STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	425 N ELM STREET SAUK CENTRE, MN 56378

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** - Minimal harm or potential for 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 observation, interview and document review, the facility failed to comprehensively assess verbally abusive behaviors and identify interventions to prevent abuse for 1 of 5 residents (R4) who had a history of [REDACTED]. Findings include: A facility provided incident report dated 5/26/20, identified R2's family member (FM)-B reported to the facility on R2's behalf an allegation of emotional or mental abuse by R2's roommate R4 on 5/25/20. The report identified R2 reported to FM-B R4 had called R2 names including fat [***] . The action taken to protect the resident was identified as follows. R2 stated she was safe and smiled at the staff. Staff were made aware of the incident. R2's roommate needs physical assistance with mobility. Social services offered a room change. The investigation summary identified care plans and progress notes were reviewed. R2's care plan was updated to reflect R2's request for no room change or changes in situation. No changes to the policies were made. They would continue to offer R2 choices regarding her room. Further the summary identified R2 was physically dependent on staff for transfers and had a [DIAGNOSES REDACTED]. R2 had told family R4 had a really bad attitude but had denied being afraid of her roommate. Since admission R2 had interacted with R4 and had expressed concern regarding R4's well being. R2 was offered a room change and declined because she liked the window view she had currently. R2 was informed R4 could continue with negative statements especially if she has a change in mood or condition. R2 stated she preferred to stay in her room. Family was updated on R2 wanting to stay in her room. A follow up visit was conducted on 5/29/20, and R2 denied any ongoing conflicts with R4. Action taken to prevent reoccurrence was identified to update R2's care plan to reflect a room change would be offered as appropriate. A change in rooms may be necessary if further altercations created an unsafe situation. Staff were to observe interactions and intervene by assisting either resident from the room as necessary. R2 denied any harm. The investigation lacked interviews with staff regarding behaviors potentially exhibited by R4 along with a lack of assessments into R4's behavior for frequency, causative factors or any interventions to decrease the behaviors towards R2. R4's quarterly Minimum Data Set ((MDS) dated [DATE], identified R4 had moderate cognitive impairment and needed extensive assistance with transfers. R4 had physical behavioral symptoms directed toward others (e.g , hitting, kicking, pushing, scratching, grabbing, abusing others sexually and verbal behaviors that occurred one to three days, during the last seven days. R4 had verbal behavioral symptoms directed toward others (e.g threatening others, screaming at others, cursing at others) that occurred one to three days, during the last seven days. [DIAGNOSES REDACTED]. R4 was identified to be taking an antidepressant medication. R4's medical record lacked any assessment on verbal or physical behaviors. R4's nursing assistant group sheet dated 5/20/20, did not identify any behavioral interventions for staff to follow. R4's care plan last revised 6/5/20, did not identify any history of verbal abuse, nor did it identify any specific interventions in attempt to deter the behaviors and protect other residents. R4's progress note(s) identified the following: - 5/16/20, at 10:00 p.m. a nursing assistant reported while caring for R4 that evening R4 called R2 a [***] . R4 also told the nursing assistant three time to go [***] yourself. The nursing assistant told R4 she shouldn't talk like that and R4 told the nursing assistant to kiss my ass. - 5/25/20, at 6:29 p.m. R4 was cursing after supper at her roommate. This impacted residents care, social interactions, privacy or activity of others and disrupted care and living environment. Non pharmological interventions provided were: Writer closed curtain between roommates and turned on (R2's) music to drown out negative comments made by (R4). Resident was calling (R2) a [***] and [***] . R4's medical record lacked any specific monitoring for verbal behaviors towards R2. R2's admission MDS dated [DATE], identified R2 was cognitively intact. R2 needed extensive assistance to transfer and had a [DIAGNOSES REDACTED]. R2 denied fear of her roommate. Offered to have staff monitor the situation. Family encouraged to keep staff updated. - 5/6/20, at 1:29 p.m. family was concerned about R2 and R4 interacting. R2 was observed showing concern for R4 and R2 stated she worried about R4 getting lost when out of the room. R2 stated she felt safe and was very firm she was safe. The writer inquired if R4 had done anything to hurt her and R2 stated no and I don't think she ever would. The writer identified R2 had a poor memory. Family reported R2 stated R4 was feisty. Staff would monitor for resident interaction. - 5/25/20, at 6:27 p.m. R2 had called the writer into the room and stated she would like her roommate to stop being so mean to her. The writer pulled the curtain and turned on the music to drown out R4's comments. -5/25/20, 7:09 p.m. R2's family called and reported R2 stated R4 had been calling R2 names including ugly and a 'B'. -5/26/20, at 11:04 a.m. R2 stated I don't know what is up with her regarding R4. The writer offered to make a room change and if she were to stay in the room there would likely be continued altercations. - 6/1/20, at 11:31 p.m. a nursing assistant reported R2 stated she was afraid of R4 and R4 had been calling her nasty names at time. The social worker would be updated. During observation on 6/1/20 2:20 p.m. R4 was in her doorway to her room playing hallway bingo with staff assistance. R2 was seated in her chair with her eyes closed. On 6/2/20, at 9:29 a.m. R4 was observed seated in her chair in her room. R2 was also in the room seated in her chair looking out the window. The ladies were not interacting with each other. R4 did not respond to any questions that were asked of her. During interview on 6/2/20, at 10:04 a.m. nursing assistant (NA)-B stated she was aware R4 had a history of [REDACTED]. There were no new interventions implemented recently to their knowledge. R2 had never reported anything to NA-B. During interview on 6/2/20, at 10:09 a.m. NA-C stated she had heard R4 had been calling R2 names. She would just remove one of them from the room if she heard anything like that. There were no new interventions or monitoring NA-C was aware of for R4. There were no specific interventions in place to minimize the behavior. During interview on 6/2/20, at 10:17 a.m. R2 stated R4 had called her a [***] and stuff like that. R2 stated it bothered her when it occurred, but it wasn't R4's fault because sometimes R4's brain gets twisted. R2 doesn't report to staff when R4 swears at her and calls her names because R4 had memory problems and that wouldn't' be nice of her to tell on R4. R2 denied any physical altercations between them and stated she felt safe. She didn't feel like R4 would hurt her, but didn't like the way she acted sometimes. When interviewed on 6/2/20, at 10:25 a.m. licensed practical nurse (LPN)-A stated she was across the hall on 5/25/20, when she heard R2 yell at R4 stop being mean to me. LPN-A went into the shared room and R4 had a scowl on her face. R2 reported R4 called her a [***] . R4 wouldn't leave the room so LPN-A pulled the divider curtain and turned on the music so R2 couldn't hear R4. R4 was swearing and LPN-A told her it was inappropriate. LPN-A stated she reported the situation to the registered nurse (RN) who was working. LPN-A stated R4 had a long history with having roommate problems. Previous roommates had to be moved to other rooms because R4 was verbally abusive. Those resident that moved no longer resided in the facility. R4 got very paranoid and frustrated and frequently accused people of taking things that she misplaced. There were no specific interventions developed to minimize R4's behaviors and prevent others from being verbally abused. Further, LPN-A stated she didn't believe R4 was suited to have any roommates. R2 had never stated she was afraid of R4, nor had she had any behavioral changes as a result of R4's behaviors. During interview on 6/2/20, at 10:35 a.m. NA-D stated R4 had a history of [REDACTED]. She was aware R4 would swear at and call her roommates names. It wasn't constant and most of 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** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) time she was really sweet. R2 had never stated she was afraid of R4. During interview on 6/2/20, at 11:18 a.m. FM-A stated in the beginning of May 2020, FM-A was on the phone with R2 when she heard a commotion in the room. R2 stated it was her roommate (R4) having another fit. FM-A stated it sounded scary. FM-A asked R2 how it made her feel and R2 told FM-A she was fine most of the time but sometimes it was scary because R4 was loud and would swear at R2 and call her names. FM-A asked R2 if she had every been hit by R4 and R2 told FM-A R4 had slapped her arm. R2 had not reported this to facility staff so FM-A contacted the facility and reported the incident to the facility licensed social worker (LSW)-A. R2 stated to FM-A she felt safe. Further, R2 had short term memory problems and would often forget details. FM-A stated R2 didn't deserve to be subjected to that type of behavior and R2 would likely just put up with it and not say anything, because that was the way R2 was. When interviewed on 6/2/20, at 11:48 a.m. RN-A stated she was aware R4 could be verbally abusive; however had not ever witnessed it. R2 had reported R4 had used foul language and made rude comments to R2. R4 had been this way on and off for years. They just try to redirect R4 when they see her acting out. R4's behaviors had not been assessed to identify interventions to prevent verbal abuse. During interview on 6/2/20, at 1:15 p.m. LSW-A stated R2's family had contacted her at the beginning of May 2020, with concerns between R2 and her roommate R4. LSW-A stated the family stated R4 was swearing and calling R2 names and R4 had also slapped R4 in the arm. LSW-A stated she went and asked R2 about the incident and R2 denied being hurt by R4 and felt safe, therefore she didn't do any further investigation into the situation. LSW-A stated R2 did have a [DIAGNOSES REDACTED]. Regarding the incident on 5/25/20, R2 was offered a room change and declined, R2 was told R4 could continue to have verbal altercations with her if she remained in the room. LSW-A was not aware of the progress note made the evening before on 6/1/20, identifying R2 stated she was afraid of her roommate and her roommate called her nasty names. No behavioral assessments were completed on R4 to implement interventions to attempt to decrease the verbal behaviors. Further there was no formal monitoring in place to ensure the behaviors were not continuing and R2 felt safe. During interview on 6/2/20, at 2:25 p.m. the director of nursing (DON) stated the facility was challenged to find a good roommate for R4 related to her verbal behaviors. R4 had a history of [REDACTED]. Before COVID-19 R4's son would visit and help alleviate some of the behaviors. The team discussed potentially moving R4's room, however R4 had been in that room for many years and it could lead to more behaviors to move her. Further, R4 needed to be near the nursing station as she was at risk for falls. R4's dementia had been advancing however, the behaviors had not been assessed and specific interventions initiated to prevent verbal abusive behavior. The facility Vulnerable Adults-Abuse Prevention Policy- Long Term Care policy dated 4/19, defined verbal abuse as the use of oral written, or gestured language that willfully included disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. Physical abuse was defined as the use of physical force that may result in bodily harm, physical pain or impairment. This includes, but is not limited to hitting, slapping, pinching and kicking. It also included controlling behavior through corporal punishment.
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 interview and document review the facility failed to report an allegation of resident to resident abuse to the State Agency (SA) for 1 of 1 residents (R2) reviewed who reported allegations of abuse by R4 to the facility. In addition, the facility failed to report an allegation of resident to resident abuse to the SA within 2 hours for 1 of 3 residents (R2) reviewed for timely reporting of abuse allegations. Findings include: R4's quarterly Minimum Data Set ((MDS) dated [DATE], identified R4 had moderate cognitive impairment and needed extensive assistance with transfers. R4 had physical behavioral symptoms directed toward others (e.g , hitting, kicking, pushing, scratching, grabbing, abusing others sexually and verbal behaviors that occurred one to three days, during the last seven days. R4 had verbal behavioral symptoms directed toward others (e.g threatening others, screaming at others, cursing at others) that occurred one to three days, during the last seven days. [DIAGNOSES REDACTED]. R4 was identified to be taking an antidepressant medication. R2's admission MDS dated [DATE], identified R2 was cognitively intact. R2 needed extensive assistance to transfer and had a [DIAGNOSES REDACTED]. R2 stated it was her roommate R4 having another fit. FM-A stated it sounded scary. FM-A asked R2 how it made her feel and R2 told FM-A she was fine most of the time but sometimes it was scary because R4 was loud and would swear at R2 and call her names. FM-A asked R2 if she had every been hit by R4 and R2 told FM-A R4 had slapped her arm. R2 had not reported this to facility staff so FM-A contacted the facility and reported the incident to the facility licensed social worker (LSW)-A. R2 stated to FM-A she felt safe. Further, R2 had short term memory problems and would often forget details. The facility had provided all investigated incidents within the last 30 days and the incident described by FM-A was not included in reports made to the SA. R2's social worker progress note dated 5/6/20, at 1:29 p.m. identified family was concerned about R2 and R4 interacting. R2 was observed showing concern for R4 and R2 stated she worried about R4 getting lost when out of the room. R2 stated she felt safe and was very firm she was safe. The writer inquired if R4 had done anything to hurt her and R2 stated no and I don't think she ever would. The writer identified R2 had a poor memory. Family reported R2 stated R4 was feisty. Staff would monitor for resident interaction. The note did not identify the family concern regarding verbal and physical abuse. During interview on 6/2/20, at 1:15 p.m. LSW-A stated R2's family had contacted her at the beginning of May 2020, with concerns between R2 and her roommate R4. LSW-A stated the family stated R4 was swearing and calling R2 names and R4 had also slapped R4 in the arm. LSW-A stated she went and asked R2 about the incident and R2 denied being hurt by R4 and felt safe, therefore she didn't report the allegation to the SA. LSW-A stated R2 did have a [DIAGNOSES REDACTED]. LATE REPORT A facility provided Incident Report dated 5/26/20, identified an allegation of emotional/mental abuse by R2. The report was submitted to the SA on 5/26/20, at 1:41 p.m. The date of the incident was identified to happen on 5/25/20, at 7:00 p.m. The incident description identified the reported had received a phone call from R2's FM-B. FM-B stated R2 reported R4 had called R2 names that day including fat [***] and many other names. R2's progress note dated 5/25/20, at 7:09 p.m. identified a family member called and stated R2 had been called ugly and a 'B'. family stated other mean things were said. The family would be calling social services in the morning. During interview on 6/2/20, at 11:48 a.m. registered nurse (RN)-A stated she was not working the evening of the incident. The RN's make vulnerable adult reports on behalf of the residents. If the incident involved physical abuse or injury then the report needed to be made immediately, but within two hours. All other allegations needed to be reported within 24 hours. RN-A stated the administrative team was notified of all allegations immediately after the residents safety was assured. During interview on 6/2/20, at 1:15 p.m. LSW-A stated she was aware the allegation that occurred on 5/25/20, was reported late. The report should have been submitted to the SA within two hours. Further the RN who was working was fairly new to the process and had been re-educated on the reporting process; however, all staff responsible for reporting to the SA had not been re-educated to ensure timely reports were made. When interviewed on 6/2/20, at 2:25 p.m. the director of nursing (DON) stated all allegations of abuse needed to be reported to the SA within two hours of of the allegation, to ensure resident safety and investigation of the incident. The facility Vulnerable Adults- Abuse Prevention Policy- Long Term Care dated 4/19, identified all alleged violations of abuse were to be reported to the administrator and SA immediately but no later than two hours.
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 interview and document review, the facility failed to ensure allegations of abuse were thoroughly investigated, and provide for immediate protection along with systemic correction to prevent further incidents for 2 of 3 residents (R1, R2) who reported allegations of abuse to the facility. Findings include: R1's quarterly Minimum (MDS) data set [DATE], identified R1 had intact cognition and required extensive assistance to transfer. A facility provided incident report dated 5/26/20, identified R1 had reported during their care conference that day he was handled roughly the previous week by a staff member assisting him to bed. R1 reported he cried out ouch, ouch while being transferred. R1 had stated this was a fill in nurse. Immediate action taken to protect R1 was identified: the charge nurse was notified of the incident and R1's arm was examined where R1 had expressed discomfort, there were no signs of bruising. R1's spouse stated the incident was not reported to them by R1. Staff would be educated on possible transfer skills for the resident. It did not identify what was put in place to protect the resident from further potential abuse while the investigation was pending. The investigative summary dated 5/29/20, identified the facility reviewed R1's care plan, progress notes and skin assessments, and all areas of the care plan and procedures were followed. The investigative summary identified R1 was dependent on staff

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) for mobility, had muscle weakness, diabetes and [MEDICAL CONDITION]. The care plan supported the need for transfer assistance with one to two staff and mechanical lift. Several nursing assistants (NA) identified R1 was not bearing weight consistently and had increased weakness. The new NA working with R1 was following the care plan and did attempt to transfer R1 which was uncomfortable for him. NA-A was educated by her partner on better transfer technique with transfers and would use the standing lift. There was no evidence of any injury. Action taken to prevent reoccurrence was identified as education was provided to NA-A and requested a physical therapy evaluation from R1's physician. There would be continuing education to the NA's to follow the plan of care. There was no harm to the resident. The summary identified the facility had spoken with five nursing assistants and one registered nurse. The summary did not identify observation of care was completed. The investigation notes containing staff interview and observations made during the investigation were requested and none were provided. R1's medical record lacked a re-assessment of transfer ability. R1's nursing assistant group sheeted dated 5/20/20, identified R1 was an assist of one with transfers with a transfer belt and to use the standing lift as needed (PRN). R1's care plan dated 5/27/20, identified R1 needed extensive assistance of one to two with a transfer belt and could use the standing lift PRN. The care plan did not address when a standing lift would be needed versus using one to two staff and a transfer belt would be needed. During interview on 6/2/20, at 9:39 a.m. R1 stated NA-A had grabbed him by the arm when transferring him to bed. NA-A stopped as soon as he told her it hurt. Further when NA-A was transferring him R1 stated he didn't like the way NA-A transferred him and it felt like NA-A was going to break his bones. The NA should have used a transfer belt or the lift. R1 stated he preferred the standing lift for getting in and out of bed; however, could transfer fine from the wheelchair to the toilet and back as long as the staff used the transfer belt. No one had been in to observe how he transferred and had not been screened by the therapist yet. During interview on 6/2/20, at 10:00 a.m. NA-B stated she was not aware of any changes to R1's care plan regarding transfer assistance. R1 transferred to the toilet with an assist of one and used the standing lift to help get him out of bed. She had not been observed transferring R1 or had any re-education on transfers with R1. During interview on 6/2/20, at 10:09 a.m. NA-C stated she had not had any re-education regarding transfers nor had anyone observed NA-C transfer R1 or any other residents. During interview on 6/2/20, at 10:35 a.m. NA-D stated R1 needed to use a standing lift to get in and out of bed but otherwise transferred well to and from the bathroom. NA-D was not re-educated on any new transfer procedures for R1. During interview on 6/2/20, at 11:48 a.m. RN-A stated she was aware of R1's allegation of rough transferring and stated it had been addressed. They were still waiting on the physician to sign the order for the therapy screen. RN-A stated R1's care plan was updated to now include one to two staff but a transfer assessment had not been completed along with observing the staff complete transfers to ensure they are transferring R1 safely. When interviewed on 6/2/20, at 1:15 p.m. licensed social worker (LSW)-A stated R1 had reported to her that the staff transferring him was new and there were no new people working the day they conducted the investigation so R1 was protected. When they figured out what nursing assistant transferred R1 they interviewed her and her preceptor as NA-A was still in training. NA-A told them how she transferred R1 and that the other aid in the room had re-educated her on a better way to transfer R1. No one had completed observations of transfers or re-educated NA-A or the other nursing assistants on the proper way to transfer. LSW-A stated she did not have the notes she took when interviewing the staff as she was not aware it was an expectation to keep all documentation on the investigation conducted to prove a though investigation was completed. LSW-A just spoke with the nursing assistants and had the nurse assess for injury to determine no abuse occurred. During interview on 6/2/20, at 1:56 p.m. NA-A stated she had only been working at the facility for a few weeks and was still in orientation. She was shown how to transfer R1 by another unidentified nursing assistant. They had shown her to grab the back of R1's pants and then hold on to R1's arm while transferring him. NA-A stated she didn't think that was right but it was what she was shown. She was transferring R1 with another nursing assistant observing and they told her she needed to use a transfer belt or use the standing lift. NA-A stated a nurse had not re-educated her on appropriate transferring of a resident; however, she was now using the transfer belt all the time and using the standing lift to transfer R1. R2's admission Minimum Data Set ((MDS) dated [DATE], identified R2 was cognitively intact. R2 needed extensive assistance to transfer and had a [DIAGNOSES REDACTED]. an allegation of emotional or mental abuse by R2's roommate R4 on 5/25/20. The report identified R2 reported to FM-B R4 had called R2 names including fat [***] . The action taken to protect the resident was identified as follows. R2 stated she was safe and smiled at the staff. Staff were made aware of the incident. R2's roommate needs physical assistance with mobility. Social services offered a room change. The investigation summary identified care plans and progress notes were reviewed. R2's care plan was updated to reflect R2's request for no room change or changes in situation. No changes to the policies were made. They would continue to offer R2 choices regarding her room. Further the summary identified R2 was physically dependent on staff for transfers and had a [DIAGNOSES REDACTED]. R2 had told family R4 had a really bad attitude but had denied being afraid of her roommate. Since admission R2 had interacted with R4 and had expressed concern regarding R4's well being. R2 was offered a room change and declined because she liked the view she had currently. R2 was informed R4 could continue with negative statements especially if she has a change in mood or condition. R2 stated she preferred to stay in her room. Family was updated on R2 wanting to stay in her room. A follow up visit was conducted on 5/29/20, and R2 denied any ongoing conflicts with R4. Action taken to prevent reoccurrence was identified to update R2's care plan to reflect a room change would be offered as appropriate. A change in rooms may be necessary if further altercations created an unsafe situation. Staff were to observe interactions and intervene by assisting either resident from the room as necessary. R2 denied any harm. The investigation lacked interviews with staff regarding behaviors potentially exhibited by R4 along with a lack of assessments into R4's behavior for frequency, causative factors or any interventions to decrease the behaviors towards R2. During interview on 6/2/20, at 10:17 a.m. R2 stated R4 had called her a [***] and stuff like that. R2 stated it bothered her when it occurred, but it wasn't R4's fault because sometimes R4's brain gets twisted. R2 doesn't report to staff when R4 swears at her and calls her names because R4 had memory problems and that wouldn ' t be nice of her to tell on her. R2 denied any physical altercations between them and stated she felt safe. She didn't feel like R4 would hurt her. During interview on 6/2/20, at 11:18 a.m. FM-A stated in the beginning of May 2020, FM-A was on the phone with R2 when she hear a commotion in the room. R2 stated it was her roommate R4 having another fit. FM-A stated it sounded scary. FM-A asked R2 how it made her feel and R2 told FM-A she was fine most of the time but sometimes it was scary because R4 was loud and would swear at R2 and call her names. FM-A asked R2 if she had every been hit by R4 and R2 told FM-A R4 had slapped her arm. R2 had not reported this to facility staff so FM-A contacted the facility and reported the incident to the facility licensed social worker (LSW)-A. R2 stated to FM-A she felt safe. Further, R2 had short term memory problems and would often forget details. During interview on 6/2/20, at 1:15 p.m. LSW-A stated R2's family had contacted her at the beginning of May 2020, with concerns between R2 and her roommate R4. LSW-A stated the family stated R4 was swearing and calling R2 names and R4 had also slapped R4 in the arm. LSW-A stated she went and asked R2 about the incident and R2 denied being hurt by R4 and felt safe, therefore she didn't do any further investigation into the situation. LSW-A stated R2 did have a [DIAGNOSES REDACTED]. Regarding the incident on 5/25/20, R2 was offered a room change and declined, R2 was told R4 could continue to have verbal altercations with her if she remained in the room. No behavioral assessment were completed on R4 to implement interventions to attempt to decrease the verbal behaviors. R4's quarterly MDS dated [DATE], identified R4 had moderate cognitive impairment and needed extensive assistance with transfers. R4 had physical behavioral symptoms directed toward others (e.g , hitting, kicking, pushing, scratching, grabbing, abusing others sexually and verbal behaviors that occurred one to three days, during the last seven days. R4 had verbal behavioral symptoms directed toward others (e.g threatening others, screaming at others, cursing at others) that occurred one to three days, during the last seven days. [DIAGNOSES REDACTED]. R4 was identified to be taking an antidepressant medication. R4's medical record lacked any assessment on verbal or physical behaviors. R4's care plan last revised 6/5/20, did not identify any history of verbal abuse, nor did it identify any specific interventions in attempt to deter the behaviors and protect other residents. The facility Vulnerable Adults-Abuse Prevention Policy- Long Term Care dated 4/19, identified an internal investigation would be completed for allegations of abuse. The investigations would include the residents and staff involved and staff and other witnesses. The residents medical record, all circumstances and incident reports would also be included in the investigation. The completed written internal investigation would be maintained by the facility. Upon immediate identification of suspected abuse the facility would provide for the immediate safety of the resident which could in include but not limited to moving the resident, providing 1:1 monitoring, suspend employees, implement discharge process if warranted and ongoing social service involvement.