

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	

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	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111</p> <p>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 1), who was cognitively impaired and dependent on staff for care, was free from abuse when certified nursing assistant (CNA) 2 called the resident an ass then smacked the side of his head with an open hand while telling the resident, That's for hitting me last week.</p> <p>As a result, Resident 1 became agitated and attempted to hit staff back. In addition, Resident 1 had seemed guarded following the incident, per staff interview. This deficient practice had the potential to cause Resident 1 to experience fear, humiliation, and emotional distress.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, dated 7/26/24, indicated the resident was admitted to the facility on [DATE] with diagnoses to include Parkinsonism (condition characterized by balance issues and tremors), unspecified psychosis (thoughts not based in reality), and dementia (condition characterized by impaired memory and judgement) with behavioral disturbance.</p> <p>A review of Resident 1's annual History and Physical, dated 4/10/24 indicated, the resident, Does not have the capacity to understand and make decisions.</p> <p>On 7/26/24, the California Department of Public Health (CDPH, state agency that licenses and certifies skilled nursing facilities) received a SOC 341 report (document used to report suspected abuse) dated 7/26/24, from the facility. The facility's SOC 341 document indicated, the facility was reporting an incident of suspected physical abuse perpetrated by CNA 2 against Resident 1 and that the incident had been witnessed by a student certified nursing assistant (SCNA).</p> <p>(continued on next page)</p>

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: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/30/24 at 10:29 A.M., a telephone interview was conducted with SCNA. SCNA stated on 7/26/24 she went to help CNA 2 and CNA 3 give Resident 1 a shower. SCNA stated she, along with CNA 2 and CNA 3, were inside the shower room with Resident 1. SCNA stated they transferred Resident 1 from his wheelchair into the shower chair. SCNA stated Resident 1 was calm and cooperative at that time. SCNA stated CNA 2 was not talking nicely about the resident and had told her Resident 1 always fights and tries to hit staff and, He's an ass. SCNA stated CNA 2 then smacked Resident 1 with an open hand on the side of his head while stating, That's for hitting me last week. SCNA stated Resident 1 became agitated, had an angry expression on his face, and raised both hands in a motion to hit CNA 3 who stood directly in front of him. SCNA stated CNA 2 had been standing off to the side and was not standing in the resident's line of sight. SCNA stated CNA 2 left the shower room and that she remained behind with CNA 3 to help shower the resident. SCNA stated CNA 3 had to calm Resident 1 back down by rubbing his back. SCNA stated, It didn't feel right . [CNA 2] wasn't treating [Resident 1] like a human . SCNA stated what she saw was abusive. SCNA stated Resident 1, Seemed too confused to report such an incident himself. SCNA stated she reported the incident immediately to her CNA instructor.</p> <p>On 8/1/24 at 9:55 A.M., an onsite visit and interview with the administrator (ADM) was conducted to investigate the facility reported allegation of abuse.</p> <p>The ADM stated she had finished her investigation of the 7/26/24 incident with Resident 1 and CNA 2 and provided a copy of the results of the investigation. The ADM stated she had substantiated SCNA's report of the incident, and that CNA 2 had acted inappropriately. The ADM stated CNA 2 had been terminated and that CNA 3 had also been terminated for failing to come forward about what occurred with Resident 1 on 7/26/24. The ADM stated CNA 2 had been hit by Resident 1 a couple of weeks ago and a facility incident report for work-related injuries was filed.</p> <p>A review of the facility's document titled [facility name] Confidential Abuse Investigation dated 7/30/24, and completed by the director of staff development (DSD) and ADM, indicated, .Interviews .[SCNA] was advised [by CNA 2] to be careful as [Resident 1] tends to be combative and hit staff during care . [CNA 2] tapped the side of [Resident 1's] head and said, ' That's for punching me.' . [CNA 2] denied tapping [Resident 1] on the head or making the comment .Findings: Although [CNA 2's] alleged actions likely stemmed from immaturity without intent to harm, the action is demeaning towards an elderly resident who lacks the capacity to make decisions and is not representative of [Facility]. [CNA 2's] employment with [facility] has been terminated. In addition, after much thought and consideration, decision was made to terminate [CNA 3] as well</p> <p>On 8/1/24 at 10:43 A.M., a telephone call was placed to CNA 3. CNA 3 did not respond or return the phone call.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 11:40 A.M., a joint interview and record review was conducted with the DSD. The DSD stated she conducted the facility's abuse prevention and dementia training. The DSD provided CNA 2 and CNA 3's training records for review and stated they were both trained on abuse prevention and dementia care. The DSD stated her staff training had included scenarios of joking around or horseplay and tapping or smacking a resident as not acceptable or appropriate behavior and such things were considered abuse. The DSD stated based on the abuse training provided by the facility, CNA 2 would have known her behavior was wrong. The DSD stated she interviewed CNA 3 about what had happened during Resident 1's shower and CNA 3 had put her head down and claimed to have not seen or heard anything on 7/26/24 during Resident 1's shower. The DSD stated this was not believable and, There's no way she didn't hear or see what happened. The DSD stated CNA 3's employment had been terminated because she would not tell the truth about what had happened. The DSD stated CNA 2 and CNA 3 were, Really good friends.</p> <p>The DSD reviewed the facility document titled Employee Incident Report dated 7/8/24, for CNA 2, which indicated, . I [CNA 2] was taking [Resident 1's] brief off. While I was bent over [Resident 1] closed fist, punched me in my face right side under eye The document listed CNA 3 and CNA 4 as a witness to the incident. The DSD further stated the SCNA started clinical training at the facility on 7/23/24 and would not have had knowledge of CNA 2 being hit by Resident 1 on 7/8/24 unless that was indeed what CNA 2 had said in the shower room on 7/26/24.</p> <p>On 8/1/24 at 12:14 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 was very confused and would sometimes try to hit or kick when he was touched during care. CNA 4 stated she had not been hit by the resident because she dodged it, or would attempt care later if the resident was agitated. CNA 4 stated she did not take Resident 1's behavior personally, because he did not understand what he was doing. CNA 4 stated on 7/8/24, she was helping CNA 2 and CNA 3 with Resident 1 when she heard a smack sound and CNA 2 said, My eye. CNA 4 stated she did not see the physical contact but that CNA 2's eye had a red mark and CNA 2 had to put ice on it.</p> <p>CNA 4 further stated discussing a resident's behavior, even if they were confused, should be done privately and not in front of the resident. CNA 4 stated it was never okay to use improper language with a resident or to smack a resident's head. CNA 4 stated she received abuse prevention training at the facility and according to her training, calling a resident an ass and smacking them on the head would be considered physical and verbal abuse. CNA 4 stated a cognitively intact person would feel bad about being treated like that.</p> <p>On 8/1/24 at 12:46 P.M., an interview was conducted with CNA 5. CNA 5 stated she knew Resident 1 well and had provided care to him since his admission to the facility. CNA 5 stated she heard Resident 1 would hit staff, but she had not seen or experienced that from the resident. CNA 5 stated Resident 1 had memory issues and was confused. The reported incident on 7/26/24 was discussed with CNA 5. CNA 5 stated she believed in the moment things were taking place, Resident 1 would have been able to understand that he was being discussed and was called an ass. CNA 5 stated Resident 1 would probably get agitated in that situation and start mumbling. CNA 5 stated Resident 1 was a military veteran and if he was smacked on the head, he could get triggered and would probably try to defend himself. CNA 5 became tearful and stated she was upset to have heard what had been reported to have happened to Resident 1 on 7/26/24 during care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA 5 stated when she worked on 7/29/24, after having had time off, Resident 1 seemed, Guarded, hesitant to accept care, and more agitated than usual. CNA 5 further stated she had not been aware of the report that Resident 1 had been called an ass and smacked on the head a few days prior to returning to work. CNA 5 stated she had not understood at that time why Resident 1 had acted different on her first day back to work. CNA 5 wiped the tears from her eyes and stated, This is abuse, picking on someone who can't defend themselves or report what happened. CNA 5 stated as a reasonable person, if she experienced what Resident 1 had, she would feel upset and want to defend herself, too.</p> <p>On 8/1/24 at 12:37 P.M., an observation was conducted of Resident 1 while inside the resident's room. Resident 1 was in bed with the blanket pulled up to his chin. Resident 1 had his eyes closed and did not respond to interview attempt. Resident did not have any observable facial/head injuries.</p> <p>On 8/1/24 at 1:19 P.M., an interview was conducted with licensed nurse (LN) 6. LN 6 stated Resident 1 was severely cognitively impaired and depended on staff to provide care. LN 6 stated Resident 1 could not walk and that it took two to three staff to safely move him between locations. LN 6 stated she heard Resident 1 could hit staff, but she had not seen it or experienced it herself. LN 6 stated she was off on 7/26/24. What was reported to have occurred on 7/26/24 between Resident 1 and CNA 2, was discussed with LN 6. LN 6 stated it was unacceptable to discuss a resident's behavior in front of the resident, even if they were confused. LN 6 stated the facility had provided training related to abuse. LN 6 stated based on her facility training, being called an ass and smacked on the head was physical and emotional abuse. LN 6 further stated it was abuse even if the resident was confused, not hit hard, or the staff thought it was a joke. LN 6 stated Resident 1 was vulnerable and was not capable of telling anyone what had occurred on 7/26/24. LN 6 stated if what happened to Resident 1 had happened to her, she would feel, Hurt, upset, and emotionally distressed.</p> <p>On 8/1/24 at 2:05 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated Resident 1 was cognitively impaired, had poor recall, and responded in a non-verbal way with mumbling that could not be understood. The ADON stated she was aware of the reported incident on 7/26/24 with CNA 2 and Resident 1. The ADON stated she had received facility training related to abuse. The ADON stated based on her training, what had occurred to Resident 1 was abuse. The ADON stated it was still considered abuse even though Resident 1 was confused and had memory issues. The ADON stated if it had happened to her, I'd feel bad.</p> <p>On 8/1/24 at 2:45 P.M., a telephone interview was conducted with CNA 2. CNA 2 stated she helped CNA 3 transfer Resident 1 from his wheelchair into the shower chair while in the shower room on 7/26/24. CNA 2 stated she had been assigned two student CNAs to follow her that day and she had not worked with them before. CNA 2 stated she had asked one of them if she wanted to observe the resident's shower care. CNA 2 stated Resident 1 had been agitated, grabbed onto the shower handrail, and would not let go, and had been trying to bite CNA 3. CNA 2 stated she told the student that Resident 1 was combative and to watch out because he hits. CNA 2 stated that was all that she said about Resident 1. CNA 2 was asked if the resident's behavior should have been discussed in front of the resident. CNA 2 stated, It should be done privately but [Resident 1's] AOx1 [only had awareness to self] and can't understand so I thought it was a good time to tell her [SCNA]. CNA 2 stated she pushed Resident 1's shoulders back when he tried to bite CNA 3 but did not touch the resident anywhere else. CNA 2 denied smacking Resident 1's head or calling the resident an ass. CNA 2 was asked how the student CNA would have known that she had been hit by Resident 1 previously. CNA 2 stated, Oh, well, I told her that he [Resident 1] punched me then, too.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/2/24 at 1:15 P.M., an interview was conducted with the administrator (ADM). The director of nursing was also present. The ADM was asked if what happened to Resident 1 on 7/26/24 was abuse. The ADM stated the incident on 7/26/24 between Resident 1 and CNA 2 was an inappropriate interaction that she attributed to CNA 2's age and immaturity. The ADM stated the incident was substantiated and CNA 2 and CNA 3's employment had been terminated as a result.</p> <p>A review of the facility's policy titled Abuse: Prevention of and Prohibition Against, dated 11/2017, indicated, It is the policy of this facility that each resident has the right to be free from abuse . exploitation and mistreatment The policy defined abuse as .willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation . Mistreatment means inappropriate treatment . of a resident . Physical abuse includes but is not limited to hitting, slapping . Verbal abuse includes the use of oral .language that willfully includes disparaging and derogatory terms to residents . regardless of their age, ability to comprehend, or disability</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111</p> <p>Based on interview and record review, the facility failed to implement one resident's (Resident 1) written care plans related to behavior as evidenced by angry outbursts after the resident hit a staff member during care.</p> <p>As a result of this deficient practice, Resident 1's behavior was not documented in the resident's clinical record and it was not reported to the physician as indicated in the resident's written care plans. This had the potential for the resident's behavior to go unmanaged.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, dated 7/26/24, indicated the resident was admitted to the facility on [DATE] with diagnoses to include Parkinsonism (condition characterized by balance issues and tremors), unspecified psychosis (thoughts not based in reality), and dementia (condition characterized by impaired memory and judgement) with behavioral disturbance.</p> <p>A review of Resident 1's written behavior care plan for angry outbursts and the potential to physically harm self and staff, dated 4/27/22, indicated, .Interventions .Monitor/document/report to MD [medical doctor] of danger to self and others</p> <p>A review of Resident 1's written care plan for the use of a psychotropic medication (drugs used to control thoughts, behavior and/or mood) for behavior management of Parkinson's Disease related psychosis as evidenced by angry outbursts dated 2/8/22, indicated, .Interventions . Monitor/record occurrence of for targeted behavioral symptoms and document</p> <p>A review of the facility document titled Employee Incident Report dated 7/8/24, for certified nursing assistant (CNA) 2, indicated, .Time of incident 12:55 P.M.I [CNA 2] was taking [Resident 1's] brief off. While I was bent over [Resident 1] closed fist, punched me in my face right side under eye The document listed CNA 4 as a witness to the incident.</p> <p>On 8/1/24 at 12:14 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 was very confused and would sometimes try to hit or kick when he was touched during care. CNA 4 stated she had not been hit by the resident because she dodged it, or would attempt care later if the resident was agitated. CNA 4 stated she did not take Resident 1's behavior personally, because he did not understand what he was doing. CNA 4 stated on 7/8/24, she was helping CNA 2 and CNA 3 with Resident 1 when she heard a smack sound and CNA 2 said, my eye. CNA 4 stated she did not see the physical contact but that CNA 2's eye had a red mark and CNA 2 had to put ice on it.</p> <p>A review of Resident 1's medication administration record (MAR) for July 2024, indicated the resident was being monitored every shift for number of episodes of target behavior angry outbursts. The MAR indicated Resident 1 had zero angry outbursts during all three shifts on 7/8/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Grossmont Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8787 Center Drive LA Mesa, CA 91942	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 1:19 P.M., a joint interview and record review was conducted with licensed nurse (LN) 6. LN 6 reviewed the Employee Incident Report dated 7/8/24, for CNA 2, and stated Resident 1 punching CNA 2's face was considered an angry outburst. LN 6 reviewed Resident 1's July 2024 MAR and stated 7/8/24 should not have been documented as zero episodes. LN 6 reviewed Resident 1's two written care plans (dated 2/8/22 and 4/27/22) related to angry outbursts and stated the care plans were not implemented. LN 6 reviewed Resident 1's clinical record and stated the resident's angry outburst was not recorded and the MD was not called. LN 6 stated Resident 1's MD should have been called as the MD may have wanted further treatment or to evaluate the resident. LN 6 stated Resident 1's written care plans should have been implemented as it was important to make sure care goals were achieved. LN 6 further stated documenting the episodes of angry outbursts was important to make sure Resident 1's psychotropic medication was addressing his target behavior.</p> <p>On 8/1/24 at 2:05 P.M., a joint interview and record review was conducted with the assistant director of nursing (ADON). The ADON stated on 7/8/24, when Resident 1 hit CNA 2's face, that was considered an angry outburst and harm to staff. The ADON reviewed Resident 1's clinical record and stated Resident 1's angry outburst should have been documented and the resident's MD should have been notified of the behavior. The ADON stated Resident 1's MAR for 7/8/24 should not be recorded as zero episodes of the target behavior. The ADON stated Resident 1's behavior care plans related to angry outbursts should have been implemented. The ADON stated either Resident 1's MAR was inaccurate on 7/8/24, or the resident's LN was not made aware of the behavior and should have been notified. The ADON stated the LN had to be aware of the resident's behavior to implement the care plans.</p> <p>On 8/1/24 at 2:45 P.M., a telephone interview was conducted with CNA 2. CNA 2 stated Resident 1 had hit her eye on 7/8/24 and that she reported it to the resident's LN. CNA 2 stated she could not recall the LN's name.</p> <p>On 8/1/24 at 3:58 P.M., a joint interview and record review was conducted with LN 7. LN 7 reviewed Resident 1's MAR for 7/8/24 monitoring episodes of target behavior angry outbursts and stated she had documented zero episodes. LN 7 reviewed the Employee Incident Report dated 7/8/24, for CNA 2. LN 7 stated she was working and providing care to Resident 1 on 7/8/24 when the incident took place at 12:55 P. M. LN 7 stated no one had notified her that this had happened, and she was completely unaware Resident 1 had hit CNA 2. LN 7 stated she should have been informed right away and that she would have called the MD and documented the incident. LN 7 reviewed Resident 1's two written care plans related to angry outbursts (dated 2/8/22 and 4/27/22) and stated these care plans were not implemented and they should have been.</p> <p>A review of the facility's undated policy titled Care Planning/Care Conference did not provide guidance related to care plan implementation.</p>		