STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Cove Post Acute	1730 Grand Ave Long Beach, CA 90804

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 0565

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to organize and participate in resident/family groups in the facility.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44958

Based on interview and record review, the facility failed to uphold residents ' rights. The facility failed to :

a.Address and ensure the concerns of the resident council (group of residents who meet to discuss and advocate for improvements in care and quality of life at the facility) which were stated during the meetings held on 1/7/2025 and 2/10/2025 regarding delayed call lights response time occurring during the 11pm-7am shift.

b. Ensure the Director of Staff Development (DSD) provided appropriate oversight to staff during the 11pm-7am shift as indicated in the facility job description Director of Staff Development.

This deficient practice resulted in residents rights , including dignity not being upheld and placed residents at risk for a delay in care and services.

Findings:

a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and traumatic partial amputation (loss of foot due to injury or accident) of right foot.

During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 1's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 1 had the ability to understand and be understood by others.

During an interview on 2/10/2024 at 9:30 a.m., Resident 1 stated the staffing during the 11pm- 7am shift is very short. Resident 1 stated during the 11pm-7am shift it takes the facility staff forever for someone to come to your room when you call.

Resident 1 stated the delayed call light response has been brought up during resident council meetings but the facility has not improved the delayed call light response time.

(continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Resident Council Agenda Minutes, dated 1/7/2025, the Resident Council Agenda Minutes indicated residents have concerns with the 11pm-7am shift not answering call lights in a timely manner. During a review of the facility ' s Resident Council Agenda Minutes, dated 2/10/2025, the Resident Council Agenda Minutes indicated residents stated Certified Nurse Assistants (CNAs) have poor customer service, resident also have a concern with call light response during the 11pm-7am shift. During an interview on 2/11/2024, at 12:38 p.m., the Activities Director (AD) stated she was aware of the resident councils ' concerns discussed during the 1/7/2025 and 2/10/2025 meetings. The AD stated, the residents stated during the meetings that the call lights are not being answered in timely manner. The AD stated she mentioned the resident councils ' concerns in daily meetings with the department heads but she is not sure what the plan is to address the residents' concerns about staff not responding to their call lights during the 11 pm.-7 am shift. During a concurrent interview and record review on 2/11/2025, at 12:45 p.m., with the AD, the Resident Council Minutes dated 1/7/2025 and 2/10/2025 were reviewed. The minutes did not indicate an explanation and or response action taken by department to resolve issues identified. The AD stated there should be a plan written down to address the residents ' specific concerns. The AD stated failure to write down the resident council ' s concerns in the resident council minutes can lead to lack of follow through by the facility leading to residents ' rights and needs not being upheld. b. During an interview on 2/11/2024, at 2 p.m., the Director of Staff Development (DSD) 2 stated she was aware that residents have voiced concerns regarding delays in call light response time during the 11pm-7am shift. DSD 2 stated on 1/31/2025, she arrived at the facility around 2:30 a.m, to work on paper work in her office. DSD 2 stated she did not check in with the staff upon arriving to the facility and instead went straight into her office without conducting rounds. DSD 2 stated after she left her office around 6 am, staff informed her that the facility was short staffed during the 11pm-7am. DSD 2 stated she did not check in with the 11pm -7 am shift prior to completing her paperwork in her office because she did not think it was part of her responsibility as a DSD. During an interview on 2/12/2024, at 2 p.m., the Assistant Director of Nursing (ADON) stated it is residents ' rights for the facility to addressthe resident council concerns and to ensure resident ' s call lights are answered timely. The ADON stated it is the role of the department heads including the DSD to check on nursing staff whenever they are in the facility. The ADON stated, the DSD is directly responsible for providing oversight to the CNAs and the DSD should be available to assist the staff while she was at the facility. The ADON stated, failure to respond to call lights in a timely manner does not uphold residents ' rights and residents ' dignity. The ADON stated it places residents at risk for a decline in mental and physical health due to the delayed care and services. During an interview on 2/12/2024, at 2:30 p.m., the Administrator (ADM) stated the facility is aware of the shortage of staff that occurs during the 11pm -7am shift and the delay in call light response time . The ADM stated the resident council meeting minutes document should clearly outline the actions that will be implemented to address the residents ' concerns. The ADM stated all department heads must conduct rounds when they are onsite at the facility. The ADMIN stated it is the role of the DSD to provide direct oversight to the CNAs and to ensure residents are receiving quality of care. The ADM stated if the DSD has further concerns regarding CNAs, she will relay the issues to the ADM and the DON. (continued on next page)

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled, Resident ' s Rights, Quality of Life revised 3/2017, the P/P indicated each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individually and receives in a person-centered manner, as well as those that support the resident in attaining or maintaining his or her highest practicable well-being. During a review of the facility's P/P titled, Resident Council revised 11/1/2013, the P/P indicated if the council raises an issue of concern, the department responsible for the issue or service is responsible for addressing the items of concerns. The P/P indicated a resident council response form is utilized to track issues and their resolution. The P/P indicated the ADM reviews the minutes and any responses from departments, responses are presented at the next meeting or sooner if indicated. During a review of the facility's job description titled Director of Staff Development (DSD) undated, the job description indicated the following : DSD reports to the Administrator and under the direction and supervision of the Administrator and through consultation and cooperation with he Director of Nursing (DON), the DSD is responsible for planning, implementing , direction and evaluation of the facility ' s educational programs for employees and quality assurance and improvement in the facility. The job description indicates the DSD will make daily rounds to ensure residents are receiving appropriate nursing care such having call lights answered promptly and or kept within reach at all times. The job description further indicates the DSD will make monthly schedule and daily assignments for CNAs, meet with personnel as appropriate to assist in identifying and correcting all problem areas and or improvement of services, counsel nursing assistants as needed under supervision of Administrator and DON.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure residents rights were maintained for one of three sampled residents (Resident 1), when the facility failed to notify Resident 1 ' s physician regarding a change of condition. On 12/3/2024, the Minimum Data Set (MDS) nurse witnessed Resident 1 holding Resident 2 hands away from him (Resident 1) and was informed by Resident 1 that Resident 1 was attempting to protect himself from being hit by Resident 2. This deficient practice resulted in Resident 1 ' s physician being unaware of the altercation between Resident 1 and Resident 2, causing a delay in needed assessments and services for Resident 1. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and traumatic partial amputation (loss of foot due to injury or accident) of right foot. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 1's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 1 had the ability to understand and be understood by others. During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnosse including type 2 diabetes, metabolic encephalopathy (brain dysfunction that occurs due to an imbalance of chemicals in the blood) and altered mental status (range of symptoms that can affect how well the brain is working). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 12/11/2024, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 2 was sometimes understood by others and sometimes had the ability to understand others. During a review of Resident 2's Change of Condition (COC) Evaluation document (a form of communication between members of a health care team), dated 12/3/2024 at 4:21 p.m., the COC indicated Resident 2 demonstrated a change in condition related to behavioral symptoms. The COC indicated Resident 2 was walking in the hallway and noted attempting to strike out at peers. The note was written by Registered Nurse (RN) 1. During a phone interview on 2/10/2024 at 8:30 a.m., the ombudsman (advocate for residents of nursing homes and other long-term care facilities) stated during her recent visit to the facility on [DATE], Resident 1 reported to her that Resident 2 attempted to hit him. The ombudsman stated she immediately notified the Administrator of the incident. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2024 at 9:30 a.m., Resident 1 stated Resident 2 tried to hit him a few months ago. Resident 1 stated, he was sitting in his wheelchair outside his room, in the doorway, when Resident 2 came up to him and started swinging his arms. Resident 1 stated, he grabbed Resident 2's arms, one in each of his hands to prevent Resident 2 from hitting him. Resident 1 stated, the MDS nurse witnessed the incident and came to take Resident 2 away. Resident 1 stated, no one came to check on him to make sure he was okay. Resident 1 stated he did not think anything was done about the incident. Resident 1 stated he still sees Resident 2 walking down the hallway and feesl like he (Resident 2) might try to hit him (Resident 1) again. During an interview on 2/10/2024 at 1:35 p.m., The MDS nurse stated sometime in December 2024, while she was in her office across from Resident 1 ' s room she heard Resident 1 yelling. The MDS nurse stated, she came out of her office to see Resident 1 in his wheelchair holding Resident 2 ' s hands. MDS nurse stated Resident 1 informed her that Resident 2 was trying to hit him. The MDS nurse stated, she redirected Resident 2 and separated Resident 2 from Resident 1. The MDS nurse stated Resident 2 could not state why his hands were being held by Resident 1. The MDS nurse stated she immediately reported what she witnessed to RN 1. The MDS nurse stated she thought RN 1 would report the incident to the Administrator, who is the abuse the coordinator and also report it to the proper agencies. During an interview on 2/10/2024 at 3:15 p.m., RN 1 stated sometime in December 2024, she recalled the MDS nurse informing her of an incident regarding Resident 1 and Resident 2. RN 1 stated she did not report the incident because she did not think it was considered abuse because neither resident was hurt. RN 1 stated she did not notify the administrator nor Resident 1 ' s physician. RN 1 stated she made a mistake and should have notified Resident 1 ' s physician of the incident. RN 1 stated, Resident 1 may have needed additional assessments and services which where not provided. During an interview on 2/12/2024 at 10:15 a.m., the Assistant Director of Nursing (ADON) stated all allegations, unusual occurrences and suspected abuse incidents should be reported the Administrator, the police, ombudsman, CDPH and the Resident's physician. The ADON stated failure to notify Resident 1 ' s physician about the incident caused a delay and or lack of needed services to Resident 1 such as behavioral health monitoring. RN 1 stated she placed Resident 1 at risk for decline in mental and physical health. During a review of the facility's policy and procedure (P/P) titled, Change of Condition notification revised 4/1/2015, the P/P indicated the facility will promptly inform the resident, consult with the resident ' s attending physician and notify the resident ' s legal representative or interested family member if known when the resident ensures a significant change in their condition caused by but not limited to an accident, a significant change in the resident ' s mental, physical, mental or psychosocial status. A change of condition related to Attending physician notified is defined as the attending physician must be notified when a sudden and marked adverse change in the resident ' s condition is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment , coordination and consultation with the attending physician and change in the treatment plan.

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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	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** 44958 Based on interview and record review, the facility failed to report a physical altercation between two of three sampled residents (Resident 1 and Resident 2), to the California Department of Public Health (CDPH), within two hours of the incident. On 12/3/2024, the Minimum Data Set (MDS a resident assessment tool) nurse witnessed Resident 1 holding Resident 2 hands away from him (Resident 1) and was informed by Resident 1 that Resident 1 was attempting to protect himself from being hit by Resident 2. The facility reported the incident on 2/6/2025 (65 days after the incident occurred). This deficient practice resulted in CDPH being unaware of the abuse incident and injury to Resident 1 and had the potential for a delay in CDPH ' s investigation and other abuse allegations to go unreported. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and traumatic partial amputation (loss of foot due to injury or accident) of right foot. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 1 had the ability to understand and be understood by others. During a review of Resident 2's Face sheet, the Face sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, metabolic encephalopathy (brain dysfunction that occurs due to an imbalance of chemicals in the blood) and altered mental status (range of symptoms that can affect how well the brain is working). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 2 was sometimes understood by others and sometimes had the ability to understand others. During a review of Resident 2's Change of Condition (COC) Evaluation document (a form of communication between members of a health care team), dated 12/3/2024 at 4:21 p.m., the COC indicated Resident 2 demonstrated a change in condition related to behavioral symptoms. The COC indicated Resident 2 was walking in the hallway and noted attempting to strike out to peers. The note was written by Registered Nurse (RN) 1. During a phone interview on 2/10/2024 at 8:30 a.m., the ombudsman (advocate for residents of nursing homes and other long-term care facilities) stated during her recent visit to the facility on [DATE], Resident 1 reported to her that Resident 2 attempted to hit him. The ombudsman stated she immediately notified the Administrator of the incident. (continued on next page)

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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	During an interview on 2/10/2024 at 9:30 a.m., Resident 1 stated Resident 2 tried to hit him a few months ago. Resident 1 stated, he was sitting in his wheelchair outside his room, in the doorway, when Resident 2 came up to him and started swinging his arms. Resident 1 stated, he grabbed Resident 2's arms, one in each of his hands to prevent Resident 2 from hitting him. Resident 1 stated, the MDS nurse witnessed the incident and came to take Resident 2 away. Resident 1 stated, no one came to check on him to make sure he was okay. Resident 1 stated he did not think anything was done about the incident. Resident 1 stated he still sees Resident 2 walking down the hallway and feesl like he (Resident 2) might try to hit him (Resident 1) again. During an interview on 2/10/2024 at 1:35 p.m., The MDS nurse stated sometime in December 2024, while she was in her office across from Resident 1 ' s room she heard Resident 1 yelling. The MDS nurse stated, she came out of her office to see Resident 1 in his wheelchair holding Resident 2 ' s hands. MDS nurse stated Resident 1 informed her that Resident 2 was trying to hit him. The MDS nurse stated, she redirected Resident 2 and separated Resident 2 from Resident 1. The MDS nurse stated Resident 2 could not state why his hands were being held by Resident 1. The MDS nurse stated she immediately reported what she witnessed to RN 1. The MDS nurse stated she thought RN 1 would report the incident to the Administrator, who is the abuse the coordinator and also report it to the proper agencies During an interview on 2/10/2024 at 3:15 p.m., RN 1 stated sometime in December 2024, she recalled the MDS nurse informing her of an incident regarding Resident 1 and Resident 2. RN 1 stated she did not report the incident because she did not think it was considered abuse because neither resident was hurt. RN 1 did not notify the administrator, nor police, ombudsman or CDPH. RN 1 stated she made a mistake and should have reported all alleged and suspected cases of abuse. RN 1 stated she placed Resident 1 at risk for further abuse and harm from Resident 2. RN 1 stated, Resident 1 may have needed additional assessments and services which where not provided. During an interview on 2/12/2024 at 10:15 a.m., the Assistant Director of Nursing (ADON) stated all allegations, unusual occurrences and suspected abuse incidents should be reported to the Administrator, the police, ombudsman and CDPH. The ADON stated failure to report abuse placed Resident 1 at risk for further instances of abuse and caused a delay and or lack of needed services to Resident 1 such as behavioral health monitoring. The ADON stated failure to report abuse can cause a delay in the investigation by CDPH and is a violation of the federal regulations. The ADON stated the MDS nurse could have also reported the incident to the administrator who is the abuse coordinator. During an interview on 2/12/2024 at 3 p.m., the Administrator stated he was not aware of the incident of between Resident 1 and Resident 2 until it was reported to him by the ombudsman on 2/6/2025 which was when he reported the incident to CDPH. The Administrator stated the facility was in violation of their policy and Federal regulations for not reporting the alleged incident of abuse between Resident 1 and Resident 2 within two hours. During a review of the facility's policy and procedure (P/P) titled, Abuse Prevention and Management revised 5/30/2024, the P/P indicated to address the health, safety, welfare, dignity and respect of residents, reports of resident abuse, mistreatment, neglect, exploitation, injuries of unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. The P/P further indicates the administrator, or designated representative will notify law enforcement by telephone immediately or as soon as practicably possible, but no longer than two hours of initial report and send a written SOC 341 report to the ombudsman, law enforcement and CDPH licensing and certification within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P/P titled, Unusual Occurrence Reporting, revised 5/30/2024, the P/P indicated the facility reports the following events by phone and in writing to the appropriate State or Federal agencies: allegation of abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to ensure a resident centered comprehensive care plan was developed for one of three sampled residents (Resident 1) when on 12/3/2024, the Minimum Data Set (MDS) nurse witnessed Resident 1 holding Resident 2 hands and was informed by Resident 1 that Resident 1 was attempting to protect himself from being hit by Resident 2. These deficient practices resulted in a delay and care and services for Resident 1 placing Resident 1 at risk for decline in mental and psychosocial well-being. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and traumatic partial amputation (loss of foot due to injury or accident) of right foot. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 1's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 1 had the ability to understand and be understood by others. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, metabolic encephalopathy (brain dysfunction that occurs due to an imbalance of chemicals in the blood) and altered mental status (range of symptoms that can affect how well the brain is working). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 2 was sometimes understood by others and sometimes had the ability to understand others. During a review of Resident 2's Change of Condition (COC) Evaluation document (a form of communication between members of a health care team), dated 12/3/2024 at 4:21 p.m., the COC Resident 2 demonstrated a change in condition related to behavioral symptoms. The COC indicated Resident 2 was walking in the hallway and noted attempting to strike out to peers. The note was written by Registered Nurse (RN) 1. During an interview on 2/10/2024 at 9:30 a.m., Resident 1 stated Resident 2 tried to hit him a few months ago. Resident 1 stated, he was sitting in his wheelchair outside his room, in the doorway, when Resident 2 came up to him and started swinging his arms. Resident 1 stated, he grabbed Resident 2's arms, one in each of his hands to prevent Resident 2 from hitting him. Resident 1 stated, the MDS nurse witnessed the incident and came to take Resident 2 away. Resident 1 stated, no one came to check on him to make sure he was okay. Resident 1 stated he did not think anything was done about the incident. Resident 1 stated he still sees Resident 2 walking down the hallway and feesl like he (Resident 2) might try to hit him (Resident 1) again. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2024 at 1:35 p.m., The MDS nurse stated sometime in December 2024, while she was in her office across from Resident 1 ' s room she heard Resident 1 yelling. The MDS nurse stated, she came out of her office to see Resident 1 in his wheelchair holding Resident 2 ' s hands. MDS nurse stated Resident 1 informed her that Resident 2 was trying to hit him. The MDS nurse stated, she redirected Resident 2 and separated Resident 2 from Resident 1. The MDS nurse stated Resident 2 could not state why his hands were being held by Resident 1. The MDS nurse stated she immediately reported what she witnessed to RN 1. The MDS nurse stated she thought RN 1 would report the incident to the Administrator, who is the abuse the coordinator and also report it to the proper agencies. but did not complete any further documentation. The MDS nurse stated Resident 1 and Resident 2 were at risk for further altercations and decline in mental and psychosocial well-being due to the altercation. The MDS nurse stated she should have created a careplan for Resident 1 and there should have been an Interdisciplinary (IDT-team of healthcare professional who work together to meet resident ' s healthcare goals) team meeting) involving Resident 1 held to address his concerns regarding the incident and to develop a plan of care. During an interview on 2/12/2024 at 10:15 a.m., the Assistant Director of Nursing (ADON) stated Resident 1 should have had an IDT and a comprehensive centered care plan developed to address his concerns and needs related to the incident that occurred on 12/3/2024. The ADON stated failing to address the incident and failing to develope a plan of care for Resident 1 places Resident 1 at risk for increased anxiety related to safety concerns, decline in mental health and distrust in the facility and other residents. During a review of the facility's policy and procedure (P/P) titled, Comprehensive Person-Centered Care Planning revised 8/24/2023, the P/P indicated the facility will provide person-centered, comprehensive and interdisciplinary care that reflects best practices for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being. The P/P indicated the comprehensive care plan will be reviewed and revised at the following times: onset of new problems, change of condition, changes in behavior and care and other times as appropriate or necessary. The P/P further indicated the facility must provide the resident and representative if applicable reasonable notice of care planning conferences to enable resident and representative of care planning conference to enable resident and resident representative participation.