STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365353	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Candlewood Healthcare and Rehabilitation	1835 Belmore Ave East Cleveland, OH 44112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, medical record review, Self-Reported Incident (SRI) review, witness statement review, policy review and interview, the facility failed to ensure Resident #64 and Resident #93 were free from incidents of physical abuse by Resident #50. This affected two residents (Resident #64 and #93) of six residents reviewed for abuse. Actual harm occurred on 09/24/24 when Resident #93 was physically abused/assaulted by Resident #50 resulting in an injury. At the time of the incident, Resident #50 punched, with a closed fist, Resident #93, unprovoked, resulting in Resident #93 experiencing pain rated a seven out of 10 (on a pain scale with 10 being the most severe pain), headache, distress with crying resulting in a transfer to the hospital emergency department where the resident was admitted to a trauma center for further evaluation and treatment and diagnosed with a nondisplaced right occipital bone fracture. As of 10/01/24 Resident #93 had not returned to the facility. Prior to this incident of physical abuse, Resident #50 was noted to have a history of abuse towards other residents. Findings include: 1. Review of the closed medical record for Resident #93 revealed the resident was admitted to the facility on [DATE] from the hospital and discharged to the hospital on 09/24/24. The resident had diagnoses including epilepsy, major depressive disorder, symptoms and signs involving cognitive functions and awareness, suicidal ideation and personal history of transient ischemic attack. Review of a Brief Interview for Mental Status (BIMS) evaluation assessment revealed Resident #93 was cognitively intact. Review of a Social Service History and assessment dated [DATE] revealed Resident #93 used a walker or cane, and rehabilitation was needed to move on to a more normal life. Review of the admission assessment dated [DATE] revealed Resident #93 was alert to person, place, time and situation and was independent with bed mobility, transferring and eating and did not have any pain. Record review revealed Resident #93 and Resident #50 were roommates from 09/17/24 to 09/24/24. Resident #93's daughter was identified to be his Power of Attorney (POA). Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of schizophrenia, dementia with psychotic disturbance, schizoaffective disorder, mood disorder, obsessive compulsive disorder, psychosis, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder and bilateral macular degeneration. (continued on next page)

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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #50 was cognitively intact, had hallucinations and delusions, had other behavioral symptoms and wandering behaviors that occurred one to three days during the assessment, and was independent with transferring and walking 150 feet. Resident #50 had legally appointed guardian. Review of a general note dated 09/24/24 timed 7:08 P.M. authored by Registered Nurse (RN) #7 revealed Resident #93 was hit by another resident (Resident #50) on the side of his head while sitting in the hallway in his wheelchair. The residents were separated from each other. Resident #93 was assessed with no apparent injuries noted. The doctor ordered Resident #93 to be sent to hospital for evaluation. Review of a facility SRI dated 09/24/24 revealed at approximately 7:20 P.M., it was reported to the Administrator that Residents #50 and #93 were involved in altercation. Resident #93 was observed sitting in his wheelchair in the hallway, and without provocation, Resident #50 smacked him on the side of his face/ear. Review of the hospital emergency department nursing note dated 09/24/24 timed 8:10 P.M. revealed Resident #93 was brought in by emergency medical services from nursing home for an altercation with his roommate. Resident #93 stated his roommate hit him in the back of his head with his fist for no reason. Resident #93 reported a seven out of 10 headache. It was noted Resident #93 took baby aspirin and was alert and oriented times four spheres (person, place, time and situation). Review of the hospital emergency department physician assistant note dated 09/24/24 timed 8:10 P.M. revealed Resident #93 presented to the emergency department after an assault. Resident #93 was punched once in the back of the head by his roommate at the nursing home around 7:00 P.M. Resident #93 did not fall to the floor. Resident #93 reported a headache now localized to the site of the punch located at the left-side of the head to neck. Resident #93 had some sensations of feeling the room was spinning which he did feel before the punch but the sensation was now consistent. Tenderness was noted over area depicted in photo [left side to middle of neck underneath the skull]. Resident #93 had full range of motion in his neck, some tenderness associated with looking to the right. Resident #93 had pain with movement and muscular tenderness was present. Review of the weight/vitals tab in the electronic medical record revealed Resident #93 had not had any pain from the time of his admission until staff documented pain on 09/24/24 at 9:35 P.M. as the resident complained of pain rated a seven out of 10. Review of the hospital emergency department physician note dated 09/25/24 timed 12:21 A.M. revealed the physician was notified by radiology of a critical finding of nondisplaced right occipital bone fracture. The note indicated neurosurgery would be consulted. Review of the CT scan of head dated 09/25/24 timed 12:32 A.M. revealed Resident #93 had a questionable nondisplaced fracture of the right occipital bone. Review of the orders-administration note dated 09/25/24 timed 7:42 A.M. revealed Resident #93 was admitted to the trauma center with a diagnosis of a hairline fracture. Review of the repeat CT scan of head dated 09/25/24 timed 8:30 A.M. revealed Resident #93 had a stable nondisplaced right occipital bone fracture. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/30/24 at 8:30 A.M. and 10:30 A.M. with Resident #93's daughter/POA revealed on 09/24/24, the nurse called her and had informed her she had observed an incident (resident to resident altercation) and reported that Resident #93 did not provoke Resident #50 in any way. The resident's daughter/POA reported Resident #93 sustained a hairline fracture of the skull as result of the hit from Resident #50. Resident #93 had CT scans of the head prior to being admitted to the facility which did not show a fracture of the skull. When Resident #93's daughter/POA spoke to Resident #93 after the incident, Resident #93 stated, oh my god, I was attacked, my head hurts so bad, my head hurts so bad. Resident #93's daughter/POA confirmed Resident #50 was Resident #93's roommate. Resident #93's daughter/POA also revealed Resident #93 was still at the hospital but was getting ready to discharge to a different long-term acute care hospital for acute rehabilitation. Observation on 09/30/24 at 9:15 A.M. revealed Resident #50 was sitting on the edge of his bed, feeding himself breakfast. Interview, during the observation, with Resident #50 revealed when asked to describe the altercation between himself and Resident #93 last week, Resident #50 responded, that did not happen, nothing happened. Interview on 09/30/24 at 9:20 A.M. with Licensed Practical Nurse (LPN) #4 revealed he received the phone call from the hospital that reported Resident #93 had sustained a hairline fracture of the skull. Interview on 09/30/24 at 11:40 A.M. with RN #7, with the DON present, revealed RN #7 was at the nurses' medication cart, passing medications when Resident #93 self-propelled out of his room and was sitting in his wheelchair in front of the elevator when Resident #50 was walking from the opposite direction then turned around and hit Resident #93 with a closed fist on the left side of Resident #93's head. RN #7 was unable to describe the exact location of the point of contact on Resident #93. RN #7 revealed there had not been any words spoken between the residents at the time of the assault; the assault was unprovoked. Resident #93 reported his head was hurting so the physician ordered to send Resident #93 to the hospital. The RN stated staff had been monitoring Resident #50 every 15 minutes. RN #7 believed she was the only staff member to witness the altercation between Residents #50 and #93. Interview on 10/01/24 at 11:30 A.M. with Physician #14 (who specialized in internal medicine and was Residents #50 and #93's physician) revealed Physician #14 reviewed Resident #93's chart at the hospital and felt Resident #93's occipital bone fracture was still questionable as the resident had prior surgery and the imaging could be unclear. When asked if it was possible that Resident #93 sustained the right occipital bone fracture from Resident #50's hit/punch, Physician #14 stated that it could go either way. Review of a hospital CT scan of the head dated 08/24/24 revealed there was no evidence of Resident #93 having a nondisplaced right occipital bone fracture at the time of this testing. Review of a hospital CT scan of the head dated 09/01/24 revealed there was no evidence of Resident #93 having a nondisplaced right occipital bone fracture at the time of this testing. 2. Review of the closed medical record for Resident #64 revealed an admitted [DATE] with diagnoses of aphasia following cerebral infarction, mild cognitive impairment and unsteadiness on feet. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data (MDS) Set 3.0 quarterly assessment dated [DATE] revealed Resident #64 had short and long-term memory problems, was unable to recall the current season and staff names and faces, was moderately impaired with daily decision making and had continuous inattention and disorganized thinking. Resident #64 did not utilize a mobility device and was independent with transferring and walking 150 feet. Resident #64 had a legally appointed guardian. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of schizophrenia, dementia with psychotic disturbance, schizoaffective disorder, mood disorder, obsessive compulsive disorder, psychosis, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder and bilateral macular degeneration. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #50 was cognitively intact, had hallucinations and delusions, had other behavioral symptoms and wandering behaviors that occurred one to three days during the assessment, and was independent with transferring and walking 150 feet. Resident #50 had legally appointed guardian. Review of the general note dated 09/12/24 timed 6:59 P.M. revealed Resident #64 was unable to communicate if he was in pain. Acetaminophen 650 milligrams was given for pain and an ice pack was applied to the right side of his mouth which was swollen. Review of the general note dated 09/12/24 timed 7:54 P.M. revealed around 6:45 P.M., Resident #64 had just finished his dinner, got up and was walking down the hall when another resident [Resident #50] struck him on the right side of his face, knocking him to the floor. Both residents were immediately separated by staff and assessed for injuries. Resident #64 had a swollen lip. A call was placed to the Medical Director with new orders for vital signs for seven days every shift and apply ice pack to right side of face. The other resident [Resident #50] was sent out to hospital for a psychiatric evaluation and a room change would be completed on a different floor. Resident #50 would remain on one-to-one supervision until the ambulance arrived. Review of the Situation Background Assessment Recommendation or Request (SBAR) Summary for Providers assessment dated [DATE] revealed Resident #64's physician ordered a facial x-ray. Review of the general note dated 09/13/24 revealed Physician #14 was in to see Resident #64 with no new orders. Resident #64 had an x-ray of the right side of this face which was negative. Review of the general note dated 09/13/24 timed 2:10 A.M. revealed Resident #64 returned from emergency department. Review of a facility SRI dated 09/12/24 revealed on 09/12/24 at approximately 6:45 P.M., it was reported that Resident #64 and Resident #50 were involved in a physical altercation. Review of the Individual Aggression Program for Resident #50 updated 09/12/24 (within the Self-Report Incident investigation) revealed to determine the reason for aggression, attempt to identify why the resident was showing such behavior as: behaviors related to reality of declining cognitive status and fear of the future and responded impulsively to other residents/staff being in their space by hitting/kicking out without harm intent. Possible situations: separate residents who were having negative interaction, do not take resident behavior personally, offer/assist with food, use of bathroom or other activities of daily living (ADLs) and encourage/assist to change location. The possible situations chosen for Resident #50 were generalized and not individualized to Resident #50. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the witness statement dated 09/12/24 (within the SRI investigation) authored by Licensed Practical Nurse (LPN) #12 revealed at approximately 6:30 P.M., LPN #12 was at the nurses' station in front of the medication cart when LPN #12 witnessed Resident #50 in the hallway close to the nurses' station. Resident #64 came walking by from the dining room and as he was walking by, Resident #50 struck him in the face, and he fell on the floor. LPN #13 immediately went to the area and removed Resident #50 from the scene while other staff assisted Resident #64. Interview on 09/30/24 at 10:55 A.M. and 11:20 A.M. with the Administrator and Director of Nursing (DON) revealed after Resident #50 hit Resident #64, Resident #50 was sent to the hospital and returned with no new orders, then Resident #50 was seen by psychiatry services and a medication review was completed by psychiatry service. Resident #50 was also moved to the third floor and had increased supervision. The DON was unable to specify the expectation for increased supervision. Upon review of Resident #50's medical record as it pertained to the incidents of physical abuse involving Resident #93 and Resident #64 it was noted the resident had a physical behaviors care plan dated 09/13/24 which indicated Resident #50 had potential to demonstrate physical behaviors hitting or attacking because he had poor impulse control. The care planned interventions were generalized and were not individualized to Resident #50. Review of Resident #50's physical behaviors care plan dated 09/25/24 revealed Resident #50 had potential to demonstrate physical behaviors of hitting other residents related to dementia. History of harm to others and intrusive wandering/exit seeking. Resident #50 was demonstrating physical behaviors (hitting other residents related to dementia, history of harm to others, poor impulse control). The care planned interventions were generalized and not individualized to Resident #50. Interview on 09/30/24 at 9:00 A.M. with Registered Nurse (RN) #1 revealed Resident #50 repeated what was spoken to him and invaded personal space. RN #1 was not aware of interventions being in place to protect other residents from Resident #50's impulsive behaviors other than every 15-minute checks. Interview on 09/30/24 at 9:12 A.M. and 10:40 A.M. with State tested Nurse Aide (STNA) #3 revealed Resident #50 had been getting more aggressive. Resident #50 had resided on the third floor, was moved to the second floor then back on the third floor which was his current location. STNA #3 was not aware of any interventions for Resident #50 other than every 15-minute checks. Observation on 09/30/24 at 9:50 A.M. revealed Resident #50 was lying in his bed, asleep. Interview on 09/30/24 at 10:50 A.M. with STNA #5 revealed Resident #50 was on every 15-minute checks. STNA #5 was not aware of any other interventions being in place to protect the safety of other residents. Observation on 09/30/24 at 10:51 A.M. and 12:45 P.M. revealed Resident #50 was lying in his bed, asleep. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation on 09/30/24 at 12:50 P.M. revealed STNA #9 sitting at the nurses' station with several papers including one paper dated 09/30/24 with Resident's #50 name on it which indicated Resident #50 was on 15-minute checks with increments of 15-minutes from 12:00 A.M. to 11:59 P.M. with staff initials next to each 15-minute increment. There was no documentation of what Resident #50 was doing when the 15-minute checks were completed. Interview, during the observation, with STNA #9 revealed Resident #50 had a recent increase in physical behaviors that were totally unprovoked. On 09/30/24 at 12:52 P.M. the every 15 minute check log for Resident #50 was requested from the the DON. Interview on 09/30/24 at 4:00 P.M. with the Administrator and Regional Director of Clinical Operations (RDCO) #12 confirmed Resident #50 hit Resident #64 and Resident #93 within less than two-week span, unprovoked. Evidence of Resident #50's every 15-minute checks was requested again. Interview on 09/30/24 at 4:20 P.M. with LPN #12 verified she witnessed Resident #64 walking along and Resident #50 hitting Resident #64, unprovoked. LPN #12 was unable to describe if Resident #50 hit Resident #64 with an open hand or closed fist. On 10/01/24 at 9:50 A.M. evidence every 15- minute checks for Resident #50 were completed was requested from Regional Director of Operations (RDO) #13. Review of the facility's Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated October 2022 revealed if a resident was accused or suspected, the facility would ensure other residents were protected as determined by the circumstances, which could include but were not limited to, increased supervision of the alleged perpetrator and/or other residents, room or staffing changes, and immediate transfer or discharge, if indicated. Whether the incident/allegation was substantiated or unsubstantiated, the Administrator and/or DON or designee would: ensure involved resident's plan of care was reviewed and revised, as appropriate, consistent with the results of the investigation. At the completion of the complaint investigation on 10/01/24, the facility provided no evidence that every 15 minute checks were completed on Resident #50. This deficiency represents non-compliance investigated under Complaint Number OH00158288 and OH00158285.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, medical record review, Self-Reported Incident (SRI) review, and interview, the facility failed to develop a care plan with individualized interventions to support the behavioral health care needs of Resident #50, who had diagnoses of major depressive disorder, schizophrenia, generalized anxiety disorder, schizoaffective disorder, mood disorder, obsessive compulsive disorder and psychosis. This affected one (Resident #50) of six residents reviewed for behavioral health care needs. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses of schizophrenia, dementia with psychotic disturbance, schizoaffective disorder, mood disorder, obsessive compulsive disorder, psychosis, alcohol dependence with alcohol-induced persisting dementia, generalized anxiety disorder and bilateral macular degeneration. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #50 was cognitively intact, had hallucinations and delusions, had other behavioral symptoms and wandering behaviors that occurred one to three days during the assessment period, and was independent with transferring and walking 150 feet. Resident #50 had legal guardian. Review of the physician orders from September 2024 revealed Resident #50 was ordered: Aripiprazole (an antipsychotic medication) oral tablet 15 milligrams (mg) once a day by mouth at bed time, Clonazepam (medication used to treat anxiety) oral tablet 1 mg by mouth two times a day, and Fluvoxamine Maleate (used to treat obsessed compulsive disorder) oral tablet 50 mg one tablet by mouth in the morning. Review of the psychiatric nurse practitioner progress note dated 09/10/24 revealed Resident #50 appeared to be at baseline for his medication regimen. Resident #50's son was involved in his care, and staff reported no behavioral issues with the resident at this time. Review of the general note dated 09/12/24 timed 8:02 P.M. revealed around 6:45 P.M., Resident #50 was standing out in the hallway when Resident #64 was passing by. Resident #50 struck Resident #64 on the right side of the face, knocking him to the ground. Both residents were separated and assessed for injuries. This resident appeared to have no injuries however the other resident (Resident #64) had a right swollen lip. Resident #50 was immediately placed on one-to-one supervision. Call to medical director with new orders to send to emergency department for psychiatric evaluation and move Resident #50 to the third floor. Review of the general note dated 09/13/24 timed 2:10 A.M. revealed Resident #50 returned from emergency department. Review of the physical behaviors care plan dated 09/13/24 revealed Resident #50 had potential to demonstrate physical behaviors hitting or attacking because he had poor impulse control. The care planned interventions were generalized and were not individualized to Resident #50. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Statement of Expert Evaluation dated 09/17/24 revealed Resident #50 had thought process, affect, memory, concentration and comprehension and judgment impairment. Resident #50 did not know the current president and was unable to count numbers. Resident #50 was recommended to have continued guardianship. Review of the general note dated 09/24/24 timed 8:32 P.M. revealed Resident #50 hit another resident on the side of his head while other resident [Resident #93] was sitting in the hallway in his wheelchair. The residents were separated from each other. The physician ordered Resident #50 to be sent to hospital for evaluation. Ambulance transported the resident to the emergency room via stretcher. Review of the physical behaviors care plan dated 09/25/24 revealed Resident #50 had potential to demonstrate physical behaviors of hitting other residents related to dementia. History of harm to others and intrusive wandering/exit seeking. The care planned interventions were generalized and were not individualized to Resident #50. Review of the physical behaviors care plan dated 09/25/24 revealed Resident #50 was demonstrating physical behaviors (hitting other residents related to dementia, history of harm to others, poor impulse control). The care planned interventions were generalized and not individualized to Resident #50. Review of the SRI dated 09/12/24 revealed on 09/12/24 at approximately 6:45 P.M., it was reported that Resident #64 and Resident #50 were involved in a physical altercation. Review of the Individual Aggression Program for Resident #50 updated 09/12/24 (within the Self-Report Incident investigation) revealed to determine the reason for aggression, attempt to identify why the resident was showing such behavior as: behaviors related to reality of declining cognitive status and fear of the future and responded impulsively to other residents/staff being in their space by hitting/kicking out without harm intent. Possible situations: separate residents who were having negative interaction, don't take resident behavior personally, offer/assist with food, use of bathroom or other activities of daily living (ADLs) and encourage/assist to change location. The possible situations for Resident #50 were generalized and were not individualized to Resident #50. Review of the SRI dated 09/24/24 revealed at approximately 7:20 P.M., it was reported to the Administrator that Residents #50 and #93 were involved in altercation. Resident #93 was observed sitting in his wheelchair in the hallway, and without provocation, Resident #50 smacked him on the side of his face/ear. Interview on 09/30/24 at 9:00 A.M. with Registered Nurse (RN) #1 revealed Resident #50 repeated what was spoken to him and invaded personal space. RN #1 was not aware of additional interventions for Resident #50 other than every 15-minute checks. Interview on 09/30/24 at 9:12 A.M. and 10:40 A.M. with State tested Nurse Aide (STNA) #3 revealed Resident #50 had been getting more aggressive. Resident #50 had resided on the third floor, then was moved to the second floor then currently back on the third floor. STNA #3 was not aware of additional interventions for Resident #50 other than every 15-minute checks. (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/30/24 at 9:15 A.M. revealed Resident #50 was sitting on the edge of his bed, feeding himself breakfast. Interview, during the observation, with Resident #50 revealed when asked to describe the altercation between himself and Resident #93 last week, Resident #50 responded, that did not happen, nothing happened. Observation on 09/30/24 at 9:50 A.M. revealed Resident #50 was lying in his bed, asleep. Interview on 09/30/24 at 10:50 A.M. with STNA #5 revealed she was not aware of additional interventions for Resident #50 other than every 15-minute checks. Observation on 09/30/24 at 10:51 A.M. revealed Resident #50 was lying in his bed, asleep. Interview on 09/30/24 at 10:55 A.M., 11:20 A.M. with the Administrator and Director of Nursing (DON) revealed after Resident #50 hit Resident #64, Resident #50 was sent to the hospital and returned with no new orders then Resident #50 was seen by psychiatry services and a medication review was completed by psychiatry service. Resident #50 was also moved to the third floor and had increased supervision. The DON was unable to specify the expectation for increased supervision. Interview on 09/30/24 at 11:40 A.M. with RN #7, with the DON present, revealed RN #7 was at the nurses' medication cart, passing medications when Resident #93 self-propelled out of his room and was sitting in his wheelchair in front of the elevator when Resident #50 was walking from the opposite direction then turned around and hit Resident #93 with a closed fist on the left side of Resident #93's head. RN #7 revealed there hadn't been any words spoken to each other at the time of the assault and the assault was unprovoked. The staff had been monitoring Resident #50 every 15-minutes. Observation on 09/30/24 at 12:45 P.M. revealed Resident #50 was lying in his bed, asleep. Interview on 09/30/24 at 12:50 P.M. with STNA #9 revealed Resident #50 had a recent increase in physical behaviors that were totally unprovoked. Interview on 09/30/24 at 4:00 P.M. with the Administrator and Regional Director of Clinical Operations (RDCO) #12 verified Resident #50 hit Resident #64 and Resident #93 within less than two-week span, unprovoked. During an interview on 10/01/24 at 11:25 A.M. with the Administrator and RDCO #12 they refused to verify that individualized care plan interventions were not in place for Resident #50 after the altercation on 09/12/24. This deficiency represents non-compliance investigated under Complaint Number OH00158288 and OH00158285.