STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265865	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Pointe Health and Rehabilitation	3705 S Jefferson Ave Springfield, MO 65807

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on record review and interview, the facility staff failed to take steps to prevent further abuse and protect resident safety when staff failed to implement and care plan consistent and effective interventions for one resident (Resident #1) after resident-to-resident altercations with five residents (Resident #2, #3, #4, #5, and #6) resulting in continued altercations. The facility census was 99. Review of the facility's policy titled, Reporting Abuse, undated, showed the following: -The facility will not condone resident abuse by anyone, including staff members and other residents; -Physical abuse is defined as hitting, slapping, punching, kicking, etc. Review of the facility's policy titled, Preventing Resident Abuse, undated, showed the following: -Preventing resident abuse is a primary concern for the facility. It is the facility's goal to achieve and maintain an abuse-free environment; -The facility's abuse prevention program includes, assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect and assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 03/22, showed the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident; (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change; - The interdisciplinary team reviews and updates the care plan:when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment. 1. Review of Resident #1's face sheet (a snapshot of resident information) showed the following: -Initial admitted [DATE]; -Current admitted [DATE]; -Diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with behavioral disturbances, generalized anxiety disorder, major depressive disorder, restlessness and agitation, excoriation (skin-picking) disorder, cognitive communication deficit, and hallucinations. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/03/24, showed the following: -Severe cognitive impairment; -The resident had hallucinations and delusions; -Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred one to three days of the review period; -Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) occurred one to three days of the review period; -The resident was independent with transfers. Review of the resident's care plan, revised 07/31/23, showed the following: -The resident had physical (hitting) and verbal (cursing, yelling) aggressive threatening behaviors due to dementia and poor impulse control; -Staff to administer Seroquel (an antipsychotic medication) 50 milligrams, two tabs in evening and as needed; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Educate staff to be aware of beginning signs early for potential development of altercations. Review of the resident's care plan, revised 05/07/24, showed the following: -Resident had a diagnosis of dementia unspecified; -Provide the resident with a program of activities that is meaningful and of interest like watching tv and/or listening to music; -Encourage and provide opportunities for exercise, physical activity. Review of the resident's nursing notes showed the following: -On 05/24/24, at 1:38 P.M., Resident #1 slapped another resident on the right shoulder with an open hand. The residents can't recall the event. There was no redness or bruising to either resident. The residents were immediately separated. Staff initiated 15-minute checks for the aggressor. There were no visual witnesses. Review of camera footage confirmed event; -On 05/24/24, at 1:45 P.M., the resident was observed approaching another resident who was seated in a chair near the nurses' station. Resident #1 leaned in close to the other resident and started yelling at him/her, It is 144 degrees outside! Go home or you will die! Staff intervened and separated the resident without further incident; -On 05/24/24, at 2:05 P.M., resident walked toward another resident asking, Do you have a room here? When peer answered yes, Resident #1 sat down in a chair beside him/her and with a raised voice said, Well, you better go to it. Resident #1 is currently being monitored on 15-minute checks. Staff immediately separated the residents. Both residents said they felt safe. Resident #1 said mind your own business and leave me alone when asked why he/she told peer to go to their room. The resident paced in the dining room in line of sight; -On 05/25/24, at 4:30 P.M., the resident continued to be monitored due to recent incident with another resident with no aggressive or inappropriate behaviors noted or reported. Resident ambulated ad lib (at will) with rollator-style walker and continued to pace the unit. Resident has been belligerent with staff and resists redirection; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/26/24, at 4:28 P.M., the resident observed on multiple occasions this shift acting in an aggressive manner towards staff, another resident, and his/her responsible party. Resident also observed pacing through unit and being belligerent with staff with each interaction. Multiple times this shift, resident has attempted to strike or actually struck staff members with his/her rollator-style walker with redirection attempts not successful. The resident's walker had a malfunction to front left wheel, causing wheel to sit at an angle without turning. This caused resident to struggle using the walker for ambulation. Several times, the resident was approached and informed of the issue with the wheel and the risk of continuing to use the walker. This nurse asked to look at the wheel to determine what the issue was several times, to which the resident responded, Just leave me the hell alone, although resident allowed this nurse to assess the walker one time. While this nurse attempted to examine malfunctioned wheel, resident shoved the walker forward, striking this nurse in the face with the frame of the walker, at which time this nurse retreated from the resident's immediate area. When this nurse called resident's responsible party to notify him/her of the resident's behaviors, the responsible party informed him/her that the resident had struck him/her with his/her walker earlier this morning while he/she was visiting. The responsible party also said he/she was agreeable to the resident having a psychiatric evaluation completed due to increased behaviors and aggressive episodes; -On 05/26/24, at 1:06 P.M., Resident #5 sat in his/her wheelchair in the hallway. Resident #1 ambulated past the resident and slapped Resident #5 in the face. Staff did not visibly witness the strike, but it was audible to several staff members. Resident #5 immediately cried out for assistance and when asked by staff what had happened, he/she said, He/She slapped me! Right in the face! I didn't even do anything to him/her! Resident #1 said Get the hell away from me! I didn't do anything to him/her! The residents were immediately separated by staff. There was no injury; -On 05/29/24, at 4:21 A.M., staff noted on 05/28/24, at 8:30 A.M., Resident #5's hair was pulled/grabbed by Resident #1. Resident #1 was heard yelling, Get out of my room. When staff responded to scene both residents were in the doorway of their shared room. Resident #1 was holding on to Resident #5's hair. The residents were separated and Resident #1 started walking towards Resident #5. In efforts to redirect resident, staff stepped in front of wheelchair and grabbed the armrest. Resident #1 attempted to ram his/her wheelchair into the staff member's legs. Resident #1 then said, Let go of me or I'll knock the hell out of you. Resident #5 was questioned about incident and said, I was just trying to get by and he/she grabbed a hold of my hair and kept telling me to move. I told him/her to let go of me and she/he said he/she wasn't going to. I'm afraid he/she's going to do it again and if he/she does I'm going to get him/her back next time. What's wrong with him/her? Do you think he/she's missing something from his/her diet? Resident #1 said Yeah, I pulled him/her hair because he/she was in my way. I'll do it to you too. Get away from me and stop bothering me. Staff escorted Resident #5 to the nurses' station for one-on-one supervision until room change. Resident #5 denied any pain or discomfort. Staff implemented 15-minute checks Resident #1 until he/she's in bed for the night. Hot rack charting in place related to several resident-to-resident altercations where this resident was the aggressor. Resident remains on 15-minute checks until in bed for the night. A one time only dose of Seroquel 25 mg administered per physician. The resident's pacing/wandering has decreased. -On 05/29/24, at 9:30 A.M., during one-on-one monitoring for safety with a CNA, resident abruptly struck the face of a facility nursing aide student several times. Resident denied recollection of event when questioned; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/29/24, at 9:23 A.M., the Director of Nursing (DON) said he/she spoke with Resident #1's responsible party regarding the resident's violent behavior and verbal threats towards peers and staff that required continual observation and one-on-one cares. As a result of these events and for the safety and well-being of all parties on the Memory Care Unit (MCU), an emergency discharge notice had been prepared and the facility would discharge the resident to his/her place of residence on this date. The resident's responsible party verbalized his/her understanding. The DON acknowledged that this may present a difficult circumstance for him/her to navigate considering the amount of time for preparation. The on-call provider was informed of increased behaviors and aggressive actions and a new order for a psychiatric evaluation was given. New order noted and carried out. Resident transported to hospital via ambulance without further incident at approximately 4:00 P.M.; -On 5/29/24, at 4:58 P.M., staff noted at 9:00 A.M., the physician was contacted that there was an incident of unknown origin with suspicion of resident-to-resident altercation. A witness said he/she saw Resident #6 being shooed out of Resident #1's room. Resident #1 was pushing a wheelchair into Resident #6 in a herding fashion. Resident #6 said He/She's trying to kill me. When asked if he/she was okay, Resident #6 showed new hematomas (is an abnormal collection of blood outside of a blood vessel or significant bruising) on his/her hands and said he/she beat me. Resident #1 said I better not talk about it. Go away. A skin assessment was completed on Resident #6 with a hematoma found on left hand, middle finger, wrapping to webbing of fingers and a hematoma on dorsum (back) of his/her right hand. Residents were immediately separated. A CNA is to stay with Resident #1 for one-on-one supervision; -On 05/29/24, at 12:19 P.M., staff noted the resident was discharged from the facility at 11:42 A.M., in the custody of his/her responsible party; -On 06/14/24, at 1:03 P.M., the Social Services Director (SSD) documented Resident #1's family appealed the decision that was made to do an emergency discharge. Resident #1 had hurt many residents in the MCU. The physician and staff had tried everything to help him/her not cause physical harm to other residents, but he/she continued to hurt residents and staff. The last time he/she physically hurt a resident, the decision had to made to do an emergency discharge. The DON and unit nurse had to make the decision he/she could no longer stay or come back to keeping other residents safe. SSD sent a response to the State why the facility did not feel it in the best interest for the safety of our other residents to have her come back. SSD sent the same letter to the Ombudsman and his/her responsible party; -On 06/20/24, at 3:59 P.M., the resident was admitted to the facility. Review of the resident's care plan showed staff update the care plan regarding any additional monitoring to protect other residents when the resident readmitted to the facility. Review of the resident's nursing notes showed the following: -On 06/21/24, at 3:00 P.M., staff noted the resident was alert and oriented to self only and verbalized needs to staff without difficulty. The resident paced the memory care unit and denied pain or discomfort. No aggression or inappropriate behaviors observed or reported at this time; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/22/24, at 8:29 P.M., the resident paced laps on unit, opened residents' doors and leaving them open, which caused other residents' distress. Staff was unable to redirect the resident; -On 06/22/24, at 8:55 P.M., staff entered another resident's room and found Resident #1 in the room. Resident #1 was informed it was not his/her room and he/she walked towards the door. Resident #1 told him/her, I'm going to hit the hell out of you one of these days, and walked out of the room; -On 06/22/24, at 9:55 P.M., a certified nurse aide (CNA) redirected the resident out of the wrong room and resident said, move out of my way or I'm going to pounce you; -On 06/23/24, at 5:28 P.M., staff heard raised voices from down the hall. Upon investigation he/she found a resident in a wheelchair in the door to her room with Resident #1 attempting to pull the other resident's wheelchair out of the room while he/she said, you are in my room. Staff separated the residents and Resident #1 was informed where his/her room was. Resident #1 than went to his/her room and sat down on the bed. When interviewed regarding what occurred Resident #1 did not provide any new information that had not been provided by the other resident during the interview. Staff implemented immediate Intervention of residents separated and 15-minute location monitoring initiated for Resident #1; Review of the resident's care plan showed staff did not care plan regarding the resident's behaviors since admission or new interventions to protect other residents. Review of the resident's nursing notes showed the following: -On 06/23/24, at 10:18 P.M., a CNA reported that, Resident #1 was in Resident #2's room again. When he/she got to room Resident #2's room, Resident #2 was in his/her wheelchair in the doorway to his/her room. Resident #2 reported that Resident #1, pushed me out. He/she asked Resident #2 if Resident #1 had pushed him/her wheelchair or his/her body. Resident #2 rubbed his/her left forearm and said, with my body. The nurse entered the room and found Resident #1 sitting on Resident #2's bed. He/she Instructed Resident #1 to stand and leave the room because it is not his/her room. Resident #1 stood and walked out of the room with his/her wheeled walker. He/She took a few steps and started to turn around and come back. The nurse stopped the walker with his/her hand and the resident struck the nurse's right arm with an open hand and walked away. A physical assessment completed on both residents with no signs or symptoms of injury. Staff initiated 15-minute monitoring Resident #1. Staff notified the on-call provider for both residents and family/responsible party for both residents. Immediate intervention of Resident #1 removed from Resident #2's room and instructed not to return. Resident #2 was brought to the nurses' station and continued 15-minute checks on both residents. (Staff previously documents 15-checks implemented earlier on 06/23/24.) Review of the resident's care plan showed staff did not care plan regarding the resident's behaviors since admission or new interventions to protect other residents. Review of the resident's nursing notes showed the following: -On 06/24/24, at 5:50 A.M., staff noted hot rack charting related to two incidents in which this resident was the physical aggressor against another resident, the same resident both times. Resident rested well overnight in his/her bed with no further episodes of anxiety or aggression; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/24/24, at 3:21 P.M., staff noted hot rack charting related to two incidents in which this resident was the physical aggressor. Resident is on 15-minute checks and walked with his/her walker around the unit. Resident ate breakfast and lunch. The resident is adjusting, but he/she was not friendly; -On 06/25/24 at 3:54 P.M., staff noted hot rack charting related to resident being physically aggressive with another resident. Resident is irritable when spoken too, however, he/ she was not aggressive towards resident nor staff this shift; -On 06/26/24, at 1:38 P.M., staff noted hot rack charting with continued to monitor for aggressive behavior with no such behavior noted or reported at this time. Resident ambulates ad lib with rollator-style walker and continuously paces the MCU; -On 06/26/24, at 1:35 P.M., staff noted Resident #1 was readmitted to MCU with a current order for Seroquel 25 mg twice daily. The resident continues to pick skin, trying to shoo bump others with his/her walker, yell out, speak rudely to staff, and aggressive/agitated with peers. There were two additional resident-to-resident altercations since being readmitted to memory care unit. Current interventions included sertraline (antidepressant), Depakote (antiepileptic than can be used as a mood stabilizer), participated in group activities parallel to others in group setting, one-on-one activities, and snacks. Interdisciplinary Plan to continue to monitor behaviors and intervene as needed. The physician does not feel resident is appropriate for gradual dose reduction of medication this time due to extent of skin picking, refusal of cares, and verbal threats towards others. (Staff did not address the 15-minute checks previously implemented.) Review of the resident's care plan, revised 06/27/24, showed the following: -Staff will continue to monitor the resident for aggression, location, and potential aggression toward others; -Staff to redirect resident from area where others are at risk; -Resident will not be involved in further altercations; -Staff to redirect resident from others that he/she has been known to have altercations previously. Review of the resident's nursing notes showed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/30/24, while in the dining room, the aides heard a resident call out for assistance on the other side of the dining room. Upon investigating, a resident said Resident #1 struck her. The residents were immediately separated. Resident #1 denied having struck the other and told this nurse, Go to hell. Staff notified administrative on-call and reviewed camera footage. Review of the footage showed Resident #1 was ambulating and attempting to go around the other resident, who was seated in his/her wheelchair. Resident #1 was unable to go around the other resident and attempted to move the other resident's wheelchair. A verbal altercation took place between the two residents and Resident #1 struck the other resident on the right shoulder with an open hand four times. The other resident began calling for help and Resident #1 walked away. Following the incident, a physical assessment attempted on Resident #1. Resident #1 was noncompliant and refused to allow this nurse to perform a physical assessment. Staff initiated 15-minute checks for location monitoring for Resident #1. Staff reported incident to on-call physician and the resident's responsible party; -On 07/01/24, at 12:54 P.M., staff noted on 06/30/24, at 8:43 A.M., while in the dining room, the aides heard a resident call out for assistance on the other side of the dining room. Upon investigating, a resident said Resident #1 struck him/her. Staff immediately separated the residents. Resident #1 denied having struck the other and told this nurse, Go to hell. Staff notified administrative on-call and reviewed camera footage. Review of the footage showed Resident #1 was ambulating and attempting to go around the other resident, who was seated in his/her wheelchair. Resident #1 was unable to go around the other resident and attempted to move the other resident's wheelchair verbal altercation took place between the two residents and Resident #1 struck the other resident on the right shoulder with an open hand four times, the other resident began calling for help and Resident #1 walked away. Following the incident, a physical assessment attempted on Resident #1. Resident #1 was noncompliant and refused to allow this nurse to perform a physical assessment. Staff initiated 15-minute checks for location monitoring for Resident #1. The incident reported on-call physician and the residents responsible party. Long term intervention of staff will monitor Resident #1's location at all times when he/she ambulates in close proximity of any other residents. Staff will be especially aware when the resident is in close location of residents who present as weaker, or more confused. The resident has been observed targeting this type of resident when he/she is agitated or anxious. Staff will add to care plan that staff will monitor the resident's location at all times when he/she ambulates in close proximity of any other residents and will be especially aware when he/she is in close location of residents who present as weaker, or more confused. The resident had been observed targeting this type of resident when he/she is agitated or anxious. Staff delivered a 30-day exit notice to resident and representative due to unsafe behaviors. Review of the resident's care plan, revised 07/01/24, showed the following -The resident had a resident-to-resident altercation; -The resident will not cause injury or receive injury from resident-to-resident altercations; -Physical assessment attempted and resident was noncompliant and refused; -Staff initiated 15-minute location monitoring from 8:45 A.M. to 5:45 A.M.; -Staff gave the resident's responsible party a 30-day exit notice due to unsafe behaviors; (continued on next page)

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	265865	A. Building B. Wing	07/12/2024

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Birch Pointe Health and Rehabilitation	3705 S Jefferson Ave Springfield, MO 65807

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #1 was again placed on 15-minute locator monitoring; -Staff is [NAME] about resident location and behavior; -The facility continued to actively attempt to find more compatible placement for the resident. Review of the resident's nursing notes showed the following: -On 07/05/24, at 7:52 P.M., staff noted a dietary aide brought resident to the nurses' desk and said, He/She's trying to jump him/her. Upon review of cameras Resident #1 viewed standing aggressively over peer as peer is trying to get away in his/her wheelchair. The resident followed him/her using a wheeled walker. Resident #1 viewed striking him/her right forearm in the dining room. Immediate intervention of residents separated and new order for Zyprexa (antipsychotic medication) received and Seroquel increased to three times daily. Staff will monitor the resident closely and redirected when necessary; -On 07/06/24, at 12:05 A.M., staff noted the resident continued on hot rack charting for increase in Seroquel and new orders for Zyprexa and Depakote. The resident also continued on monitoring for aggression towards peers. The resident as viewed persistently going after peer as peer was attempting to get away and pacing hallways circling around to posture to peer as he/she passed. Staff monitors closely to keep residents separate. Will continue to monitor for changes in condition; -On 07/06/24, at 2:15 P.M., staff noted hot rack charting of resident continued to be monitored for adverse effects of recent medication changes. The resident was observed to pace the MCU continuously. Several times this shift, resident has entered into another resident's room and became belligerent with the room's occupant and staff when attempts to redirect resident to his/her own room are attempted. Staff notified administration and on-call provider of continued aggressive behavior. The nurse was instructed by administration to contact a psychiatric facility regarding possible transfer to that facility. The nurse was informed by the psychiatric facility that facility has placement available, and that the facility required medical clearance prior to admission, which could be performed at the hospital. Staff notified on-call provider of continuing aggressive behaviors and received new order to send resident to the hospital. Review of the resident's care plan, revised 07/07/24, showed the following: -Resident #1 has episodes of verbal and physical aggression including: yelling, cursing, verbally threatening, and physically hitting peers and staff; -The resident will have no increase in episodes of verbal/physical aggressive behavior this next review period; -Resident to remain separated from targeted resident with 15-minute location monitor until bedtime; -Staff to supervise for further indicators of aggression. Review of the resident's physician orders sheets, dated June 2024 and July 2024, showed staff did not document any specific behavior monitoring in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265865	A. Building B. Wing	07/12/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included dementia, generalized anxiety disorder, and major depressive disorder. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -The resident displayed no behaviors in the assessment period; -The resident required substantial assistance for transfers. Review of the resident's care plan, updated 12/11/23, showed the following: -The resident had impaired cognitive function/dementia or impaired thought processes; -Staff to use positive approach techniques including approach the resident from the front, use a wave and extend hand, then approach, modify hand position to engage the hand under hand technique, move to the side of the resident, and stay at eye level; -Present just one thought, idea question, or command at a time. Review of the resident's nurses' notes showed the following: -On 06/23/23, at 4:49 P.M., staff heard raised voices from down the hall. Upon investigation the nurse found a resident in a wheelchair in the door to his/her room with Resident #1 attempting to pull the other resident's wheelchair out of the room while he/she said, you are in my room. Resident #2 said He/She hit me. He/She threw water at me. He/She hit me with water, not her hand. If he/she had hit me with his/her hand, I would've hit her back; -On 06/23/24, at 10:18 P.M.,staff noted a CNA reported Resident #1 is in Resident #2's room again. When he/she got to room Resident #2's room, Resident #2 was in his/her wheelchair in the doorway to his/her room. Resident #2 reported that Resident #1, pushed me out. He/she asked Resident #2 if Resident #1 had pushed him/her wheelchair or his/her body. Resident #2 rubbed his/her left forearm and said, with my body. LPN E entered the room and found Resident #1 sitting on Resident #2's bed. He/she Instructed Resident #1 to stand and leave the room because it is not his/her room. Resident #1 stood and walked out of the room with his/her wheeled walker. He/She took a few steps and started to turn around and come back. The nurse stopped the walker with his/her hand and Resident #1 struck LPN E's right arm with an open hand and walked away. A physical assessment was completed on both residents with no signs or symptoms of injury. Staff initiated 15-minute monitoring was for Resident #1. Staff notified on-call provider and family/responsible party was notified for both residents. Immediate intervention was Resident #1 removed from Resident #2's room and he/she was instructed not to return. Resident #2 brought to the nurses' station and continued 15-minute checks on both re[TRUNCATED]