairs and local Primary Care Provider (PCP) Physician Assistant Certified (PA-C). Per pharmacy send Medication Administration Record (MAR)/Treatment Administration Record (TAR) to VA provider so she could order medications through VA. At 1 a.m. fax prepared and sent to provider at VA attaching her faxed orders, 2, from visit on 6/12/25, copy of face sheet and copies of Resident #4's MAR and TAR. At 1:27 a.m. Fax completed and 19 pages confirmed sent. On 8/1/25 at 3:18 p.m. call from VA informing Resident #4 approved to see provider closer to his home at local			

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F0561 SS = D	Continued from page 2 clinic scheduled for 8/18/25 PA:C and she could send orders to VA and would get meds sent, but if needed sooner let VA know and a provider would okay for 30 day supply until seen by PCP. On 8/18/25 at 2:42 p.m. Resident #4 out of facility in van to appointment at clinic at 2:15 p.m. Returned to facility at 2:25 p.m.. Appointment had been cancelled 8/17/25 by text confirmation. Appointment scheduled for Sept 2 at 4 p.m. On 9/2/25 at 5:22 p.m. appointment with PA-C, initial community care for VA visit. Due for labs this month. The record lacked any additional information r/t VA meds. On 10/6/25 at 5:05 p.m. Staff E Licensed Practical Nurse (LPN) stated they had 2 residents on VA meds, but not Resident #4. On 10/8/25 at 9 a.m. the Administrator stated she went to the resident's home to do the admission paperwork. She marked yes on the form for VA meds. She gave the paperwork to the Assistant Director of Nursing (ADON) (no longer employed by the facility) to process. She assumed it would be taken care of appropriately. She said then they received a call in July about getting him on VA meds. She said the previous DON was working on the VA meds for Resident #4, and then she left suddenly. She assumed this was taken care of. She did not realize they still did not have VA meds. They still needed to get his meds through the VA. The Administrator admitted with the staff changes this had been missed. She planned to take the paperwork to the clinic.	F0561		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600		

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F0600 SS = E	Continued from page 3 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure residents were free from abuse for 2 of 3 residents reviewed (Resident #2 and #3) by another resident (Resident #1). Resident #1 touched Resident #2 inappropriately on the chest on 2 separate occasions, and Resident #3 on 1 occasion. The facility reported a census of 27 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated 8/6/25, Resident #2 scored 2 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required partial to moderate assistance wheeling self in wheel chair 50 feet and making turns, and when wheeling self 150 feet in a corridor or similar space. The resident's diagnoses included aphasia (language disorder affecting a person's ability to communicate), non- Alzheimer's dementia and traumatic brain injury. The Care Plan revised 11/21/24 identified Resident #2 had impaired cognitive function/dementia or impaired thought processes related to (r/t) dementia and a history of traumatic brain injury. Interventions included: a. Using Resident #2's preferred name, identifying yourself at each interaction, facing her when speaking and making eye contact, reducing any distractions, turning off the TV, radio, close door etc. providing her with necessary cues, stop and return if agitated. b. Supervision/assistance with all decision making. c. Keeping routine consistent and trying to provide consistent care givers as much as possible in order to decrease confusion. The Progress Notes documented the following: On 5/6/25 at 7:30 p.m. the nurse heard Resident #2 calling for help. When she entered the living room, she observed a male resident in a wheelchair reaching over hugging Resident #2 with his right arm and his left hand was under Resident #2's shirt touching her right	F0600	**F 0600** It is the intent of Laurens Care Center to consistently follow the facility Dependent Adult Abuse Policy to keep all residents free and safe from abuse. On October 9, 2025, a family meeting with resident #4's POA for Healthcare and other family members was held at the facility. At this time, it was determined that the 30-Day Notice of Involuntary Discharge was necessary. Per family request, attempts to find placement close to the area were unsuccessful. On October 17, 2025, a facility in Southern Iowa responded to the inquiry that had been sent regarding resident #1, stating that there was availability for him/her. A new 30-Day Notice of Involuntary Discharge was then sent out this same day, specifically stating the name and location of the accepting facility. On October 31, 2025, resident #1 was discharged and transported to the accepting facility by Laurens Care Center staff. Resident #1's POA for Healthcare chose to follow the transport van in their personal vehicle. Effective November 3, 2025 a new preadmission assessment tool was implemented to more closely screen potential admits. All identified concerns regarding residents who demonstrate inappropriate/unwanted abusive tendencies will continue to be immediately presented to the QAPI Committee for feedback and resolution. Also, moving forward a 30-Day Notice of Involuntary Discharge will be issued immediately to any resident who demonstrates any tendencies abusive in nature towards fellow resident(s) in case facility interventions to prevent further occurrences are ineffective.	

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F0600 SS = E	Continued from page 4 breast. Resident #2's bra was in place between his hand and her breast. The male resident immediately removed from the area. Resident #2 taken to room to be assessed. Resident #2 voiced he grabbed her. No red or bruised areas noted to breast area. When asked resident if she felt safe at facility resident responded yes. On 5/7/25 at 8:48 a.m. Resident #2's family member called to speak with the DON regarding the incident. The DON relayed information regarding what had occurred. The family member voiced understanding and stated that she had worked in healthcare for many years. She was aware accidents happened and that they were doing everything they could to ensure it did not happen again. On 9/25/25 at 9:35 a.m. Resident #2 sat in her w/c in the living room, when a CNA noted a male resident (Resident #1) touching her chest over her shirt. The CNA snapped her fingers and said Resident #1's name to get his attention away from Resident #2. The CNA then removed Resident #1 from the living room. No anxiety was noted with Resident #2 and she smiled at the nurse when asked if she was okay and if she felt safe. The Social Worker would visit with Resident #2's family member. On 9/2625 at 9:23 a.m. Resident #2 was pleasant smiled when spoken to continuing to smile when asked if she felt safe. No appearance of distress. During an observation on 10/06/25 at 11:22 a.m. Resident #2 in sat in the dining room at the assist table, receiving cues from a CNA to pick up her fork and start to eat. Resident #2 picked to the left of her plate at table cloth, nothing there and brought her hand to her mouth as if to eat something but had nothing in her hand. A CNA guided her hand and fork to the plate. The CNA instructed her to pick up a glass to drink. She reached for salt. The CNA continued to guide Resident #2, and give cues to self feed. On 10/06/25 at 11:35 a.m. Resident #1 entered the dining room away from Resident #2 at a table near the window with back facing residents. No contact noted. 2) According to the MDS assessment dated 4/16/25, Resident #3 scored 10 on the BIMS indicating moderate cognitive impairment. The resident required substantial to maximal assistance wheeling self in wheel chair 50 feet and making turns, and when wheeling self 150 feet in a corridor or similar space. The resident's diagnoses included Parkinson's disease.	F0600		

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F0600 SS = E	Continued from page 5 The Care Plan dated 6/27/22 and revised 5/20/25 identified Resident #3 had impaired cognition related to dementia. Interventions included: a. Identifying yourself at each interaction, facing her when speaking and make eye contact, reducing any distractions, turning off the TV, radio, close door etc. b. Engaging Resident #3 in simple, structured activities that avoided overly demanding tasks. The Care Plan revised 9/10/23 identified trauma informed care and indicated past physical abuse endured while staying with a former friend. Interventions included Resident #3 tried not to think about past abuse, that was her coping mechanism. The Progress Notes dated 5/25/25 documented at 11:20 a.m. a CNA reported she walked residents down the hall to lunch when she noticed another resident's wheel chair (w/c) very close to Resident #3's. The CNA approached the residents and noticed the male resident touching Resident #3's breast over the top of her blouse. The CNA advised the male resident (Resident #1) he needed to keep his hands to himself, and he refused, continuing to touch her breast. When moving Resident #3 she said something the CNA did not catch. When the nurse spoke to Resident #3 she stated she wheeled herself down to eat when Resident #1 grabbed her w/c and started grabbing her breasts. Resident #3 stated she asked Resident #1 to keep his hands to himself and he refused and continued to touch her. Resident #3 was tearful, but said okay. Resident #3 denied any injuries or further concerns. She requested to go to the dining room to eat. The nurse reassured her they would continue to monitor her and to let them know if she had any concerns or felt unsafe at any time. 3) According to the MDS assessment dated 4/10/25, Resident #1 scored 4 on the BIMS indicating severe cognitive impairment. The resident required partial to moderate assistance wheeling self in wheel chair 50 feet and making turns, and when wheeling self 150 feet in a corridor or similar space. The resident's diagnoses included non- Alzheimer's dementia. The Care Plan identified Resident #1 had a history of making sexual comments/advances towards staff and residents initiated:4/6/25 and revised 5/6/25 with a goal to have fewer episodes. Interventions included: a. Intervening as necessary to protect the rights and safety of others.	F0600		

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F0600 SS = E	Continued from page 6 b. Approaching/Speaking in a calm manner. c. Diverting attention. d. Removing from situation and taking to alternate location as needed. Date Initiated: 04/06/2025 CNA e. 15 minute checks would be done to keep watch on my location and who I am around. Date Initiated: 05/26/25. f. Administration working with the chief of police and case manager of to develop a plan to ensure the safety of other residents. Date Initiated: 05/26/2025. g. Continuing to remind him any hugging or physical contact with staff or residents was not appropriate. Date Initiated: 05/07/2025. h. A police officer has been doing walk throughs to ensure support of preventing any further incidents. Date Initiated: 05/26/25. i. Increased monitoring 1700-2200. Date Initiated: 05/07/25.	F0600		
	j. Med review and telehealth appt. completed 9/26/25 resulting in medication changes. Date Initiated: 09/26/25. k. Room change to 104. Date Initiated: 05/07/25. The Progress Notes documented the following: On 4/16/25 at 7:35 p.m. another resident approached the nurse at the med cart down 200 hallway. The other resident was tearful, stating Resident #1 needed to stop. She said Resident #1 touched her arm and it made her feel uncomfortable. She said Resident #1 said he loved her. The nurse told the other resident to stay with her. The nurse went in to a resident room to start a treatment, and when she came out the other resident was next to the med cart, and Resident #1 was right next to her and attempting to hold her hand. The nurse intervened and asked Resident #1 to go up front to the living room or down his hallway. Resident #1 refused to do so and stated he could be there. The nurse told Resident #1 he made the other resident feel uncomfortable. Resident #1 said he didn't care. Attempted to take Resident #1 to the living room and put his feet down. Again the nurse told Resident #1 he needed to leave the other resident alone. The nurse told the other resident to go past the med cart and go down the hall. The nurse had to lift Resident #1's feet			

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F0600 SS = E	Continued from page 7 up on to the wheelchair (w/C) pedals and he kept them there until got to the sitting area, then he put his feet down again. Resident #1 stated he loved the other resident and was going to marry her. He said you can't help love. Resident #1 then attempted to go down the 200 hall again. The other resident was in her room. Told Resident #1 behavior was unacceptable and he could not do this. Attempted to redirect and able to move resident further over by the time clock. Placed the med cart across the 200 hall so if he did come down he could not get through. The nurse spoke with the other resident and assured her she would try her best to keep him off the 200 hallway. Spoke with staff and they were able to take Resident #1 to his room. Resident #1 then refused bedtime (HS) cares. Another CNA attempted and he refused cares also. A 3rd CNA was able to get his cares done but he would not leave his w/c. The other resident stated Resident #1 touched her left shoulder/arm area and was rubbing his hand on her. Resident #1 sat in his w/c with a blanket over his head, refusing to go to bed or his recliner. Attempts were made throughout the shift. On 4/1725 at 8:24 p.m. Resident #1 propelled himself down the 200 hall trying to reach the same resident from incident on 4/16/25 stating he wanted to talk to her and make sure she was okay. The nurse explained to Resident #1 the other resident didn't want to talk to him, and he was assisted back to his room. Resident #1 becomes agitated and uncooperative and continued to state he just wanted to make sure she was okay, because he didn't think she was. Attempted to explain to Resident #1 we need to respect other resident's wishes and not talk to her. Resident #1 refused to leave the hall and went to room doors that were closed pushing them open. Resident #1 redirected back to the lobby where he sat. When the nurse was out of his sight he attempted to go back down the 200 hall. Staff provided 1:1. Resident #1 then propelled himself down the 100 hall attempting to open closed resident doors and yelling he didn't do a damn thing, they were all lying. The nurse allowed the resident to wheel up and down the 100 hall with supervision. The resident then propelled himself to his own room down the 300 hall and allowed a CNA to assist him with HS cares and transfer into bed. Resident pleasant to CNA during this time. On 4/18/25 at 12:38 p.m. placed a call to Resident #1's family member regarding continued unwanted behavior towards a fellow resident. Explained that staff intervention had been unsuccessful and he had been very challenging to redirect. To the facilities knowledge, no inappropriate comments or contact had occurred. The resident being bothered simply did not like it. The	F0600		

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F0600 SS = E	Continued from page 8 family member expressed understanding regarding this and stated she was sorry that this happened and another family member would be there after 5 p.m. to speak with the resident regarding his behavior. On 4/29/25 at 9:24 a.m. sent a fax to the Primary Care Provider (PCP) to advise per the family request for a mood stabilizer. The resident continued to yell out et difficult to redirect, threatening staff and disrupting in the dining room. On 4/30/25 at 8:55 a.m. the fax returned signed by the PCP citing the resident could be seen on rounds, make an office visit, or refer to the Psychiatric (Psych) Nurse Practitioner (NP). The resident's family member opted to have the resident seen at the facility.. On 5/5/25 at 2:47 p.m. the Psych NP gave a new order for Lorazepam (antianxiety) 0.5mg every day at 4 p.m. and every 4 hours as needed. Follow up in 2 weeks. Call placed to family member and she approved of the medication changes. Resident interactions: 1) On 5/6/25 at 7:30 p.m. the nurse heard a female resident (Resident #2) calling for help. When entered the living room observed Resident #1 in his wheelchair leaning over hugging Resident #2 with his right arm, and his left hand under her shirt touching her right breast. A bra was intact between Resident #1's hand and Resident #2's breast. Resident #1 removed immediately from the area and taken to his room. Explained to him the behavior was inappropriate. Resident #1 was agitated voicing he owned the place and and they were all fired. They would provide increased monitoring for any further behaviors. On 5/6/25 at 9 p.m. the resident agitated wheeling up and down the halls opening resident's room doors. When attempt to redirect, the resident became more agitated stating to leave him alone, and put his arm making a fist at a CNA. Resident reapproached by another staff member, offered toilet and snack prior to administering medication. On 5/7/25 at 8:01 a.m. the Director of Nursing (DON) spoke with the resident regarding his behaviors the previous night. Resident #1 stated he did not remember that happening. When let him know his actions, he agreed this would not happen again because it was highly inappropriate and made others feel uncomfortable. He agreed not to do this again.	F0600		

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F0600 SS = E	Continued from page 9 On 5/7/25 at 8:54 a.m. the Psych NP returned phone call regarding behaviors. She recommended increased monitoring, and reminding the resident at this point any hugging or physical contact with staff/other resident's was not appropriate. She was reviewing medications for the resident and would call back with any changes. On 5/7/25 at 1:44 p.m. a CNA reported when helping the resident with toileting cares in the afternoon. Resident #1 placed his hand on her buttock and grabbed. The CNA advised the resident it was inappropriate and to please stop. The CNA reported to the nurse and the DON. On 5/7/25 at 3:33 p.m. received phone call from the Psych NP with a verbal order to start the resident on Sertraline (antidepressant) 50 mg daily for anxiety. Family notified and agreeable to plan. On 5/9/25 at 10 a.m. Resident #1 denied any problems with new room. When asked if he liked the room he responded it's okay. On 5/17/25 at 4:47 p.m. checked on Resident #1 and monitored frequently. Noted the resident approaching a female resident and reached for the female resident's hand. The nurse removed the female resident from the area. Reminded Resident #1 he needed to keep a distance from other residents, and not to touch anyone. He expressed understanding. The female resident denied any contact with male resident and said he did not touch her hand. On 5/18/25 at 4:19 p.m. continued with increased monitoring of resident. Family in to visit this pm. No behaviors noted. On 5/19/25 at 2:33 p.m. Resident #1 seen on rounds of the Psych NP. The resident continued to have some behaviors and new orders for Lorazepam 0.5 mg to be scheduled for 4 p.m. and 8 p.m. and continue as needed order. 2) On 5/25/25 at 11:20 a.m. a CNA reported she walked residents down the hall to lunch when she noticed Resident #1's wheelchair very close to Resident #3's wheelchair. The CNA approached the residents and noticed Resident #1 touching Resident #3's breast over the top of her blouse. The CNA advised Resident #1 that he needed to keep his hands to himself. He refused and continued touching her breast. While staff moved Resident #3, she stated something that CNA did not catch. Resident #1 called the resident being currently	F0600		

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F0600 SS = E	Continued from page 10 assisted to the dining room and the CNA fat bitches. Resident #1 became very verbally aggressive and attempted to kick his feet while yelling that the nurse was a dumb expletive. Resident #1 continued yelling and insisted that he was going to the dining room. Staff offered Resident #1 a room tray, and he accepted. Resident ate in the family room where he would be highly monitored. Called and spoke to the DON, followed up with a call to the Administrator, and the Police Department (PD). Both parties' families were notified of the occurrence and the actions that were taken, prevalent to their family member. Resident #1's family present at bedside and he appeared calm with no concerns currently. An officer with the PD phoned Chief of Police along with the Mental Health and Substance Abuse Case Manager. All staff were notified to continue 15-minute monitoring and checks on resident 24 hours daily until further notice. Resident #1 to be monitored constantly to verify there be no interaction between both parties and limited/monitored with any female interaction. Night nurse to always sit with hall and room in view when available. On 5/25/25 at 11:35 a.m. called: Resident #1's family member and updated on Resident #1"s behavior of touching another resident inappropriately in the hallway. Resident #1 touched another resident on the breasts over her clothes. Informed family the Police were notified and coming to the facility. The Administer also updated. On 5/27/25 at 12:23 p.m. phone conversation with the Psych NP regarding Resident #1's behaviors. Discussed the interventions they were currently doing: 15 minute checks, med recommendations from pharmacy consultant, utilizing PRN medications, educating the resident behaviors were not appropriate, police rounding, asked the family to do PRN visits as able, removing from a situation that may result in an incident, room change, etc. The Psych NP ordered Depakote 250 mg every HS for mood lability/impulsivity. Contacted a family member and she verbalized consent for use of the medication. Stated she would be coming to the facility soon to sign and discuss the resident's care. On 5/27/25 at 12:35 p.m. had a Zoom meeting with the Mental Health Coordinator at 10 a.m. to discuss Resident #1's health and behavioral history, and steps to develop a more detailed plan of care around his hypersexual behavior. The DON, ADON, MDS Coordinator, and Administrator participated in the meeting. Conversation focused around resident's health and behavioral history prior to admission, cognitive diagnosis, potential pharmaceutical interventions to	F0600		

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F0600 SS = E	Continued from page 11 decrease resident's hypersexual behaviors, and review of interventions currently in place as they planned and coordinated his care for a more effective, long-term intervention(s). The Administrator sent an email summary of the meeting to the resident's family to include a request for family assistance through evening visits that occur in his room, as their visits helped him maintain a positive mood and kept him occupied. Resident #1's family were on the way to the facility to visit with resident and also meet with facility leadership for further discussion of incident that lead to a second self-report Sunday May 25, 2025. On 5/28/25 at approximately 1:15 p.m. CNA staff were having a difficult time attempting to redirect Resident #1from heading into the front living room, where facility Resident's #2 and #3 were. Resident #1 spoke loudly saying get out of the way, that was his ex-wife and he was going to talk to her, and pointed to Resident #3. Efforts to reassure him that Resident #3 was not his ex wife, did not deter him and he planted his feet down to prevent anyone from moving his wheelchair. Reminded him that law enforcement officers had been coming to visit with him frequently the past few days, and tasked him if he would like an officer in to visit with him. Resident#1 looked angry, but allowed a CNA to move him in his wheelchair and wheel him to his room to rest in his recliner. On 6/1/25 at 2:46 p.m. Resident #1's family there and wanted to sit at table in the living room towards the west wall. A female resident sat at the table on the East side of the living room. The nurse passed and heard someone say he could not go over there. Resident #1 yelled at family and tried to wheel himself over there and family held the wheelchair. Resident #1 said to just leave him alone and wheeled himself towards the other resident with his family present. Staff intervened and took Resident#1 back to the table towards the west wall, and the resident sat at the table with family. On 8/31/25 at 5:32 p.m. a CNA reported Resident #1 approached women in the living room. The CNA attempted to redirect the resident and he refused to leave the living room. He became upset and began screaming at the CNA. The female residents were assisted from the living room. The two female residents reported the resident only talked with them. 3) On 9/25/25 at 9:35 a.m. a CNA noted Resident #1 in the living room. When the CNA turned, she saw Resident #1 in front of Resident #2, touching her chest over her shirt. The CNA snapped her fingers and said his name to	F0600		

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F0600 SS = E	Continued from page 12 get Resident #1's attention away from Resident #2. The CNA went to the living room and assisted Resident #1 into his recliner in his room. The nurse discussed this behavior with Resident #1 and reminded him that it was not appropriate. He responded okay and looked at the nurse. Administrator was notified. Left message at 10:35 for the family to return call. On 9/25/25 at 10:35 p.m. a CNA voiced Resident #1 became agitated at the evening meal yelling at his table mate accusing the tablemate of touching him. CNA's reported the residents were not close enough to touch. They said Resident #1 raised his fist at the tablemate, but no contact was made. They removed Resident #1 from dining room and assisted with HS cares and placed him in his recliner. No further behaviors noted or reported. On 9/26/25 at 1:22 p.m. Resident #1 seen virtually by the Psych NP with new orders to increase Depakote from 250 mg daily to 250 mg in the morning and 500 mg at HS, and notify if changes in mood, behavior, or medication side effects, including sedation or unsteady gait. Observations: On 10/6/25 at 11:10 a.m. Resident #1 sat in a w/c in in room. He talked about working for the railroad and being injured. He said they treated him good at the facility and he liked it, and denied any problems. On 10/6/25 at 2:15 p.m. Resident #1 slept in the recliner. On 10/6/25 at 5:10 p.m. Resident #1 in the dining room eating supper. Sat across from another male resident. On 10/7/25 at 8:10 a.m. Resident #1 awake in recliner, stating ready to get up. On 10/7/25 at 11:45 a.m. Resident #1 eating lunch. Nursing staff supervised the residents. On 10/7/25 at 11:55 a.m. went to resident's' room to set door bell off. Could not hear door bell. Went to nurses station to listen while Staff E Licensed Practical Nurse (LPN) walked over the threshold. Could barely hear it in the nurses station. Staff E had the Maintenance Man look at it, and the volume had been turned down. On 10/8/25 at 10:35 a.m. stood by CNA room while another person walked in and out of Resident #1's room. The nurse's station door was closed and could faintly	F0600		

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F0600 SS = E	Continued from page 13 hear the tone of the door bell. Staff H RN working at the med cart stated they did not leave the door open when no one was in the nurse's station, but they were usually right there. Staff interviews included: On 10/7/25 at 9:05 a.m. Staff A Registered Nurse (RN) stated Staff B CNA reported Resident #1 was touching Resident #2 inappropriately. She had separated the residents. Staff A said Resident #1 had a door bell at the entrance of his room, and they kept the doors to the living room shut so he couldn't see who was in there, and enter there. She said she had walked by his room when coming up from the dining room and saw the resident in his room at 9:20 a.m. and the doors to the living room were closed. She said they were doing different things to try and deter this from happening again. She said they did a med review. They tried having him sit in a recliner in the lounge area close to the nurses station but he did not like it. 10/7/25 1 p.m. Staff A stated she did not hear the doorbell prior to that incident. She may have gone down the 200 hole to pass some pills so she would not have heard it. On 10/7/25 at 9:23 a.m. Staff C CNA stated when the incident occurred she was in the CNA room and Staff B was in there with her, the door was partially open. When Staff B turned to walk out she could see right into the living room. Staff C did not see it. She said she was well aware of the issues with Resident #1 approaching the women and inappropriate touching, and they needed to keep him away from the women. Staff C said the interventions were in place were 15 minute checks, a doorbell, and closing first doors to the living room. She said it depended on where you were whether you could hear the doorbell or not. On 10/7/25 at 9:40 a.m. Staff D CNA stated she filled out the 15 minute checks for Resident #1 the day of the last incident. She said she had seen him at 9:30 a.m. in his room with the TV on. The next thing she knew, Staff D asked for help getting him to his recliner. She did not hear a doorbell and was unsure about the double doors. 10/7/25 10:19 a.m. Staff E Licensed Practical Nurse (LPN) stated she did not recall the second incident. She said she was aware that Resident #3 had made gestures like reaching for a staff member, so they were aware they had to continually remind him that that was inappropriate behavior. She said the police officers had been there on occasions and talked with Resident #1.. She said they did 15 minute checks and the doors	F0600		

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F0600 SS = E	Continued from page 14 to the family room on that hall were to be so Resident #1 couldn't see who was in the family room, and he had a doorbell in the doorway of his room so if somebody went in or out, they tried to run and see where he was, or where he was going so they could keep an eye on him. She said they had tried a recliner in the lobby area where he would be in visual sight of the nurses station but he did not like that. On 10/7/25 at 10:40 a.m. Staff F CNA stated she had been on night shift and recently came to day shift. Staff F said she knew Resident #1 usually went to his recliner after meals and he liked to watch TV. She knew about incidents that had occurred. On 10/7/25 at 12:50 p.m. Staff B CNA stated Resident #1 was probably in his room or in the hallway prior to the incident occurring. She said she was not in the CNA room, she was outside holding the door open when she looked over and saw Resident #1 in the family room. She said he would have had to have slipped in through the first doors that are on his hall for her not to have seen him. Staff B said the doors were not closed. She said unless he opened the doors himself and got in, but she did not feel that he would be able to do that without slipping out of his wheelchair. She did not hear the doorbell. She said they were still doing the 15 minute checks, and they tried to watch him if he was out of his room, but they couldn't watch him 24/7. On 10/8/25 8:05 a.m. Staff G CNA (last day of work 9/24/25) stated she did witness the incident in late May and she walked up the 100 hall to the dining room and she saw Resident #1 with his hand in Resident #3's lap and the other hand under her shirt. She immediately moved the resident's apart. She said as soon as she got them apart she notified nurse on duty about what had happened, and the nurse took over from there. She said the nurse called dispatch for the police and they had to talk to them about the situation. She said after they put Resident #1 on 15 minute checks, and if he was out of his room they tried to keep an eye on him to make sure he wasn't getting close to any female resident. She thought that was working fairly well. On 10/8/25 at 9:15 a.m. the Administrator stated if they had known Resident #1 had these kind of behaviors they would have considered carefully whether they would have taken him. And after the first incident and they got Interventions in place he had the second incident. They put the 15 minute checks in place. She said she wasn't for sure when the doorbell started. When she did the report to state and then the follow up she had written on the timeline that they hadn't had to start	F0600		

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F0600 SS = E	Continued from page 15 it yet. But they had set it up and she found out later that it had been put in place. The doorbell was above his door frame so when they went in or out it sounded in the nurses station. If there was nurse in there the door was usually open. It was unusual for them to have it shut if they were in there, except when they needed to discuss confidential information. She said they had done so much to try and prevent this from happening again, and then it happened the third time. She said they couldn't make him stay in his room all the time, he still had rights also. She struggled with how they could prevent this with their current situation. They had increased some staffing. They have an afternoon activity person who comes in and is in the front area around the living area so if Resident #1 wanted to be out for activities, she's there to supervise, and also for some of the other residents that need some things to do. She had contacted the ombudsman and the healthcare association to see if they had any ideas that might help with their current situation. The facility Abuse Prevention, Identification, Investigation, and Reporting Policy revised 4/18/17 documented Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Sexual abuse was non-consensual sexual contact of any type with a resident. Resident-to-resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility would presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary.	F0600		