DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0170	A. BUILDING: _____ B. WING _____	C 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF FAIRFIELD	3000 WEST MADISON AVENUE FAIRFIELD, IA 52556

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 42 Number of tenants with cognitive disorder: 1 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 4 TOTAL Census of Assisted Living Program for People with Dementia : 48 The following regulatory insufficiencies were cited during the investigation into Complaints #104942-C and #104919-C.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an incident report for all accidents or unusual occurrences involving 1 of 4 current tenants and 1 of 3 discharged tenants reviewed. Findings follow:	A 130		

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A 130	Continued From page 1 Review on 7/26/22 of an Internal Investigation by the program revealed the daughter of Tenant C1 informed the Health Care Coordinator (HCC) she was upset about an incident of which she just learned occurred during the fall. The daughter was told by a former employee Tenant #1 showed his penis to Tenant C1, placed his hand on her mother's hand and then used her mother's hand to stroke his penis. The employee who witnessed the interaction, Staff A, was interviewed as a part of the investigation. Staff A said she reported the incident immediately to her direct supervisor, who no longer worked for the program. Staff A said she physically witnessed Tenant #1's penis out of his pants with Tenant C1's hand on Tenant #1's penis. Tenant C1 did not seem distressed over the incident. The HCC interviewed Staff A's former supervisor who said she did not report the incident because during the investigation, it was found the event was not actually witnessed. The former supervisor said Staff A told her she did not see anything physically. Since the incident, Tenant #1 was not allowed on the memory care unit without a chaperone. Staff A reported Tenant C1 did not sustain any physical issues following the incident. There was no incident report on file so there was no specific time frame of the incident the Health Care Coordinator could refer to. On 7/27/22 at 2:15 PM, the HCC confirmed there was no incident report for Tenant #1 or Tenant C1 about the event on the unknown date discussed in the Internal Investigation, although one should have been written when the incident was initially reported.	A 130		

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A 155	Continued From page 2	A 155		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure tenants were consistently treated with consideration and respect. Findings follow. Record review on 7/26/22 revealed an Internal Investigation by the program noted the daughter of Tenant C1 informed the Health Care Coordinator she was upset about an incident of which she just learned occurred during the fall. The daughter was told by a former employee Tenant #1 showed his penis to Tenant C1, placed his hand on her mother's hand and then used her mother's hand to stroke his penis. The employee who witnessed the interaction, Staff A, was interviewed. Staff A said she reported the incident immediately to her direct supervisor, who no longer worked at the program. Staff A said she physically witnessed Tenant #1's penis out of his pants with Tenant C1's hand on Tenant #1's penis. Tenant C1 did not seem distressed over the incident. The Health Care Coordinator interviewed Staff A's former supervisor who said she did not report the	A 155		

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incident because during the investigation, it was found the event was not actually witnessed. The former supervisor said Staff A told her she did not see anything physically. Since the incident, Tenant #1 was not allowed on the memory care unit without a chaperone. Staff A reported Tenant C1 did not sustain any physical issues following the incident. There was no incident report on file so there was no specific time frame of the incident the Health Care Coordinator could refer to.

When interviewed on 7/25/22 at 1:00 PM, Tenant #2 reported Tenant #1 entered her apartment without permission 8-10 times. She would return to her apartment and find him sitting in her recliner. Tenant #2 complained to the former Community Director about Tenant #1's actions. Tenant #1 moved to the Assisted Living Program on 5/25/21. Tenant #2 said Tenant #1 started entering her apartment without her permission shortly after his admission. Tenant #2 recalled one time she was in her bathroom sitting on the toilet. Tenant #2 had her apartment door closed as well as the door to her bedroom. Tenant #1 entered her apartment and went through both doors and watched her sitting on the stool while she yelled at him to leave.

When interviewed on 7/25/22 at 4:15 PM, Tenant #3 reported Tenant #1 entered her apartment one time. She came in to her apartment and found Tenant #1 sitting there. Tenant #3 told Tenant #1 to leave and he did. Tenant #3 told staff and the former Community Director about Tenant #1's actions. Tenant #3 said Tenant #1 came into her apartment a long time ago.

When interviewed on 7/25/22 at 12:25 PM, Tenant #4 recalled having a friend (Tenant C2)

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who used to live in the building who had a problem with Tenant #1 entering her apartment. He came in about three times. Tenant #4 moved into the building in August, 2021 and Tenant C2 told her she had this issue with Tenant #1 prior to Tenant #4's admission.

When interviewed on 7/25/22 at 11:53 AM, Tenant #5 reported Tenant #1 did not enter her apartment, but women in the program now lock their doors due to concerns about him. She reported Tenant #1 was a rude man who often made rude comments to staff and spit in his food.

When interviewed on 7/25/22 at 1:50 PM, Staff A reported she was not aware of any issues with Tenant #1 acting out sexually on the memory care unit prior to the incident she witnessed between him and Tenant C1, during which Tenant #1 was standing and holding Tenant C1's hand. Tenant #1's penis was out and his pants were unzipped. Staff A was in another tenant's room and when she came out and witnessed this, she asked Tenant #1 what he was doing and he said nothing. Tenant C1 repeated "him" three times. Tenant #1 zipped his pants and Staff A told him he needed to go. Tenant #1 said he had a right to be in the memory care unit (as his wife had an apartment there) and Staff A told him not when you do this. Staff A got coverage for the unit and reported the incident to her former supervisor. Staff A said for the longest time, Tenant #1 was not allowed on the memory care unit and his wife had to go to the front of the building for supervised visits. However, after a while, Tenant #1 started to come back in. They would tell Tenant #1 he had to leave and he would do so. At times she would find Tenant #1 sitting at a table with a female tenant but he was not doing anything inappropriate.

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A 155	Continued From page 5 When interviewed on 7/25/22 at 2:15 PM, Staff D reported Tenant #2 pushed her pendant for assistance. She found Tenant #1 in Tenant #2's room. Tenant #1's back was to the door and Tenant #2 was demanding he leave. Tenant #1 was irritable, but he did leave. Staff D did tell the former supervisor about this interaction. When interviewed on 7/26/22 at 10:00 AM, Staff G recalled a few months ago, Tenant #1 came to the memory care unit and stood next to his wife's recliner. He was "grinding" his body against the recliner his wife was sitting in. Tenant #1 kept adjusting his pants and Staff G asked Tenant #1 what he was doing and he replied nothing. Staff G told him he could not be in the memory care unit if he was doing that and he left. When interviewed on 7/26/22 at 11:40 AM, Staff B stated she was aware the female tenants started locking their doors when they previously did not do so due to Tenant #1 entering their apartments without permission. Staff B first heard about this about six months ago. Tenant #1 made comments to Staff B about her breasts and buttocks. He also made a comments to her about rolling around with him. Staff B told Tenant #1 it was inappropriate to make these comments and he stared at her. When interviewed on 7/25/22 at 2:40 PM Staff E reported she had to ask Tenant #1 to leave female tenants' apartments because when they asked him to leave, he would not do so. Tenant #2 pushed her pendant once and Staff E had to assist Tenant #1 in leaving Tenant #2's apartment. Staff E also recalled another tenant (likely Tenant C2) who pushed her pendant after Tenant #1 entered her apartment. Tenant C2 was	A 155		

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uncomfortable. Staff E witnessed Tenant #1 have an outburst before, so she said she needed to speak with Tenant C2 privately in order to get Tenant #1 to leave the apartment without incident. Staff E said she heard Tenant #1 bully a dining room worker about her size until she cried. Tenant #1 spit on the tableware and now received plastic plates and paper napkins. He would also ask staff, "What do you think you are, as smart as a fifth grader?"

When interviewed on 7/25/22 at 1:30 PM, Staff F stated Tenant C2 told her Tenant #1 came into her apartment, stood in the kitchenette and did unquestionable things. Tenant C2 would not specify what these things were. Tenant C2 started locking her apartment door after this encounter. Staff F thought this happened at least 6-8 months ago. Staff F was aware Tenant #1 had been in Tenant #2's apartment. She reported Tenant #3 said she locked her door due to an unknown man being in her apartment when she came home. Staff F said Tenant #1 spit on the dishes in the dining room and thought someone talked with him about this.

On 7/25/22 at 10:15 AM, the Community Director reported she was appointed to her current position on 2/3/22 although she did work in the building prior to that. The Community Director was aware of an incident in which Tenant #1 was masturbating when the former housekeeper went in to Tenant #1's apartment and did not stop when asked to do so. This incident was reported to the former Maintenance Director. She also reported Tenant C3, who has since discharged. complained of Tenant #1 walking into her apartment reportedly without permission. Tenant #1 reportedly lingered when he was asked to leave her apartment.

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A 155	Continued From page 7 The program installed pin pad devices outside the doors to the memory care unit on 1/13/22, which would have required a person to input a code to enter the memory care unit, however they were not activated. The pin pad devices would have kept individuals who were not given the code from entering the memory care unit as an extra layer of security for the tenants. The former Community Director and former Maintenance Director left the program at the beginning of February 2022. The current Community Director was not aware of the incident between Tenant #1 and Tenant C1, so she did not pursue getting them activated to keep Tenant #1 from entering the memory care unit. When the Community Director was informed of the incident on 5/27/22, she called Midwest Alarm to have them send someone out to see what was needed to get the pin pads functioning. The company did send someone out to determine what was needed and an installation was scheduled for 7/5/22. No one returned to the building on 7/5/22. The Community Director learned on 7/6/22 the reason a worker did not come to the building was because there was an outstanding invoice and they are trying to get this issue resolved. Tenant #1 was issued a 15 day move out notice on 6/28/22. The Community Director reported the local long-term ombudsman informed her Tenant #1 had to be issued a 30 day move out notice, not a 15 day notice, so a 30 day move out notice was provided to Tenant #1 on 7/11/22. According to the Community Director, Tenant #1 was given notice due to his sexual behaviors, specifically related to the issues with Tenant C2, Tenant #2 and Tenant C3. The Community Director said she only recently became aware of all three of these issues.	A 155		

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A 155	Continued From page 8 The Community Director confirmed the previous Director should have addressed the issues with Tenant #1. She reported the female tenants in the building should feel safe where they live.	A 155		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 5 tenants reviewed who displayed behavior that put others at risk. Findings follow: Review on 7/26/22 of an Internal Investigation by the program revealed the daughter of Tenant C1 informed the Health Care Coordinator she was upset about an incident, of which she just learned, which occurred during the fall. The daughter was told by a former employee Tenant #1 showed his penis to Tenant C1, placed his hand on her mother's hand and then used her mother's hand to stroke his penis. The employee who witnessed the interaction, Staff A, was interviewed. Staff A said she	A 160		

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reported the incident immediately to her direct supervisor, who no longer worked at the program. Staff A said she physically witnessed Tenant #1's penis out of his pants with Tenant C1's hand on Tenant #1's penis. Tenant C1 did not seem distressed over the incident.

The Health Care Coordinator interviewed Staff A's former supervisor who said she did not report the incident because during the investigation, it was found the event was not actually witnessed. The former supervisor said Staff A told her she did not see anything physically. Since the incident, Tenant #1 has not been allowed on the memory care unit without a chaperone. Staff A reported Tenant C1 did not sustain any physical issues following the incident. There was no incident report on file so there was no specific time frame of the incident the Health Care Coordinator could refer to.

On 7/25/22 at 1:00 PM, Tenant #2 reported Tenant #1 entered her apartment without permission 8-10 times. She would return to her apartment and find him sitting in her recliner. Tenant #2 complained to the former Community Director about Tenant #1's actions. Tenant #1 moved to the Assisted Living Program on 5/25/21. Tenant #2 said Tenant #1 started entering her apartment without her permission shortly after his admission. Tenant #2 recalled one time she was in her bathroom sitting on the toilet. Tenant #2 had her apartment door closed as well as the door to her bedroom. Tenant #1 entered her apartment and went through both doors and watched her sitting on the stool while she yelled at him to leave.

On 7/25/22 at 4:15 PM, Tenant #3 reported Tenant #1 entered her apartment one time. She

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came in to her apartment and found Tenant #1 sitting there. Tenant #3 told Tenant #1 to leave and he did. Tenant #3 told staff and the former Community Director about Tenant #1's actions. Tenant #3 said Tenant #1 came into her apartment a long time ago.

On 7/25/22 at 12:25 PM, Tenant #4 recalled having a friend (Tenant C2) who used to live in the building who had a problem with Tenant #1 entering her apartment. He came in about three times. Tenant #4 moved into the building in August, 2021 and Tenant C2 told her she had this issue with Tenant #1 prior to Tenant #4's admission.

On 7/25/22 at 1:50 PM, Staff A reported she was not aware of any issues with Tenant #1 acting out sexually on the memory care unit prior to the incident she witnessed between him and Tenant C1. Tenant #1 was standing and holding Tenant C1's hand. Tenant #1 made Tenant C1 touch his penis. Tenant #1's penis was out and his pants were unzipped. Staff A was in another tenant's room and when she came out and witnessed this, she asked Tenant #1 what he was doing and he said nothing. Tenant C1 repeated "him" three times. Tenant #1 zipped his pants and Staff A told him he needed to go. Tenant #1 said he had a right to be in the memory care unit (as his wife had an apartment there) and Staff A told him not when you do this. Staff A got coverage for the unit and told her former supervisor. Staff A said for the longest time, Tenant #1 was not allowed on the memory care unit and his wife had to go to the front of the building for supervised visits. However, after a while, Tenant #1 started to come back in. They would tell Tenant #1 he had to leave and he would do so. At times she would find Tenant #1 sitting at a table with a female

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tenant but he was not doing anything inappropriate.

On 7/25/22 at 2:15 PM, Staff D reported Tenant #2 pushed her pendant for assistance. She found Tenant #1 in Tenant #2's room. Tenant #1's back was to the door and Tenant #2 was demanding he leave. Tenant #1 was irritable, but he did leave. Staff D did tell the former supervisor about this interaction.

On 7/26/22 at 10:00 AM, Staff G recalled a few months ago, Tenant #1 came to the memory care unit and stood next to his wife's recliner. He was "grinding" his body against the recliner his wife was sitting in. Tenant #1 kept adjusting his pants and Staff G asked Tenant #1 what he was doing and he replied nothing. Staff G told him he could not be in the memory care unit if he was doing that and he left.

On 7/26/22 at 11:40 AM, Staff B stated she was aware the female tenants started locking their doors when they previously did not do so due to Tenant #1 entering their apartments without permission. Staff B first heard about this about six months ago. Tenant #1 made comments to Staff B about her breasts and buttocks. He also made a comments to her about rolling around with him. Staff B told Tenant #1 it was inappropriate to make these comments and he stared at her.

On 7/26/22 at 10:30 AM, Staff C said Tenant #1 would initially get upset with her about small things. If she put his silverware on his left, he said put it on the right. If she put it on the right, he told her to put it on the left. Tenant #1 then told Staff C she was too skinny. Once Staff C was in the bathroom and when she opened the

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door, Tenant #1 was standing in the doorway as she attempted to leave. He physically pushed past her when she attempted to exit.

Staff E reported on 7/25/22 at 2:40 PM she has had to ask Tenant #1 to leave female tenant's apartments because when they asked him to leave, he would not do so. Tenant #2 pushed her pendant once and Staff E had to assist Tenant #1 in leaving Tenant #2's apartment. Staff E also recalled another tenant (likely Tenant C2) who pushed her pendant after Tenant #1 entered her apartment. Tenant C2 was uncomfortable. Staff E had seen Tenant #1 have an outburst before, so she said she needed to speak with Tenant C2 privately in order to get Tenant #1 to leave the apartment. Staff E said she heard Tenant #1 bully a dining room worker about her size until she cried.

On 7/25/22 at 1:30 PM, Staff F stated Tenant C2 told her Tenant #1 came into her apartment, stood in the kitchenette and did unquestionable things. Tenant C2 would not specify what these things were. Tenant C2 started locking her apartment door after this encounter. Staff F thought this happened at least 6-8 months ago. Staff F was aware Tenant #1 had been in Tenant #2's apartment. She reported Tenant #3 said she locked her door due to an unknown man being in her apartment when she came home.

On 7/25/22 at 10:15 AM, the Community Director reported she was appointed to her current position on 2/3/22, although she did work in the building prior to that. The Community Director was aware of an incident in which Tenant #1 was masturbating when the former housekeeper went in to Tenant #1's apartment and did not stop when asked to do so. This incident was reported to the

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former Maintenance Director. She also reported Tenant C3, who has since discharged. complained of Tenant #1 walking into her apartment reportedly without permission. Tenant #1 reportedly lingered when he was asked to leave her apartment.

The program installed pin pad devices outside the doors to the memory care unit on 1/13/22, which would have required a person to input a code to enter the memory care unit, however they were not activated. The pin pad devices would have kept individuals who were not given the code from entering the memory care unit as an extra layer of security for the tenants. The former Community Director and former Maintenance Director left the program at the beginning of February, 2022. The current Community Director was not aware of the incident between Tenant #1 and Tenant C1, so she did not pursue getting them activated to keep Tenant #1 from entering the memory care unit. When the Community Director was informed of the incident on 5/27/22, she called Midwest Alarm to have them send a technician out to see what was needed to get the pin pads functioning. The company did send someone out to determine what was needed and parts were to be installed on 7/5/22. No one returned to the building on 7/5/22. The Community Director learned on 7/6/22 the reason a worker did not come to the building was because there was an outstanding invoice and they were trying to get this issue resolved.

Tenant #1 was issued a 15 day move out notice on 6/28/22. The Community Director reported the local long-term ombudsman informed her Tenant #1 had to be issued a 30 day move out notice, not a 15 day notice, so a 30 day move out notice was provided on 7/11/22. According to the

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A 160	Continued From page 14 Community Director, Tenant #1 was given notice due to his sexual behaviors, specifically related to the issue with Tenant C2, Tenant #2 and Tenant C3. The Community Director said she only recently became aware of all three of these issues. The Community Director confirmed, although she was not previously aware of the issues with Tenant C2 and Tenant #2, they had been going on long before Tenant #1 was given notice on 6/28/22 and put other tenants at risk.	A 160		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update 1 of 2 current tenants' service plans reviewed (Tenant #1) as his needs changed. Findings follow: Record review on 7/26/22 revealed an Internal Investigation by the program revealed the daughter of Tenant C1 informed the Health Care Coordinator (HCC) she was upset about an incident, of which she just learned, which occurred during the fall. The daughter was told by a former employee Tenant #1 showed his penis to Tenant C1, placed his hand on her	A 350		

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mother's hand and then used her mother's hand to stroke his penis.

The employee who witnessed the interaction, Staff A, was interviewed. Staff A said she reported the incident immediately to her direct supervisor, who no longer worked at the program. Staff A said she physically witnessed Tenant #1's penis out of his pants with Tenant C1's hand on Tenant #1's penis. Tenant C1 did not seem distressed over the incident.

The Health Care Coordinator interviewed Staff A's former supervisor who said she did not report the incident because during the investigation, it was found the event was not actually witnessed. The former supervisor said Staff A told her she did not see anything physically. Since the incident, Tenant #1 was not allowed on the memory care unit without a chaperone. Staff A reported Tenant C1 did not sustain any physical issues following the incident. There was no incident report on file so there was no specific time frame of the incident the Health Care Coordinator could refer to.

On 7/25/22 at 1:00 PM, Tenant #2 reported Tenant #1 entered her apartment without permission 8-10 times. She would return to her apartment and find him sitting in her recliner. Tenant #2 complained to the Former Community Director about Tenant #1's actions. Tenant #1 moved to the Assisted Living Program on 5/25/21. Tenant #2 said Tenant #1 started entering her apartment without her permission shortly after his admission. Tenant #2 recalled one time she was in her bathroom sitting on the toilet. Tenant #2 had her apartment door closed as well as the door to her bedroom. Tenant #1 entered her apartment and went through both doors and

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watched her sitting on the stool while she yelled at him to leave.

On 7/25/22 at 4:15 PM, Tenant #3 reported Tenant #1 entered her apartment one time. She came in to her apartment and found Tenant #1 sitting there. Tenant #3 told Tenant #1 to leave and he did. Tenant #3 told staff and the former Community Director about Tenant #1's actions. Tenant #3 said Tenant #1 came into her apartment a long time ago.

On 7/25/22 at 1:50 PM, Staff A reported she was not aware of any issues with Tenant #1 acting out sexually on the memory care unit prior to the incident she witnessed between him and Tenant C1. Tenant #1 was standing and holding Tenant C1's hand, he then made Tenant C1 touch his penis. Tenant #1's penis was out and his pants were unzipped. Staff A was in another tenant's room and when she came out and witnessed this, she asked Tenant #1 what he was doing and he said nothing. Tenant C1 repeated "him" three times. Tenant #1 zipped his pants and Staff A told him he needed to go. Tenant #1 said he had a right to be in the memory care unit (as his wife had an apartment there) and Staff A told him not when you do this. Staff A got coverage for the unit and told her former supervisor about the incident. Staff A said for the longest time, Tenant #1 was not allowed on the memory care unit and his wife had to go to the front of the building for supervised visits. However, after a while, Tenant #1 started to come back in. They would tell Tenant #1 he had to leave and he would do so. At times she would find Tenant #1 sitting at a table with a female tenant but he was not doing anything inappropriate.

On 7/25/22 at 2:15 PM, Staff D reported Tenant

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#2 pushed her pendant for assistance. She found Tenant #1 in Tenant #2's room. Tenant #1's back was to the door and Tenant #2 was demanding he leave. Tenant #1 was irritable, but he did leave. Staff D did tell the former supervisor about this interaction.

On 7/26/22 at 10:00 AM, Staff G recalled a few months ago, Tenant #1 came to the memory care unit and stood next to his wife's recliner. He was "grinding" his body against the recliner his wife was sitting in. Tenant #1 kept adjusting his pants and Staff G asked Tenant #1 what he was doing and he replied nothing. Staff G told him he could not be in the memory care unit if he was doing that and he left.

On 7/26/22 at 11:40 AM, Staff B stated she was aware the female tenants started locking their doors when they previously did not due to Tenant #1 entering their apartments without permission. Staff B first heard about this about six months ago. Tenant #1 made comments to Staff B about her breasts and buttocks. He also made a comments to her about rolling around with him. Staff B told Tenant #1 it was inappropriate to make these comments and he stared at her.

On 7/26/22 at 11:00 AM, the Culinary Coordinator reported Tenant #1 made derogatory comments to Staff C about her weight. He also made rude comments if he was served last. Every month she held a meeting with tenants about dining services and the other tenants complained about Tenant #1's loudness and rudeness in the dining room. In the last 1-2 months, Tenant #1 also started spitting on his plate and into his cup, which he did not used to do. Tenant #1 was asked to refrain from this behavior and they started giving him plastic plates, cups and

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A 350	Continued From page 18 silverware. On 7/26/22 at 10:30 AM, Staff C said Tenant #1 would initially get upset with her about small things. If she put his silverware on his left, he said put it on the right. If she put it on the right, he told her to put it on the left. Tenant #1 then told Staff C she was too skinny. Once Staff C was in the bathroom and when she opened the door, Tenant #1 was standing in the doorway as she attempted to leave. He physically pushed past her when she attempted to exit. Tenant #1 grabbed drinks out of the culinary staff members hands. Staff C recalled Tenant #1 looked at another dining room staff member and then spit in his vegetables and mixed it in. Another time he said I've got my loogie (a lump of phlegm or spittle) problem figured out and spit on the dishes. Now the staff give Tenant #1 plastic dishes. Staff E reported on 7/25/22 at 2:40 PM she has had to ask Tenant #1 to leave female tenant's apartments because when they asked him to leave, he would not do so. Tenant #2 pushed her pendant once and Staff E had to assist Tenant #1 in leaving Tenant #2's apartment. Staff E also recalled another tenant (likely Tenant C2) who pushed her pendant after Tenant #1 entered her apartment. Tenant C2 was uncomfortable. Staff E had seen Tenant #1 have an outburst before, so she said she needed to speak with Tenant C2 privately in order to get Tenant #1 to leave the apartment without incident. Staff E said she heard Tenant #1 bully a dining room worker about her size until she cried. Tenant #1 spit on the tableware and now received plastic plates and paper napkins. He would also ask staff, "What do you think you are, as smart as a fifth grader?".	A 350		

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A 350	Continued From page 19 On 7/25/22 at 1:30 PM, Staff F stated Tenant C2 told her Tenant #1 came into her apartment, stood in the kitchenette and did unquestionable things. Tenant C2 would not specify what these things were. Tenant C2 started locking her apartment door after this encounter. Staff F thought this happened at least 6-8 months ago. Staff F was aware Tenant #1 had been in Tenant #2's apartment. She reported Tenant #3 said she locked her door due to an unknown man being in her apartment when she came home. Staff F said Tenant #1 spit on the dishes in the dining room and thought someone talked with him about this. On 7/25/22 at 10:15 AM, the Community Director reported she was appointed to her current position on 2/3/22, although she did work in the building prior to that. The Community Director was aware of an incident in which Tenant #1 was masturbating when the former housekeeper went in to Tenant #1's apartment and did not stop when asked to do so. This incident was reported to the former Maintenance Director. She also reported Tenant C3, who has since discharged. complained of Tenant #1 walking into her apartment reportedly without permission. Tenant #1 reportedly lingered when he was asked to leave her apartment. Tenant #1 was issued a 15 day move out notice on 6/28/22. The Community Director reported the local long-term ombudsman informed her Tenant #1 had to be issued a 30 day move out notice, not a 15 day notice, so a 30 day move out notice was provided on 7/11/22. According to the Community Director, Tenant #1 was given notice due to his sexual behaviors, specifically related to the issue with Tenant C2, Tenant #2 and Tenant	A 350		

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C3. The Community Director said she only recently became aware of all three of these issues.

A review of Tenant #1's Charting Notes and Progress Notes from 5/1/21 - 6/14/22 revealed no documentation about his behavior. On 6/20/22, there was a note from the Health Care Coordinator indicating Tenant #1 has had increased behaviors over the last weekend. Tenant #1 attempted to go in memory care multiple times. He was also noted to make inappropriate remarks to staff members. This nurse talked with the tenant and discussed appropriate and inappropriate behaviors. He was not receptive to the conversation and became angry and agitated but was redirected. Also on 6/20/22, it was reported to the Health Care Coordinator Tenant #1 came to a tenant's room unannounced. He did leave when asked but the tenant was very bothered by this. Other female residents have reported they keep their door locked for this reason. Tenant #1 was educated this was not appropriate and he should knock and wait for permission before entering another person's apartment. He voiced understanding.

A 90-day review was completed on 6/22/22. Tenant #1 was alert and oriented times three. He continued to have inappropriate behavior with staff. He was often redirected due to inappropriate comments and behaviors. Tenant #1 was not receptive when told he had to follow rules and had to be continually redirected.

On 6/30/22, Tenant #1 was in the memory care unit and escorted out by a caregiver. He was also noted to make inappropriate comments regarding staff at the dining room table.

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A 350	Continued From page 21 A change of condition assessment was completed on 7/1/22 due to being given a 5-day notice with continued inappropriate behaviors. He continued to go into the memory care unit as well as others' rooms without permission. He was redirected daily not to enter the memory care unit but was noncompliant with the request. Tenant #1 had a Nurse Review written on 9/20/21 which noted he was alert and oriented times three. No further recommendations or changes were needed at that time. A review of Tenant #1's Service Plan's revealed he had a service plan dated 12/30/21 which noted he exhibited socially appropriate interactions with other tenants and staff. Tenant #1's 3/26/22 service plan noted he was oriented and able to recall or retain information. A change was made to Tenant #1's service plan on 7/1/22. It noted Tenant #1 demonstrated deficits in judgement related to safety. He had a history of poor decision making. His son would assist with his decision making as needed. Staff would redirect Tenant #1 when he was making inappropriate comments. Staff would also redirect Tenant #1 when he attempted to enter the memory care unit. Tenant #1 would be redirected by staff as needed due to inappropriate behaviors. There was no specific mention of Tenant #1 entering female tenants' apartments. There was no mention of specific interventions staff should use when Tenant #1 made inappropriate comments. Tenant #1's service plan noted he was independent with meals, eating and drinking. There was no mention of his spitting in the dining room or need for alternate table service.	A 350		

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A 350	Continued From page 22 The Health Care Coordinator confirmed Tenant #1's needs were not addressed on his service plan on 7/27/22 at 2:15 PM.	A 350		