STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035062	A. BUILDING _____ B. WING _____	**01/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT HAVEN CARE CENTER	**2645 EAST THOMAS ROAD PHOENIX, AZ 85016**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on record review, staff interview and review of policies and procedures, and review of the State Agency data base, the facility failed to ensure that alleged violations involving abuse or mistreatment for [REDACTED].#1, 2, 3, 4) were reported to APS (Adult Protective Services) and failed to ensure that the results of investigation of alleged violations involving abuse or mistreatment for [REDACTED].#1, 3, 4, 5) were reported to the State Agency. The deficient practice could result in additional allegations of abuse or mistreatment not being reported to APS, and additional results of investigations of abuse or mistreatment not being reported to the State Agency. Findings include: -Resident #1 was admitted on (MONTH) 13, (YEAR) and readmitted on (MONTH) 5, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 21, 2019 included a BIMS (Brief Interview for Mental Status) score of 15, which indicted the resident was cognitively intact. The assessment included that resident #1 had verbal behavioral symptoms directed at others, refused care and wandered. A Health Status Note dated (MONTH) 16, 2019 at 1:00 a.m. included that during a smoke break, a peer (resident #5) had grabbed the cigarette supply and that resident #1 had observed resident #5 grab the cigarettes. The note included that resident #1 tried to take the cigarettes from resident #5, and resident #5 then grabbed the sweater of resident #1, who slid to the floor. The note included that there were no injuries. A Behavior Note dated (MONTH) 21, 2019 at 3:30 p.m. included that the resident had hit another resident on the right cheek and pulled the other resident's hair while they were fighting over (pet) birds, in the other resident's room. The note included that the other resident had grabbed the arm of resident #1, and the resident's were separated. The note included that there were no injuries. Review of the plan of care for resident #1 revealed that it was updated on (MONTH) 21, 2019 to include that resident #1 had a confrontation with another resident over birds, and had hit the other resident on the cheek and pulled her hair. -Resident #5 was admitted on (MONTH) 31, 2019 with [DIAGNOSES REDACTED]. An admission MDS assessment dated (MONTH) 9, 2019 included that resident #5 had a BIMS score of 7 which indicated that resident #5 had severe cognitive impairment. The assessment included that resident #5 had verbal and physical behavioral symptoms directed towards others, no functional limitations in range of motion and used a wheelchair. An Incident Note dated (MONTH) 15, 2019 at 11:34 p.m. included that during a smoke break, resident #5 had grabbed all of the cigarettes, which caused an argument with a peer. The note included that resident #5 grabbed the peer by her sweater, which caused the peer to slide to the floor, and there were no injuries. An investigative report dated (MONTH) 20, 2019 included that on (MONTH) 15, 2019 at 7:10 p.m. as residents were headed to a smoke break, and when resident #1 noticed that resident #5 had the box of (resident) cigarettes, resident #1 became angry and confronted resident #5, and resident #5 grabbed the sweater of resident #1. The report included that when resident #5 grabbed the sweater of resident #1, this caused resident #1 to fall to the ground. The report included that the AZDHS (Arizona Department of Health Services), Phoenix Police, local Ombudsman and responsible parties were notified of the incident. Review of the facility investigation did not reveal a fax receipt, and review of the State Agency data base did not reveal any documented evidence that the facility sent a summary report of the incident on (MONTH) 15, 2019 to AZDHS. -Resident #2 was admitted on (MONTH) 29, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included that resident #2 had moderately impaired cognition and problems with short and long term memory, and behavioral symptoms not directed at others. The assessment included that the resident was short tempered, easily annoyed, and had trouble concentrating. A Behavior Note dated (MONTH) 21, 2019 at 4:01 p.m. included that resident #2 had grabbed another resident by the arm when the other resident tried to take her pet birds away from her. The note included that resident #2 said that the other resident hit her on the cheek and pulled her hair, and that the other resident was trying to take her pet birds away from her when she grabbed the other resident by the arm. The note included that there were no injuries. An investigative report dated (MONTH) 24, 2019 included that on (MONTH) 21, 2019 at 3:00 p.m. resident #1 entered resident #2's room and was observing pet birds that resident #2 keeps on her dresser, and resident #1 attempted to remove the birds in their cage from the room. The report included that resident #2 grabbed resident #1's arm, and resident #1 retaliated by pulling resident #2's hair and slapping her across the face. Staff separated the resident's and there were no injuries. The report included that the AZDHS (Arizona Department of Health Services), Phoenix Police, local Ombudsman and responsible parties were notified. However, there was no documentation that APS had been notified of the incident on (MONTH) 21, 2019. Review of the facility investigation revealed a form titled Desert Haven Care Center State Report File Folder. The form included multiple entries where staff recorded that the incident was reported on (MONTH) 21, 2019 to AZDHS, the Phoenix PD (Police Department), the resident's responsible party, and the State Ombudsman. However, the form did not include a space to record that APS had been notified of the incident. -Resident #4 was admitted on (MONTH) 8, 2019 with [DIAGNOSES REDACTED]. An Admission MDS assessment dated (MONTH) 20, 2019 included that resident #4 had a BIMS score of 3, which indicated that the resident had severely impaired cognition, difficulty focusing attention and physical behaviors directed at others. An Incident Note dated (MONTH) 7, 2019 at 10:36 a.m. included that resident #4 and resident #5 had engaged in a verbal altercation in the dining room, when resident #4 reached over and struck resident #5 on the right arm. The note included that he resident's were separated by staff, and there were no injuries. -Resident #3 was admitted on (MONTH) 6, 2014 with [DIAGNOSES REDACTED]. A Quarterly MDS assessment dated (MONTH) 9, 2019 included that the resident had speech that was unclear or slurred, and that he usually understands others. The assessment included that the resident had a BIMS score of 9, which indicated that the resident had moderately impaired cognition, and verbal behavioral symptoms directed at others. An Incident Note dated (MONTH) 17, 2019 at 10:31 a.m. included that resident #4 and resident #5 had engaged in a verbal altercation in the dining room, when resident #4 reached over and struck resident #5 on the right arm. The note included that he resident's were separated by staff, and there were no injuries. An investigative report dated (MONTH) 20, 2019 included that on (MONTH) 17, 2019 residents #4 and #3 were in the unit dining room, and began to have a verbal altercation, and that resident #4 reached over and hit resident #3 on the right arm. The report included that the residents were immediately separated and there were no injuries.

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

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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Review of the facility investigation revealed a State Report File Folder form, which included that the incident was reported on (MONTH) 17, 2019 to AZDHS, the Phoenix PD (Police Department), the resident's responsible party, and the State Ombudsman. However, there was no documentation on the form that APS had been notified of the incident. Also, review of the facility investigation did not reveal a fax receipt, and review of the State Agency data base did not reveal any documented evidence that the facility sent a summary report of the incident to AZDHS. The following interviews were interviews conducted on (MONTH) 6, 2020 with the Director of Nursing/staff #120: -At 1:45 p.m. the Director stated that he tries to save fax receipts when he sends the 5 day summary report of the investigation to AZDHS. However, the fax machine had broken down and he was unable to print fax receipts. The Director also stated that the facility does report allegations of abuse to APS, and notifications to APS are sometimes done by the nurse on duty. However, the Director examined the Report File Folder forms, and stated that APS was not listed on the form to be notified of an allegation, which may have resulted in the nurse not notifying APS. -At 2:25 p.m. the Director stated that he had phoned APS to determine if APS had received reports of the incidents on (MONTH) 17, 2019 and (MONTH) 21, 2019, and stated that APS had never received notification of the incidents A policy and procedure titled Abuse Investigations included a statement that all allegations/signs of resident abuse, neglect and injuries of unknown source shall be immediately reported and thoroughly investigated by facility management. The policy included that the Administrator of designee will review and if incidents meet the elements of reporting within 2 hours, will ensure appropriate Regulatory Agencies, Law enforcement, Medical Director and Representative are notified. The policy also included that the Administrator or designee will provide a written report of the results of all abuse investigations and appropriate action taken to the State Survey and Certification Agency, the local police department, the Ombudsman and others as may be required by State or local laws, within 5 days of the incident.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff interviews, record reviews and review of policies and procedures, the facility failed to ensure that an allegation of resident to resident abuse for two residents (#1, 2) was thoroughly investigated. The deficient practice could result in additional allegations of abuse not being thoroughly investigated by the facility. Findings include: -Resident #1 was admitted on (MONTH) 13, (YEAR) and readmitted on (MONTH) 5, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 21, 2019 included a BIMS (Brief Interview for Mental Status) score of 15, which indicted the resident was cognitively intact. The assessment included that resident #1 had verbal behavioral symptoms directed at others, refused care and wandered. A Behavior Note dated (MONTH) 21, 2019 at 3:30 p.m. included that the resident had hit another resident on the right cheek and pulled the other resident's hair while they were fighting over (pet) birds, in the other resident's room. The note included that the other resident had grabbed the arm of resident #1, and the resident's were separated. The note included that there were no injuries. Review of the plan of care for resident #1 revealed that it was updated on (MONTH) 21, 2019 to include that resident #1 had a confrontation with another resident over birds, and had hit the other resident on the cheek and pulled her hair. -Resident #2 was admitted on (MONTH) 29, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included that resident #2 had moderately impaired cognition and problems with short and long term memory, and behavioral symptoms not directed at others. The assessment included that the resident was short tempered, easily annoyed, and had trouble concentrating. A Behavior Note dated (MONTH) 21, 2019 at 4:01 p.m. included that resident #2 had grabbed another resident by the arm when the other resident tried to take her pet birds away from her. The note included that resident #2 stated that the other resident hit her on the cheek and pulled her hair, and that the other resident was trying to take her pet birds away from her when she grabbed the other resident by the arm. The note included that there were no injuries. An investigative report dated (MONTH) 24, 2019 included that on (MONTH) 21, 2019 at 3:00 p.m. two CNA's (Certified Nursing Assistants) witnessed an altercation, and that the staff stated that resident #1 entered resident #2's room (located on the Magnolia Unit) and was observing pet birds that resident #2 keeps on her dresser, and resident #1 attempted to remove the birds in their cage from the room. The report included that resident #2 grabbed resident #1's arm, and resident #1 retaliated by pulling resident #2's hair and slapping her across the face. The report included that the staff who were present immediately separated the resident's, the residents were assessed for injuries, and there were no injuries present. Review of the facility investigation, did not incude any direct witness statements, or reveal the names of the two CNA's who witnessed the altercation, or identify the staff who separated residents #1 and #2. The following interviews were conducted on (MONTH) 7, 2020 with the following staff who were assigned to the Magnolia Unit on (MONTH) 21, 2019 when the incident occurred: -At 10:00 a.m. a CNA/staff #86 stated that when the incident occurred she was not present on the unit at that time because she was on a break and that she believed that two other CNA's (staff #173, and #71) and a nurse (staff #21) remained on the unit while she was on break. -At 10:09 a.m. a CNA/staff #143 stated that she did not witness what actually happened because she was in another room with another CNA (staff #71) providing care to a resident. Staff #143 stated she heard a commotion and when she went out of the room saw resident #1 placing resident #2's pet birds in the hallway, the two resident's were arguing and she helped to separate them. Staff #143 stated that another CNA was supposed to be monitoring the hallway while she and staff #71 were in another room providing care, and she did not know the location of the nurse at the time of the incident. -At 10:22 a.m. a CNA/staff #71 stated she did not observe what happened because she was assisting staff #143 to provide care in another room when the incident occurred. Staff #71 stated that there should have been a nurse and at least one of possibly two CNA's on the unit when she was in another room providing care. -At 11:35 a.m. an LPN/staff #21 stated that when the incident occurred she was off the unit on a break and did not witness the incident. The following interviews were conducted on (MONTH) 7, 2020 with the Director of Nursing/staff #120: -At 9:00 a.m. the Director identified 3 CNA's who were assigned to work on the Magnolia Unit on (MONTH) 21, 2019 at the time of the incident, and stated that witness statements had not been obtained from the CNA's. -At 10:26 a.m. the Director identified a nurse who was assigned to work on the Magnolia Unit on (MONTH) 21, 2019 at the time of the incident, and stated that witness statements had not been obtained for this investigation. A policy and procedure titled Abuse Investigations included a statement that all allegations/signs of resident abuse, neglect and injuries of unknown source shall be thoroughly investigated by facility management, and that the Administrator or his/her designee will appoint a member of management to investigate the alleged incident. The policy included that the individual conducting the investigation will, as a minimum interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident and the witness reports will be obtained in writing.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff interviews, record reviews and review of policies and procedures, the facility failed to ensure that multiple residents with aggressive behaviors (#1, 2, 4, 5) were provided adequate supervision to prevent the residents from behaving in a physically aggressive manner towards other residents. The deficient practice could result in multiple residents behaving aggressively towards other residents. Findings include: -Resident #1 was admitted on (MONTH) 13, (YEAR) and readmitted on (MONTH) 5, 2019 with [DIAGNOSES REDACTED]. A written care plan initiated on (MONTH) 25, 2019 and updated on (MONTH) 8, 2019 included that resident #1 had a history of [REDACTED]. A Behavioral Plan dated (MONTH) 9, 2019 included that on admission the resident had a history of [REDACTED]. The behavioral

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) plan included that currently, the resident makes false accusations of peers taking her belongings, and has a history of physical altercations with peers. The behavioral plan listed multiple interventions included to monitor resident #1 for her peer's safety, listen to her concerns and to remove peers for their safety. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 21, 2019 included a BIMS (Brief Interview for Mental Status) score of 15, which indicted the resident was cognitively intact. The assessment included that resident #1 had verbal behavioral symptoms directed at others, refused care and wandered. Review of the MAR (Medication Administration Record) for (MONTH) 2019 revealed that resident #1 had the following behaviors which were documented in sections of the record for daily behavioral monitoring: -Verbally abusive behaviors were recorded on (MONTH) 1, 3, 5, 9, 10, 12 and 15, 2019. -Angry outbursts were recorded on (MONTH) 3, 5, 9, 10, and 12, 2019. -Delusions were recorded on (MONTH) 1, 4, 6, 7, 8, 11, 14, and 15, 2019. -False accusations were recorded on (MONTH) 8, 10, and 15, 2019. A Health Status Note dated (MONTH) 16, 2019 at 1:00 a.m. included that during a smoke break, a peer (resident #5) had grabbed the cigarette supply and that resident #1 had observed resident #5 grab the cigarettes. The note included that resident #1 tried to take the cigarettes from resident #5, and resident #5 then grabbed the sweater of resident #1, who slid to the floor. The note included that there were no injuries. Review of the MAR for (MONTH) 2019 revealed that resident #1 had following behaviors which were documented in daily behavioral monitoring: -Verbally abusive behaviors were recorded on (MONTH) 5, 6, 8, 12, 14, 15, 17, 19, 20, and 21, 2019. -Angry outbursts were recorded on (MONTH) 8, 12, 14, 16, 17, 20, and 21, 2019. -Delusions were recorded on (MONTH) 1-5, 8, 9, 12, 14, 15, 16, and 18-21, 2019. -False accusations were recorded on (MONTH) 8, 9, and 19-21, 2019. -Combativeness was recorded on (MONTH) 17, 2019. A Behavior Note dated (MONTH) 21, 2019 at 3:30 p.m. included that the resident had hit another resident on the right cheek and pulled the other resident's hair while they were fighting over (pet) birds, in the other resident's room. The note included that the other resident had grabbed the arm of resident #1, and the resident's were separated. This note included that there were no injuries. Review of the plan of care for resident #1 revealed that it was updated on (MONTH) 21, 2019 to include that resident #1 had a confrontation with another resident over birds, and had hit the other resident on the cheek and pulled her hair. -Resident #5 was admitted on (MONTH) 31, 2019 with [DIAGNOSES REDACTED]. An admission MDS assessment dated (MONTH) 9, 2019 included that resident #5 had a BIMS score of 7 which indicated that resident #5 had severe cognitive impairment. The assessment included that resident #5 had verbal and physical behavioral symptoms directed towards others, no functional limitations in range of motion and used a wheelchair. A psychiatric evaluation dated (MONTH) 10, 2019 included that resident #5 had displayed intermittent irritability, impulsivity, agitation, demanding behavior and verbal aggression. A plan of care for resident #5 for impaired cognitive function related to dementia, had multiple interventions listed including to cue, re-orient and supervise the resident as needed. A plan of care of care for a history and [DIAGNOSES REDACTED]. Review of the MAR for (MONTH) 2019 revealed that resident #5 had demanding and verbally abusive behaviors recorded in daily behavioral monitoring for (MONTH) 1-5, 7, 8. 11. and 13-15, 2019. An Incident Note dated (MONTH) 15, 2019 at 11:34 p.m. included that during a smoke break, resident #5 had grabbed all of the cigarettes, which caused an argument with a peer. The note included that resident #5 grabbed the peer by her sweater, which caused the peer to slide to the floor, and there were no injuries. An investigative report dated (MONTH) 20, 2019 included that (MONTH) 15, 2019 at 7:10 p.m. as residents were headed to a smoke break, and when resident #1 noticed that resident #5 had the box of (resident) cigarettes, resident #1 became angry and confronted resident #5, and resident #5 grabbed the sweater of resident #1, The report included that when resident #5 grabbed the sweater of resident #1, this caused resident #1 to fall to the ground. -Resident #2 was admitted on (MONTH) 29, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included that resident #2 had moderately impaired cognition and problems with short and long term memory, and behavioral symptoms not directed at others. The assessment included that the resident was short tempered, easily annoyed, and had trouble concentrating. A written plan of care for resident #2 included a plan for impaired cognitive function related to dementia, that had multiple interventions including to cue, reorient and supervise the resident as needed. A Behavior Note dated (MONTH) 4, 2019 at 10:16 a.m. included that resident #2 was worried that resident #1 was getting into her closet when she was out out of her room. A Health Status Note dated (MONTH) 8, 2019 at 5:18 p.m. included that resident #2 had complained that resident #1 had been in her room and was afraid that resident #1 would take her possessions. The note included that staff would monitor the resident for any changes and safety. A Behavioral Plan dated (MONTH) 9, 2019 included that resident #2 grabs at other residents, and that she appears to be targeting a specific peer, and takes the peers belongings. The plan included to monitor and redirect her away from a specific peer. A Behavior Note dated (MONTH) 15, 2019 at 9:02 a.m. included that resident #2 and #1 had an argument and were redirected away from each other to de-escalate the argument. A Behavior Note dated (MONTH) 21, 2019 at 4:01 p.m. included that resident #2 had grabbed another resident by the arm when the other resident tried to take her pet birds away from her. The note included that resident #2 stated that the other resident hit her on the cheek and pulled her hair, and that the other resident was trying to take her pet birds away from her when she grabbed the other resident by the arm. The note included that there were no injuries. An investigative report dated (MONTH) 24, 2019 included that on (MONTH) 21, 2019 at 3:00 p.m. resident #1 entered resident #2's room and was observing pet birds that resident #2 keeps on her dresser, and resident #1 attempted to remove the birds in their cage from the room. The report included that resident #2 grabbed resident #1's arm, and resident #1 retaliated by pulling resident #2's hair and slapping her across the face. Staff separated the resident's and there were no injuries. During an interview with an LPN (Licensed Practical Nurse/staff #72) conducted on (MONTH) 6, 2020 at 2:45 p.m. the LPN stated that the staff circulate about the unit continuously to monitor resident's behavior and for safety. The LPN stated that the unit is usually staffed with 1-2 nurses and 3 CNA's (Certified Nursing Assistants). The following interviews were conducted on (MONTH) 7, 2020 with the following staff regarding the incident that occurred on (MONTH) 21, 2019: -At 10:00 a.m. a CNA/staff #86 stated that when the incident occurred she was not present on the unit at that time because she was on a break and that she believed that two other CNA's (staff #173, and #71) and a nurse (staff #21) remained on the unit while she was on break. -At 10:09 a.m. a CNA/staff #143 stated that she did not witness what actually happened because she was in another room with another CNA (staff #71) providing care to a resident. Staff #143 stated she heard a commotion and when she went out of the room saw resident #1 placing resident #2's pet birds in the hallway, the two resident's were arguing and she helped to separate them. Staff #143 stated that another CNA was supposed to be monitoring the hallway while she and staff #71 were in another room providing care, and she did not know the location of the nurse at the time of the incident. -At 10:22 a.m. a CNA/staff #71 stated she did not observe what happened because she was assisting staff #143 to provide care in another room when the incident occurred. Staff #71 stated that there should have been a nurse and at least one of possibly tow CNA's on the unit when she was in another room providing care. -At 11:35 a.m. an LPN/staff #21 stated that when the incident occurred she was off the unit on a break and did not witness the incident. The following interviews were conducted on (MONTH) 7, 2020 with the Director of Nursing/staff #120: -At 11:50 a.m. the Director stated that there should always be a staff present in the hallway on the unit and that the staff have scheduled break times to ensure there is staff coverage on the unit. The Director stated that there may have been a miscommunication which resulted in the nurse and a CNA being off the unit at the same when the incident occurred n (MONTH)

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) 21, 2019. -At 1:30 p.m. the Director stated that one staff is assigned to assist the resident's with smoke breaks, and that one staff is sufficient to provide safety for the residents while they smoke. The Director stated that on (MONTH) 15, 2019 when the incident occurred between resident #1 and resident #5 during the smoke break, there was one staff present, however she was unable to reach the resident's quickly enough to prevent resident #5 from grabbing resident #1. -At 3:05 p.m. the Director stated that resident #5 was very compulsive about smoking from the time she was admitted and that interventions were not effective. The Director stated that resident #5 had grabbed a box of resident cigarettes, and resident #1 tried to take it from her to protect the cigarettes and that's when resident #5 pushed down resident #1. -Resident #4 was admitted on (MONTH) 8, 2019 with [DIAGNOSES REDACTED]. An Admission MDS assessment dated (MONTH) 20, 2019 included that resident #4 had a BIMS score of 3, which indicated that the resident had severely impaired cognition, difficulty focusing attention and physical behaviors directed at others. Review of the clinical record did not reveal that a written plan of care for physical behaviors directed at other residents had been initiated. An Incident Note dated (MONTH) 7, 2019 at 10:36 a.m. included that resident #4 and resident #5 had engaged in a verbal altercation in the dining room, when resident #4 reached over and struck resident #5 on the right arm. The note included that he resident's were separated by staff, and there were no injuries. -Resident #3 was admitted on (MONTH) 6, 2014 with [DIAGNOSES REDACTED]. A Quarterly MDS assessment dated (MONTH) 9, 2019 included that the resident had speech that was unclear or slurred, and that he usually understands others. The assessment included that the resident had a BIMS score of 9, which indicated that the resident had moderately impaired cognition, and verbal behavioral symptoms directed at others. A written plan of care included that resident #3 has a [DIAGNOSES REDACTED]. The plan of care included a goal that the resident would refrain from verbally or physically abusive behavior and listed multiple interventions including to intervene by speaking calmly and professionally and in a soft tome of voice. The plan of care also included a that the resident had a communication problem related to weak voice and that he whispers, and listed multiple interventions including to allow the resident adequate time to respond. An Incident Note dated (MONTH) 17, 2019 at 10:31 a.m. included that resident #4 and resident #5 had engaged in a verbal altercation in the dining room, when resident #4 reached over and struck resident #5 on the right arm. The note included that he resident's were separated by staff, and there were no injuries. An investigative report dated (MONTH) 20, 2019 included that on (MONTH) 17, 2019 residents #4 and #3 were in the unit dining room, and began to have a verbal altercation, and that resident #5 reached over and hit resident #3 on the right arm. The report included that the residents were immediately separated and there were no injuries. During an interview conducted on (MONTH) 8, 2020 at 10:00 a.m. with the Director of Nursing/staff #120, he stated that resident #4 had never behaved aggressively towards another resident before this incident. The Director stated that sometimes resident #3 says things under his breath that are insulting to other residents, and that may have been why resident #4 struck resident #3. The Director stated that there was a CNA in the dining room at the time of the incident. A policy and procedure titled Problematic Behavior Management-Clinical Guideline included a statement that as part of the initial assessment, the staff and physician will identify individuals with a history of impaired cognition, problematic behavior, or mental illness, and that nursing staff will document the nature, duration, and associated features of any changes over time in behavior, cognition, or mood. The policy included that if the resident is being treated for [REDACTED].