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FORM APPROVED

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
	S0011	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

(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) COMPLETE DATE
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. Tenants without cognitive impairment: 18 Tenants with cognitive impairment: 12 Total census: 30 The following regulatory insufficiencies were cited during the investigation of Complaint #132230-C and the recertification visit conducted to determine compliance with licensing rules for an Assisted Living Program for People with Dementia.	A 000	See attached POC 11/13/26	
A 121	481-67.3(1) Tenant Rights 481-67.3(231B,231C,231D) 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 1 of 4 tenants reviewed was treated with respect and dignity (Tenant #2) and also affecting an unknown number of tenants. Findings follow: 1. Record review on 8/5/26 revealed an Adult Abuse Investigation Summary dated 6/3/26 following a report Staff A saw Tenant #2 being unnecessarily restrained in his lift chair. The chair was unplugged, fully reclined and he had no	A 121	The violation will be corrected as follows: • HWD verified tenant two's lift chair is plugged in, his pendant is in reach, and updated his service plan with individualized fall interventions on 8/6/26. Staff B is no longer employed by Bickford Senior Living. • ED completed immediate dignity and abuse reporting re-education for Staff B, Staff E, and all other cited staff on 8/6/26.	11/13/2026

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A 121	Continued From page 1 way to get out of the chair. Staff A said Staff B told her she unplugged the chair so she could focus on completing her rounds without having to worry about Tenant #2 getting up and falling from his chair. The former Executive Director interviewed a number of staff from 5/28/26 - 6/2/26 to gather relevant information about the situation. Written interviews with staff revealed: - Staff A entered the secured dementia unit around 5:35 AM on 5/28/26 to gather trash. Staff B completed her rounds. Tenant #2 was in his recliner and asked Staff A if she would help him get up. She grabbed the chair remote and discovered it was turned off. While she turned it on, Staff B entered the room and asked what she was doing. Staff B told Staff A Tenant #2 just returned from the bathroom and wanted to move around but she needed to focus on completing her rounds without worrying about Tenant #2 getting up and falling while she was busy so she turned the remote off. This was the first time she witnessed Tenant #2's lift chair unplugged and in a reclined position while he was in it. Staff B told her once or twice she would occasionally turn the recliner off. Staff A believed Staff B was joking about doing this until she saw the chair turned off the morning of 5/28/26. - Staff B reportedly told Staff C she would unplug Tenant #2's lift chair in the mornings in order to get her work completed. - Staff D entered the dementia-specific unit a few months prior to her interview on 5/29/26 and discovered Tenant #2's lift chair unplugged. Either Staff B or Staff E were working, she was not sure who. Staff D believed the chair was unplugged to prevent Tenant #2 from getting up	A 121	The following measures will be taken to ensure the problem does not recur: • DDHW and DDO re-educated the ED and HWD on abuse prevention, tenant rights, dementia-related privacy, and mandatory reporting timelines on August 12, 2026. • HWD and ED to re-educate all branch staff on tenant rights, abuse identification, the prohibition of physical or environmental restrictions, and the internal reporting chain by 10/27/26. • HWD to review all current resident service plans to ensure appropriate fall interventions and dignity-promoting measures are documented by 10/27/26. • ED and HWD are responsible for ensuring all tenants are treated with respect, dignity, and autonomy, including the prohibition of unauthorized physical or environmental restrictions by 10/27/26. The program will monitor performance to ensure compliance as follows: • HWD will observe 5 resident care interactions per week for 12 weeks to verify dignity-promoting practices and that call pendants are within reach. • DDHW will audit 5 resident service plans and observation logs monthly for 6 months and annually thereafter to verify compliance. DDO/DDHW to make branch rounds during routine branch visits to ensure compliance.	

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A 121	Continued From page 2 while staff was checking on other tenants. Staff D noticed Tenant #2 seldom had his emergency call light/pendant with him when Staff E was working. - Staff F saw Tenant #2's lift chair unplugged on two occasions when he was in it and unable to get out. Staff E was working when this happened. She believed this occurred when he was antsy and Staff E was getting worked up. Staff F recalled the 3rd shift workers telling the 1st shift workers they would unplug Tenant #2's chair so he wouldn't get up while they were working. Staff D and Staff E worked 3rd shift. The other employees worked 1st shift. He did have access to his pendant. - Staff G recalled seeing Staff H resting in one recliner in the common area with it reclined all the way back. Tenant #2 was also in his lift chair in the common area with it fully reclined and unplugged. He was sleeping. - Staff B explained after taking Tenant #2 to the bathroom she needed to care for other tenants and complete her rounds. She told him to use his pendant if he needed to get up and she would help him, but she was going to unplug the chair so he couldn't get up and fall. Staff B believed the chair was unplugged for about 4 minutes. Tenant #2's service plan dated 3/11/26 noted he was a level 3 fall risk. His pendant was to be in reach at all times with his lanyard around his neck. He continued to get up without assistance several times per hour. Staff were to keep Tenant #2 engaged and provide one on one conversation and activities. During an interview on 8/5/26 at 1:50 PM Staff D	A 121		

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A 121	Continued From page 3 reported Tenant #2 usually wore his pendant on the outside of his shirt. When Staff E gave report at the end of 3rd shift, she told Staff D she put his call light in his room because he pushed it so much. Staff E would make negative comments about how frequently Tenant #2 got up and down throughout the night. Staff D, who worked 1st shift, noticed Tenant #2's pendant wouldn't be answered for 30-40 minutes when Staff E worked. It seemed to her as if Staff E chose to ignore his pendant. Tenants were supposed to have their pendants with them at all times. Staff D felt like Tenant #2's chair was his personal property to use as he wanted and employees didn't have the right to unplug it. The tenants paid a lot of money to live there and it was their job to meet tenants' needs. Staff F was interviewed on 8/5/26 at 2:15 PM and explained she didn't work the same shift as Staff E but interacted with her at shift change. Staff E would comment about how she was frustrated with him being up all night. When Staff F came to work she would find Tenant #2 without his pendant when Staff E worked more frequently than with any other staff. Staff F did not report these observations to management. When interviewed on 8/5/26 at 3:03 PM Staff I recalled Staff E told her she took Tenant #2's pendant away. The manner in which Staff E said this gave Staff I the impression his pendant was removed regularly. Staff E reported this to the former ED but as far as she knew, nothing was done with the information. Tenants were supposed to have their pendants with them at all times. He knew how to use his pendant to call for assistance. If he fell, he needed to have his pendant so he could call for help.	A 121		

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A 121	Continued From page 4 Staff G was interviewed on 8/5/26 at 3:25 PM and explained she went to the dementia-specific unit to cover Staff H's break at which time she found Tenant #2's chair unplugged. Staff G sat in the common area prepared to provide assistance to him or any other tenants who required it after witnessing the chair unplugged and Staff H resting. She did not report this to anyone at the time but knows she should have done so. During an interview with the Divisional Director of Operations (DDO) on 8/5/26 at 4:40 PM she reported the employees should have reported the situations involving Tenant #2's chair being unplugged and his pendant being removed when they occurred. The DDO provided in-person dependant adult abuse training to staff when she became aware his movements were being restricted. 2) Record review of Notes and Incidents for Tenant #1 revealed the following: - On 5/19/26 Tenant #1 was found in Tenant #5's apartment. She stole food from her room and would not give it back. - On 5/28/26 Tenant #6 reported Tenant #1 was going into others' apartments. Staff found her sitting by an exit door. She was sitting on a bucket, using it as a toilet. Later in the day staff heard someone yelling, "get out". Staff saw Tenant #1 inside of Tenant #7's apartment, shoving Tenant #7 out of the apartment. Tenant #1 was grabbing Tenant #7's hand and trying to hit it each time she touched the door knob. Tenant #7 was very upset and angry about being kicked out of her own room. - Tenant #1 was found in Tenant #5's room on 6/6/26 after dinner and refused to leave. Staff	A 121		

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A 121	Continued From page 5 were able to get her out of the apartment but then got a call from Tenant #8 alerting them Tenant #1 was in the apartment and needed to leave. When staff arrived, Tenant #1 stormed out. - Tenant #1 was spending time in the dementia-specific unit on 6/23/26. She got in the faces of two tenants and asked them a number of intimidating questions. This upset the tenants and one remained agitated after Tenant #1 left the unit. Tenant #1 returned to the dementia-specific unit in the evening. She touched other tenant's silverware and cups at supper. She entered other tenant's apartments during the evening leaving them anxious. - On 6/28/26, Tenant #9 entered her apartment and found Tenant #1 in her bathroom. Staff D tried to enter the bathroom and was told to get out. Staff D got another employee to assist her. They helped Tenant #1 get changed, cleaned Tenant #1's bathroom and Tenant #1 left the apartment. - Tenant #1 purposefully set off the fire alarm at 2:10 AM on 7/2/26. - On 7/8/26, Tenant #1 grabbed Tenant #6's wrist and tried to push her away after the other tenant asked what she was doing. Later in the day an employee was walking with a tenant to her apartment. Tenant #1 tried to enter the apartment with them. The staff told her she could not come in and Tenant #1 punched the employee in the face twice before walking away. - Tenant #10's daughter reported to staff Tenant #1 was in her mother's apartment on 7/19/26. - On 7/30/26, Tenant #1 had a bowel movement	A 121		

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A 121	Continued From page 6	A 121		

in the salon. It appeared she tried to clean it up herself. She would not let staff change her clothing.

- On 7/31/26, staff heard a noise in the salon. Staff found Tenant #1 in the salon with her pants pulled down and asked if she had to go to the bathroom. Tenant #1 agreed to use the bathroom.

- Staff noticed Tenant #1's lap was brown at the lunch table on 8/3/26 at 12:30 PM initially thinking it was coffee. They realized later it was liquid diarrhea and her incontinence brief was filled. Tenant #1 pulled the fire alarm at 4:45 PM.

- An entry dated 8/4/26 noted Tenant #1 pulled the fire alarm the previous night.

Tenant #5 was interviewed on 8/6/26 at 1:20 PM. She explained she knew someone had been in her apartment a few times before 6/6/26 as there was torn up toilet paper in her bathroom and her quilt was thrown on the ground. However one night Tenant #1 entered her apartment when she was in bed. She was horrified. The staff came in and were able to get her out. Tenant #5 got a key to her door and now keeps her apartment locked. She has tried to avoid the woman since that time.

When interviewed on 8/6/26 at 2:55 PM Tenant #11 explained Tenant #1 had entered his apartment uninvited a couple of times and would not leave. He pushed his pendant and staff were able to get her out. Tenant #1 would prefer this did not happen.

During an interview with Tenant #9 on 8/5/26 at 9:55 AM she reported she felt safe at the Program with the exception of a time when

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A 121	Continued From page 7 Tenant #1 came into her apartment. She used the bathroom and made a terrible mess. Staff did clean it up right away. During an exit meeting with the DDO, Health and Wellness Director and Divisional Director of Health and Wellness they reported they believed they were taking steps to meet the needs of Tenant #1 while keeping the other tenants safe as well.	A 121		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 1 tenants reviewed had his tubigrips applied according to physician's orders (Tenant #1). Findings follow: Record review on 8/6/26 revealed signed Physician's orders for Tenant #4 which noted they were current as of 7/21/26. Staff were to apply his tubigrips every morning and remove them every night. If the pharmacy was going to provide	A 152	The violation will be corrected as follows: • HWD obtained the correct size measurements for tenant four, secured the tubigrips supply, and updated the MAR to reflect accurate administration on 8/6/26. The following measures will be taken to ensure the problem does not recur: • DDHW re-educated HWD on medication and treatment administration according to physician orders on September 10, 2026; HWD to re-educate all nurses and Med Techs on administering treatments as prescribed and documenting on the MAR by 10/27/26. • HWD to review all current resident MARs and treatment orders to ensure all prescribed treatments have necessary supplies and are documented accurately by 10/27/26. • HWD is responsible for ensuring medications and treatments are administered as prescribed and documented accurately on the MAR by 10/2726. HWD to complete medication audit weekly to ensure compliance. The program will monitor performance to ensure compliance as follows: • DDHW will audit 5 resident MARs and treatment records monthly for six months and annually thereafter to verify compliance.	11/10/2026

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A 152	Continued From page 8 the tubigrips, they would need his size in order to supply them. Tenant #4's face sheet noted his move-in date was 7/18/26. The July and August Medication Administration Record (MAR) identified staff applied his Tubigrips on 7/19/26, 7/20/26, staff removed them on 7/30 and 7/31 (although staff did not document putting them on in the morning), 8/1/26, 8/2/26 and removed them on 8/3/26 (but staff documented there was no supply in the morning). During an interview with Staff K on 8/6/26 at 1:00 PM she explained she did not think Tenant #4 had tubigrips while at the Program as he needed to be measured for them. A tenant could be measured by staff or the nurse for tubigrips and this information would then be provided to the pharmacy. Staff F was interviewed on 8/6/26 at 1:55 PM and reported she did not think Tenant #4 had tubigrips throughout his stay at the Program. During an exit meeting on 8/6/26 at 3:15 PM with the Health and Wellness Director (HWD), Divisional Director of Health and Wellness and Divisional Director of Operations, the HWD stated the Program had some tubigrips Tenant #4 was able to wear at different times during his stay at the Program. He experienced some bouts of diarrhea and they were soiled. There were times she noticed Tenant #4 did not have his tubigrips on and would direct staff to apply them. The staff may not have reflected this in the MAR. She ordered new tubigrips for Tenant #4 on 8/6/26.	A 152		

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A 309	Continued From page 9	A 309		
A 309	481-67.18(3)b Record Checks 481-67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.18(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall complete the background check requirements set forth below. b. Conducting a background check. The program will either request that the department of public safety perform a criminal history check and that HHS perform child and dependent adult abuse record checks of the person in this state or access the single contact repository (SING) to perform the required background check. If SING is used, the program will submit the person's maiden name, if applicable, with the background check request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete the background check process for 1 of 7 employees reviewed (Staff M). Findings follow: The Divisional Director of Operations provided a list of currently employed staff with hire dates via email on 8/5/26 at 12:03 PM. Staff M was hired to work on 3/3/26. Record review on 8/5/26 of the Iowa SING result summary for Staff M revealed the Program submitted searches for her name on the dependent adult abuse registry, Iowa sex offender registry and for her Iowa criminal history. No records were found. The	A 309	The violation will be corrected as follows: • ED completed the child abuse registry check for Staff M on 08/12/26, with results placed in the personnel file. The following measures will be taken to ensure the problem does not recur: • DDO re-educated the ED on pre-employment background check requirements, including child and dependent adult abuse registry checks, on 09/15/26. • ED to re-educate all branch hiring managers on completing all required background checks, including child abuse registry checks, prior to any employee's start date by 10/27/26. • ED to audit all personnel files of employees hired within the last 90 days to ensure child abuse registry checks are present by 10/27/26. • ED is responsible for ensuring all pre-employment background checks, including criminal, sex offender, dependent adult abuse, and child abuse registry checks, are completed and documented in the personnel file prior to the employee's start date by 10/27/26. The program will monitor performance to ensure compliance as follows: • DDO will audit 5 personnel files monthly, including all new hires, for six months and annually thereafter to verify compliance.	10/27/2026

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A 309	Continued From page 10 Program did not check the child abuse registry to ensure she did not have a history of child abuse. During an exit meeting on 8/6/26 and in an email on 8/10/26 the Divisional Director of Operations reported the Program could produce evidence the child abuse registry was checked prior to hiring Staff M but failed to do so by the end of the day on 8/11/26.	A 309		
A 310	481-67.18(3)c Record Checks 481-67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.18(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall complete the background check requirements set forth below. c. If a person considered for employment has been convicted of a crime under the law of any state. The program will request that HHS perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete the background check process when 1 of 7 employees reviewed had a criminal history (Staff L). Findings follow: The Divisional Director of Operations provided a list of currently employed staff with hire dates via email on 8/5/26 at 12:03 PM. Staff L was hired to	A 310	The violation will be corrected as follows: • ED submitted the record check evaluation form to the state department for staff twelve to obtain a formal employment determination on 8/12/26. The following measures will be taken to ensure the problem does not recur: • DDO re-educated ED on the requirement to obtain a state department evaluation and divisional approval prior to employment when criminal history is identified on a background check on September 10, 2026. • ED is responsible for ensuring all background checks are completed and any required state evaluations are obtained prior to an employee's start date by 09/15/26. • ED to audit all current personnel files to ensure completed background checks and required state evaluations are present by 09/15/26. The program will monitor performance to ensure compliance as follows: • DDO will audit 3 personnel files monthly, including all new hires, for six months and annually thereafter to verify compliance.	09/15/2026

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A 310	Continued From page 11 work on 6/22/26. The Program submitted a background check request to Iowa Sing on 6/8/26. The Program was notified on 6/8/26 Staff L had a criminal history. The Program failed to ask Health and Human Services for an evaluation of her criminal history. During an exit meeting on 8/6/26 and in an email on 8/10/26 the Divisional Director of Operations reported the Program could produce evidence Health and Human Services completed an evaluation of Staff L's criminal history but failed to do so by the end of the day on 8/11/26.	A 310		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the service plans for 2 of 4 current tenants reviewed addressed their individual needs (Tenant #1 and Tenant #2). Findings follow: Record review on 8/5/26 revealed a service plan for Tenant #1 dated 5/4/26. It noted she was incontinent of urine and bowel most of the time. She needed toileting reminds to change her briefs. She was on a toileting schedule. Tenant #1 would occasionally have a bowel movement and refuse to get up. She was known to have	A 285	The violation will be corrected as follows: • HWD updated the service plans for resident one and resident two to address their specific behavioral needs, including physical aggression, inappropriate defecation, fire alarm pulling, and inappropriate sexual behaviors, on August 10, 2026. Medication reviews were completed by the PCP. The following measures will be taken to ensure the problem does not recur: • DDHW re-educated HWD on service plan content requirements, including documenting all identified behavioral needs and interventions, on September 10, 2026. • HWD to re-educate all branch staff on identifying, documenting, and reporting changes in resident behaviors and needs by 10/27/26. • HWD to review all current resident service plans to ensure all identified behavioral needs are addressed with appropriate interventions by 10/27/26. • HWD is responsible for ensuring resident service plans are individualized and accurately reflect all identified needs and preferences by 10/27/26.	10/27/2026

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
	S0011	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

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A 285	Continued From page 12 occasional behaviors and needed to be redirected. She could be verbally disruptive and might wander into other tenant's apartments. A review of three months of Notes and Incidents included but was not limited to: - On 5/28/26 Tenant #6 reported Tenant #1 was going into others' apartments. Staff found her sitting by an exit door. She was sitting on a bucket, using it as a toilet. Later in the day staff heard someone yelling, "get out". Staff saw Tenant #1 inside of Tenant #7's apartment, shoving Tenant #7 out of the apartment. Tenant #1 was grabbing Tenant #7's hand and trying to hit it each time she touched the door knob. Tenant #7 was very upset and angry about being kicked out of her own room. - Tenant #1 purposefully set off the fire alarm at 2:10 AM on 7/2/26. - On 7/8/26, Tenant #1 grabbed Tenant #6's wrist and tried to push her away after the other tenant asked what she was doing. Later in the day an employee was walking with a tenant to her apartment. Tenant #1 tried to enter the apartment with them. The staff told her she could not come in and Tenant #1 punched the employee in the face twice before walking away. - On 7/30/26, Tenant #1 had a bowel movement in the salon. It appeared she tried to clean it up herself. She would not let staff change her clothing. - On 7/31/26, staff heard a noise in the salon. Staff found Tenant #1 in the salon with her pants pulled down and asked if she had to go to the bathroom. Tenant #1 agreed to use the bathroom.	A 285	The program will monitor performance to ensure compliance as follows: • DDHW will audit 3 resident service plans monthly for six months and annually thereafter to verify compliance.	

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
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A 285	Continued From page 13 - Staff noticed Tenant #1's lap was brown at the lunch table on 8/3/26 at 12:30 PM initially thinking it was coffee. They realized later it was liquid diarrhea and her incontinence brief was filled. Tenant #1 pulled the fire alarm at 4:45 PM. - An entry dated 8/4/26 noted Tenant #1 pulled the fire alarm the previous night. She got in staff's face and told staff they better shut up because she wasn't listening to them. - On 8/5/26 Tenant #1 got in an employee's face. Tenant #1's service plan did not address her physical aggression, defecating in inappropriate places or pulling the fire alarm. 2) Tenant #2 had a service plan dated 7/22/26 which noted he was cooperative, quiet and responded appropriately during interactions with staff and other tenants. A review of three months of Notes and Incidents revealed the following: - When staff asked Tenant #2 how he was doing on 5/8/26 around 5:27 AM he said, "Just fine. You want to suck on it?" - Staff noted on 6/3/26 at 8:44 PM Tenant #2 asked her for a date. He reached out and tried to touch her. She identified this behavior had been going on for a week. - On 6/5/26 at 4:18 AM when staff was getting Tenant #2 settled in his chair he touched her breast. She objected and he grabbed her breast again and squeezed. She told him not to do it. Tenant #2 then asked her to sit on his lap since	A 285		

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
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A 285	Continued From page 14 no one else was present. That night at 11:28 PM he asked another employee if they could go somewhere private. The Health and Wellness Director (HWD) commented to the note, Tenant #2 "has had a decline in cognition and has had more negative behaviors lately". - Tenant #2 tried to grab an employee's breast on 8/4/26 at 3:08 AM. During an interview with Staff J on 8/6/26 at 11:05 AM she reported Tenant #2 grabbed her breast once. She worked first shift and it was her understanding he generally made these comments/actions on 3rd shift. When interviewed on 8/6/26 at 2:03 PM Staff K recalled two incidents of Tenant #2 touching her inappropriately. Once he grabbed her by the waist. Another time he squeezed her breasts. Neither Staff J or Staff K's experiences were documented in the Notes or Observations. When asked about sexual touching and comments being addressed on Tenant #2's service plan, the HWD replied in an email on 8/6/26 at 11:13 AM it was an isolated incident. An exit meeting was conducted on 8/6/26 at 3:15 PM with the HWD, the Divisional Director of Health and Wellness and the Divisional Director of Operations during which they confirmed the tenants' service plans failed to address their specified needs.	A 285		