STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035270	A. BUILDING _____ B. WING _____	**07/05/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA ESTANCIA NURSING AND REHABILITATION CENTER	**15810 SOUTH 42ND STREET PHOENIX, AZ 85048**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** >
Based on clinical record reviews, facility documentation, staff and resident interviews, and policy review, the facility failed to ensure that one resident (#2) was free from sexual abuse by another resident (#1) and failed to ensure one resident (#3) was free from physical abuse from another resident (#2). The sample size was three residents. The deficient practice could result in the potential for further resident to resident abuse.
Findings include:
-Resident #2 was admitted on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED].
A social service note dated (MONTH) 1, 2019 included that resident #2 had delusions as evidenced by verbal expressions usually pertaining to past incidents in her early life which she applied to the present time, and that the happenings in her early life play a role in her present behaviors. The note included that resident #2 was focused on fears brought on by past male relationships and the fear of being harmed.
The resident's cognition care plan, initiated on (MONTH) 10, 2019, revealed the resident had impaired cognition related to a [DIAGNOSES REDACTED]. Interventions for this care plan included:
-Evaluate behavioral symptoms for underlying causes.
-Evaluate the need for a psychiatric/behavioral health consultation.
-Redirect/re-orient using external cues as needed.
-Approach in a calm, unhurried manner, reassure as necessary.
An MDS (Minimum Data Set) assessment dated (MONTH) 29, 2019 included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 2 which indicated that the resident had severe cognitive impairment. The assessment included that the resident had difficulty focusing attention, disorganized thinking, physical behavioral symptoms directed towards others and feeling down, depressed or hopeless. The assessment also included that resident #2 did not walk, and used a wheelchair with one staff person assistance and supervision.
A monthly nurse practitioner note dated (MONTH) 17, 2019 included that resident #2 had a chronic problem with continuing behaviors that included auditory hallucinations and paranoia.
A physical behavior care plan, initiated on (MONTH) 21, 2019, included a focus that the resident exhibited or has the potential to exhibit physical behaviors related to cognitive loss/dementia and psychiatric disorder. The plan included that resident #2 had a history of [REDACTED].
A nursing note dated (MONTH) 30, 2019 at 1:15 a.m. included that the nurse had been notified by a CNA (Certified Nursing Assistant) at 12:10 a.m. of the following:
-Resident #2 had been in the courtyard, seated in her wheelchair and facing away from the door with her back to the door, and a male resident (later identified to be resident #1) had been seated in his wheelchair in a diagonal position with his right hand inside of resident #2's pants.
-When the CNA opened the door to the courtyard, the male resident removed his hand from resident #2's pants and followed the CNA out of the courtyard to the nurses station.
-When the CNA returned to the courtyard and asked resident #2 how did he touch you she responded by saying that the male resident had touched me here (pointing to the left and right breasts and the vaginal area), and the CNA assisted the resident to her bed.
The note also included that when the nurse assessed the resident she was lying in bed with her eyes closed, and when asked if she remembered what had happened in the courtyard, and if she had been touched in her vagina, resident #2 stated (with her eyes closed) no to the questions asked by the nurse.
-Resident #1 was admitted on (MONTH) 2, (YEAR) with [DIAGNOSES REDACTED].
An MDS assessment dated (MONTH) 8, 2019 included a BIMS score of 14, which indicated that resident #1 was cognitively intact. The assessment did not include any indicators for mood or behaviors, or that resident #1 had any upper body impairments and included that resident #1 used a wheelchair for locomotion, and with supervision.
A nursing note dated (MONTH) 6, 2019 at 10:47 p.m. included that resident #1 had been found in a female resident's room, sitting next to her while she was in bed sleeping and watching her sleep. The resident was asked to leave her room and not to go into her room without her permission.
A nursing note dated (MONTH) 7, 2019 at 7:12 p.m. included that earlier in the evening, resident #1 had asked the female resident if he could enter her room and she had refused. However, the note included that during the evening, resident #1 had entered the female resident's room without knocking and without asking permission to enter, and staff had redirected the resident out of the room both times. The note included that each time resident #1 entered the female resident's room, she was sleeping.
Review of the clinical record revealed a psychiatric evaluation dated (MONTH) 20, 2019 for a history of inappropriate intimate advances including that the staff had reported and that the resident had displayed daily inappropriate sexual behavior with verbal suggestions and touching others, and intrusive behaviors towards peers. The evaluation included that resident #1 displayed unstable symptoms of adjustment as evidenced by persistent intimate advances towards others, and that mental illness or cognitive impairment did not appear to be a factor in the reported behavior episodes.
Review of nurses notes dated (MONTH) 30, 2019 included that the following:
-The resident had been found in the courtyard seated in a wheelchair by a CNA (who reported the incident to the nurse) with the wheelchair facing the female resident (#2) in a diagonal position and with his right hand inside the female resident's pants.
-When the CNA opened the door she stated to resident #1 I saw what just happened and why are you touching her resident #1 replied I'm sorry it won't happen again and resident #1 followed the CNA to the nurses station.
-Police arrived at the facility at 1:30 a.m. and stationed an officer at door to resident #1's room.
-Resident #1 was taken into police custody and removed from the facility at 7:15 a.m.
Review of an investigative summary dated (MONTH) 1, 2019 included that on (MONTH) 30, 2019 at 12:00 a.m. a CNA (staff #59) had found resident #1 sitting in the courtyard next to resident #2, and resident #1 had his hands in resident #2's pants, and when the CNA opened the door, resident #1 pulled his hands out of the resident #2's pants. The report included that the CNA told resident #1 she had seen where his hands had been, and resident #1 stated he was sorry and that he would not do that again. The report included the CNA assisted resident #2 to her room, reported the incident to the nurse, and resident #1 was instructed to go to his room. The report included the police were notified and resident #2 was transferred to the

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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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) hospital for a forensic rape examination. The report included that the police had interviewed resident #1 and reported to the facility that resident #1 did not deny hand groping and sexually touching resident #2, and that he did not receive consent from resident #2 prior to touching her breast over her clothes, her vagina over her clothes and that he had inserted his finger into her vagina under her brief. The report included that resident #1 was taken into custody and removed from the facility by the police. An interview was conducted on (MONTH) 3, 2019 at 9:20 a.m. with a CNA (staff #59). During the interview, the CNA stated that on (MONTH) 30, 2019 at 12:00 a.m., she noted during rounds that resident #2 was not in her room. She stated that when she found resident #2 sitting in the courtyard with resident #1, resident #1 had his hands in her pants. The CNA stated that when she opened the door to the courtyard, resident #1 pulled his hands out of resident #2's pants and he stated I'm sorry I won't do that again. the CNA stated resident #1 followed her to the nurses station, then she returned to the courtyard. The CNA stated that resident #2 remained sitting in the courtyard and had a helpless facial expression and looked helpless, as though she had been forced to do something. The CNA stated that resident #2 pointed to her breasts and private area when asked where resident #1 had touched her and said the resident #1 had touched her there. The CNA stated she assisted resident #2 to her room and described resident #2 as subdued and detached and helpless. An interview was conducted on (MONTH) 3, 2019 at 10:00 a.m. with an LPN (Licensed Practical Nurse/staff #56). Staff #56 stated that although she had worked on (MONTH) 30, 2019 on the night shift, she had been temporarily away from the unit when the incident had occurred at 12:00 a.m. Staff #56 stated that upon return to the unit she assessed resident #2, and observed that resident #2 remained in bed and was very quiet for the remainder of the night which was very unusual for her. Staff #56 stated that the normal night time behavior for resident #2 was to be up and awake all night, spending her time in the dining room or out in the courtyard and that it was highly unusual that she remained in her bed. An interview was conducted on (MONTH) 3, 2019 at 12:05 p.m. with an LPN (staff #113). The LPN stated that she had been present at the time of the incident on (MONTH) 30, 2019 at 12:00 a.m. and that resident #1 had wheeled himself to the nurses station. Staff #113 stated that she had spoken to resident #1 and told him that he cannot touch other residents, and when she asked him about the incident in the courtyard he stated that he was depressed and wanted to go home, then he returned to his room. An interview was conducted on (MONTH) 5, 2019 at 9:55 a.m. with a psychiatrist (staff #114). The psychiatrist stated that he had evaluated resident #1 on (MONTH) 20, 2019 and that the behaviors described in the evaluation were behaviors described to him by a staff member, and that resident #1 had behaved inappropriately to staff, but not to other residents. The psychiatrist stated that when he had evaluated resident #1 on (MONTH) 20, 2019 he did not have any concerns that the resident posed a danger to other residents, or that he had posed a risk for sexual or unwanted behaviors to others. An interview was conducted on (MONTH) 5, 2019 at 12:00 p.m. with a case manager (staff #99). She stated that resident #2 had an extensive history of physical and sexual trauma dating back to her childhood that included rape and that resident #2 had told her family member (regarding resident #1), He hurt me and put his mouth on me. -Resident #3 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. An MDS assessment dated (MONTH) 1, 2019 included that resident #3 had a BIMS score of 1, which indicated severe cognitive impairment. The assessment also included that resident #3 had inattention and disorganized thinking, and used a wheelchair with supervision for locomotion. Review of nurses notes dated (MONTH) 20, 2019 revealed a note that included at 4:00 p.m. resident #3 had had an altercation with another resident (later identified to be resident #2), and was assessed to have 3 small discolored (areas) on her right hand that were not open. A nurses note at 9:52 p.m. included the resident had been assessed by the nurse at 4:45 p.m. and had 3 small abrasions to the right hand and 1 small abrasion to the left hand. The note included that the resident's behavior was at baseline and she was alert and confused. A care plan, initiated on (MONTH) 20, 2019, included a focus that resident #3 was the recipient of aggressive behavior from another resident and had 3 scratched areas with bruising on her right hand and a scratch on her left hand. Review of a facility investigative report dated (MONTH) 28, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m., while resident #2 and #3 were in the lobby, resident #2 accused resident #3 of having sent men over to her. Resident #2 grabbed resident #3 by the wrists which caused bruising to her wrists. The investigative report included a witness statement dated (MONTH) 20, 2019 that was completed by a case manager (staff #99). The statement included that staff #99 had witnessed resident #2 holding onto the wrists of resident #3. The statement included that the witness was unable to loosen resident #2's grip on resident #3 and resident #2 stated She brought those men in here at me. The statement included that resident #2 was provided reassurance that there were no men in the area who were going to attack her and was then able to loosen resident #2's grip on resident #3 and staff assisted the resident to the nurses station. During an interview with a CNA (staff #39) on (MONTH) 5, 2019 at 10:50 a.m., she stated that although she did not witness the incident on (MONTH) 20, 2019 at 4:00 p.m., she did observe that for 2 days after the incident resident #3 was upset and agitated and made statements that she wanted to go home. An interview was conducted on (MONTH) 5, 2019 at 12:00 p.m. with a case manager (staff #99). The case manager stated that on (MONTH) 20, 2019 at 4:00 p.m. she observed resident #2 gripping and squeezing onto resident #3's wrists. The case manager stated that when approached, resident #2 stated She's bringing those men into my room, they're going to hurt me. The case manager stated that after speaking to resident #2, she was able to separate the two residents. A policy and procedure titled Abuse Prohibition included that the facility prohibits abuse, mistreatment and exploitation for all residents. The policy included the following definitions of abuse: -Sexual abuse is a non-consensual sexual contact of any type with a resident. It includes but is not limited to sexual harassment, sexual coercion or sexual assault. -Physical abuse includes hitting, .slapping and pinching. -Mental abuse includes but is not limited to humiliation, harassment and may occur through conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. -Exploitation is defined as the act or process of taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. -Mistreatment is defined as inappropriate treatment or exploitation of a resident.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on staff interviews, record reviews and review of polices and procedures and review of the State Agency data base, the facility failed to implement policies and procedures regarding an allegation of abuse for two residents (#2, #3). The sample size was two residents. Findings include: -Resident #3 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. Review of nurses notes dated (MONTH) 20, 2019 revealed a note at 7:29 p.m., that at 4:00 p.m. resident #3 had an altercation with another resident (later identified to be resident #2), and was assessed to have 3 small discolored (areas) on her right hand that were not open. Another nurses note at 9:52 p.m. the same day, included that the resident had 3 small abrasions to the right hand and 1 small abrasion to the left hand. -Resident #2 was admitted on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED]. Review of a Resident/Patient Incident Report dated (MONTH) 21, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. resident #3 had an altercation with another resident (identified as resident #2) and included that resident #3 had 3 small (areas) of discoloration on the right anterior hand, and no open areas. Review of a facility investigative summary report dated (MONTH) 28, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. while resident #2 and #3 were in the lobby, resident #2 accused resident #3 of having sent men over to her. Resident #2 grabbed resident #3 by the wrists which caused bruising to her wrists. A fax receipt attached to the investigative summary report was dated (MONTH) 28, 2019 and addressed to fax number for DHS (Department of Health Services). Review if the State Agency data base revealed that the investigation summary for the allegation of abuse that occurred on (MONTH) 20, 2019 was received by the State Agency on (MONTH) 28, 2019. An interview was conducted on (MONTH) 5, 2019 at 2:15 p.m. with the Director of Nursing (staff #97). During the interview,

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the Director stated that facility investigations usually take 5 days to complete and that a summary of the investigation is faxed to the Department of Health Services within 5 business days (not counting weekends or holidays. The Director stated that she did not intend to fax the summary of the investigation to DHS more then a day late. A policy and procedure titled Abuse Prohibition included that the facility prohibits abuse, mistreatment and exploitation of all residents. The policy included that a facility designee will report findings of all completed investigations within 5 working days to the Department of Health using the state on-line reporting system or state-approved forms.
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 report the results of an abuse investigation involving two residents (#2, #3) to the State Survey Agency within 5 working days of the incident. The sample size was two residents. Findings include: -Resident #3 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. Review of nurses notes dated (MONTH) 20, 2019 revealed a note at 7:29 p.m. at 4:00 p.m. that included resident #3 had an altercation with another resident (later identified to be resident #2), and was assessed to have 3 small discolored (areas) on her right hand that were not open. A nurses note at 9:52 p.m. included that the resident had 3 small abrasions to the right hand and 1 small abrasion to the left hand. -Resident #2 was admitted on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED]. Review of a Resident/Patient Incident Report dated (MONTH) 21, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. resident #3 had an altercation with another resident (identified as resident #2) and included that resident #3 had 3 small (areas) of discoloration on the right anterior hand, and no open areas. Review of a facility investigative summary report dated (MONTH) 28, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. while resident #2 and #3 were in the lobby, resident #2 accused resident #3 of having sent men over to her. Resident #2 grabbed resident #3 by the wrists which caused bruising to her wrists. A fax receipt attached to the investigative summary report was dated (MONTH) 28, 2019 and addressed to fax number for DHS (Department of Health Services). Review if the State Agency data base revealed that the investigation summary for the allegation of abuse that occurred on (MONTH) 20, 2019 was received by the State Agency on (MONTH) 28, 2019. An interview was conducted on (MONTH) 5, 2019 at 2:15 p.m. with the Director of Nursing (staff #97). During the interview, the Director stated that facility investigations usually take 5 days to complete and that a summary of the investigation is faxed to the Department of Health Services within 5 business days (not counting weekends or holidays. The Director stated that she did not intend to fax the summary of the investigation to DHS more a day late. A policy and procedure titled Abuse Prohibition included that the facility prohibits abuse, mistreatment and exploitation of all residents. The policy included that a facility designee will report findings of all completed investigations within 5 working days to the Department of Health using the state on-line reporting system or state-approved forms.
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 to ensure that one resident (#2) was provided adequate supervision to prevent the resident from physically assaulting another resident (#3). The sample size was two residents. Findings include: -Resident #3 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. An MDS assessment dated (MONTH) 1, 2019 included that resident #3 had a BIMS score of 1, which indicated severe cognitive impairment. The assessment also included that resident #3 had inattention and disorganized thinking an used a wheelchair with supervision for locomotion. Review of nurses notes dated (MONTH) 20, 2019 revealed a late note at 7:29 p.m., at 4:00 p.m. that included resident #3 had an altercation with another resident (later identified to be resident #2), and was assessed to have 3 small discolored (areas) on her right hand that were not open. A nurses note at 9:52 p.m. included the resident had 3 small abrasions to the right hand and 1 small abrasion to the left hand, and included that the resident's behavior was at baseline and she was alert and confused. A written care plan initiated on (MONTH) 20, 2019, included a focus that resident #3 was the recipient of aggressive behavior from another resident and had 3 scratched areas with bruising on her right hand and a scratch on her left hand. -Resident #2 was admitted on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED]. A social service note dated (MONTH) 1, 2019 included that resident #2 had delusions as evidenced by verbal expressions usually pertaining to past incidents in her early life which she applied to the present time, and the happenings in her early life play a role in her present behaviors. The note included that resident #2 was focused on fears brought on by past male relationships and the fear of being harmed. A nurses note dated (MONTH) 9, 2019 at 6:39 a.m. included that resident #2 was looking for her husband on the unit and entered two resident rooms belonging to male residents. When staff approached the resident, she jumped out of her chair, and shouted at the nurse as if she was going to hit the nurse. A written care plan initiated on (MONTH) 10, 2019 for impaired cognitive function related to a [DIAGNOSES REDACTED]. -Evaluate behavioral symptoms for underlying causes. -Evaluate the need for a psychiatric/behavioral health consultation. -Redirect/re-orient using external cues as needed. -Approach in a calm, unhurried manner, reassure as necessary. Review of the written care plan initiated on (MONTH) 10, 2019 did not reveal that any additional interventions regarding behavioral monitoring or supervision had been added to the resident's care plan. A physician's orders [REDACTED]. mg. (milligrams) every 24 hours for mood disorder. A nurses note dated (MONTH) 27, 2019 at 3:07 a.m. included that resident #2 was in the hallway, confused and yelling down the hallway and had picked up a hole puncher from the nurses station. The note included that resident #2 refused to give up the hole puncher, and when staff attempted to remove the item, she bit and grabbed the nurse, then continued to attempt to hit the nurse, and pushed over computers at the nurses station. A nurses note dated (MONTH) 27, 2019 at 4:35 a.m. included that resident #2 was confused, yelling down the hallway, going out the front door and stated I ' m leaving I have to find my husband I'm going to kill you [***] es.The note included that the nurse attempted to redirect the resident multiple times, the resident continued to try to leave through the front door and was combative' with the nurse. A nurses note dated (MONTH) 7, 2019 at 12:09 a.m. included that the note was a delayed entry, and that on (MONTH) 6, 2019 between 3:00 p.m. and 11:00 p.m. resident #2 attempted to elope multiple times, was difficult to redirect, attempted to hit staff and threw water on the floor. A nurses note dated (MONTH) 9, 2019 included that resident #2 had been observed removing a bunch of laundry from a laundry cart, and when staff attempted to redirect the resident, she scratched the staff, which resulted in a 3.0 cm. (centimeter) scratch on the staff members arm. A nurses note dated (MONTH) 11, 2019 at 6;51 p.m. included that resident #2 had slapped a male resident in the face, and accused him of stealing her husband. A nurse practitioner note dated (MONTH) 17, 2019 included that over the past several months the resident's behaviors had increased, the resident was having visual and auditory hallucinations, and had become physically aggressive with staff. The note included that resident #2 heard people talking in the hallway about taking her belongings and harming her, became physically aggressive and had physically struck staff and another resident during these events. The note also included that the resident had been found outside in the parking lot on 2-3 occasions, despite having a wander bracelet in place.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) A nurse practitioner note dated (MONTH) 16, 2019 included that resident #2 had a chronic problem with continuing behaviors and continued to have auditory delusions and paranoia. A nurse note dated (MONTH) 19, 2019 at 9:31 p.m. included that resident had slapped another resident in the face and that staff separated the residents (the note did not include additional details). Continued review of the clinical record did not reveal any documented evidence that additional interventions regarding behavioral monitoring or supervision were being provided to resident #2, or that additional interventions for behavioral monitoring or increased supervision had been added to the care plan. An MDS (Minimum Data Set) assessment dated (MONTH) 29, 2019 included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 2 which indicated that the resident has severe cognitive impairment. The assessment included that the resident had difficulty focusing attention, disorganized thinking, physical behavioral symptoms directed towards others and feeling down, depressed or hopeless, and received antidepressant and antipsychotic medications The assessment also included that resident #2 did not walk, and used a wheelchair with one staff person assistance and supervision. A monthly nurse practitioner note dated (MONTH) 17, 2019 included that resident #2 had a chronic problem with continuing behaviors that included auditory hallucinations and paranoia, and included that the resident had episodes of being physically aggressive with staff, and had struck another resident Review of nurses notes dated (MONTH) 20, 2019 revealed a note at 7:30 p.m. that included resident #2 was the aggressor in an altercation with another resident and there were no injuries to resident #2. A written care plan initiated on (MONTH) 21, 2019 included a focus that the resident exhibited or has the potential to exhibit physical behaviors related to cognitive loss/dementia and psychiatric disorder. The plan included that resident #2 had a history of [REDACTED]. had delusions. The care plan listed multiple interventions with a goal that the resident will not harm others. However, there were no additional interventions added to the care plan regarding behavioral monitoring or supervision. Review of a Resident/Patient Incident Report dated (MONTH) 21, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. resident #3 had an altercation with another resident (identified as resident #2). A form titled Incident/Accident Investigation attached to the Incident Report included that resident #2 had a history of [REDACTED].? Frequent checks-both propel independently. The investigation form also included a space with the heading Immediate Actions Taken to Prevent Further Incidents/Injuries (Care Plan Adjustments): included a handwritten notation that read NO? and did not include any additional details. A section of the Investigation form titled Summary & Conclusion stated that both residents were usually in the hallway most of the time, and included every 30 minute checks, monitor frequently. The summary included that both residents were independent with wheeling throughout the facility, and to continue to promote independence and note the location of residents. The summary also included staff aware. Review of a facility investigative report dated (MONTH) 28, 2019 included that on (MONTH) 20, 2019 at 4:00 p.m. while resident #2 and #3 were in the lobby, resident #2 accused resident #3 of having sent men over to her. Resident #2 grabbed resident #3 by the wrists which caused bruising to her wrists. The investigative report included a witness statement dated (MONTH) 20, 2019 that was completed by a Case Manager (staff #99). The statement included that staff #99 had witnessed resident #2 holding onto the wrists of resident #3. The statement included that the witness was unable to loosen resident #2's grip on resident #3 and resident #2 stated She brought those men in here at me. The statement included that resident #2 was provided reassurance that there were no men in the area who were going to attack her and was then able to loosen resident #2's grip on resident #3 and staff assisted the resident to the nurses station. During an interview conducted on (MONTH) 3, 2019 at 3:05 p.m. with the Director of Nursing (staff #97), the Director stated that if a resident in the facility had behaviors, the resident's behaviors would be documented in the nurses notes. The Director stated that the facility did not use paper records or flow sheets to document behaviors. During an interview conducted on (MONTH) 5, 2019 at 10:50 a.m. with a CNA/staff #39, she stated that she did not witness the incident on (MONTH) 20, 2019 at 4:00 p.m. However, she did observe that for 2 days after the incident, resident #3 was upset and agitated, and made statements that she wanted to go home. The CNA stated that prior to the incident on (MONTH) 20, 2019, resident #2 had not been provided any specific behavioral monitoring, or 15 minute checks by the staff. An interview was conducted on (MONTH) 5, 2019 at 12:00 p.m. with a Case Manager/staff #99. The case Manager stated that on (MONTH) 20, 2019 at 4:00 p.m. she observed resident #2 was holding onto resident #3's wrists, she was gripping them and squeezing them. The Case Manager stated that when approached, resident #2 stated She's bringing those men into my room, they're going to hurt me. The Case Manager stated that after speaking to resident #2, she was able to separate the two residents. An interview was conducted on (MONTH) 5, 2019 at 2:15 p.m. with the Director of Nursing (staff #97). During the interview, the Director stated that resident #2 had not been provided additional behavioral monitoring or supervision because the staff were unable to determine what the resident's behavioral triggers were. The Director stated that because they could not determine the resident's behavioral triggers, they were unable to stop resident #2 from having aggressive behaviors towards other residents. A policy and procedure titled Behaviors: Management of Symptoms included to observe patients for early signs of withdrawal/decreased social interaction, frustration, agitation, and anger such as physical and verbal behavioral symptoms directed at others. The policy included that if behavior escalates to the point of being dangerous to self or others, take immediate measures to protect the safety of all patients and staff, to refer to A Guide to Problem Behaviors and if the patient can be managed in the center, to initiate a Behavioral Monitoring and Interventions Flow Record. The policy included to review the Behavioral Monitoring and Interventions Flow Record to identify patterns, possible causes, and results of non pharmacological interventions, and side effects of medications, if present. The policy also included to review unresolved behavioral trends for individual patients or groups of patients as part of Quality Assurance and Performance Improvement.