STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045212**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/02/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE PARK NURSING CENTER	**1513 SOUTH DIXIELAND RD** **ROGERS, AR 72756**

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 372) was substantiated, all or in part, Based on observation, record review and interview, the facility failed to ensure resident aggressive behaviors were thoroughly assessed for causative factors with interventions developed and implemented based on results of assessment; interventions were re-evaluated for effectiveness; a communication system for staff on the secure unit to use in emergency situations and sufficient numbers of staff were on duty on the male secure unit to ensure aggressive behaviors were monitored closely and to enable staff to quickly intervene for 1 of 1 (Resident #7) case mix resident who had a history of [REDACTED].#6) who was twice the victim of resident to resident physical aggression. The failed practices resulted in Immediate Jeopardy, which caused or could have caused serious injury, harm or death for Resident #6, who was hit in the abdomen on two occasions, and had the potential to affect 6 other male residents who resided on the secure male unit according to the list received from the Administrator on [DATE]. The facility was informed of the Immediate Jeopardy on [DATE] at 12:40 p.m. The findings are: 1. The Secure Unit Policy and Procedure received from the Administrator on [DATE] documented, Secure Unit (Memory Care Unit), Admit modify the admit policy for the unit, Green light: [DIAGNOSES REDACTED]. Red Light: Mental Retardation who require active treatment, acute or chronic mental illness such as Schizophrenia, Manic Depression, Bi Polar, Psychosis. Brain injury or Acute Alcohol/Drug Withdrawal. Must be at least [AGE] years old unless approved by RDCO. Medically stable with no suicidal or homicidal ideation. Resident who is deemed to be a danger to themselves or others will not be admitted . Must be ambulatory. On [DATE] the Men's Secure Unit had 7 male residents. There were 2 residents confined to wheelchairs (Resident #2 and #9), 4 ambulatory residents (Residents #1, #8, #10 and #11), and 1 resident in a geri-psychiatric unit (Resident #7). 2. Resident #6 was admitted to the facility on [DATE] per the Admission Record. and resided on the Men's Secure Unit and had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] documented the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status, had no documentation of behaviors, required supervision with ambulation in the room or corridors, extensive assistance with dressing, supervision with meals and was totally dependent with personal hygiene. a. An Incident Report Investigation Behavioral Outburst-Assault of Another Resident or Staff Member dated [DATE] at 9:00 p.m. documented, This res (resident) was hit by another res (Resident #7). was hit in the stomach. A witness statement dated [DATE] and signed by Licensed Practical Nurse (LPN #2) documented, This res (Resident #6) was struck by another res as he was walking by in unit hallway-he was hit 2 x (times) in stomach (with) closed fist from other res before Nurse et (and) CNA (Certified Nursing Assistant) could intervene/get between both. No bruising is noted. Res shows no s/s (signs/symptoms) of distress. b. An Incident Report Investigation Behavioral Outburst-Assault of Another Resident or Staff Member dated [DATE] at 7:45 a.m. documented, (Resident #6) was walking in the hall (and) was attacked by (Resident #7). Res denies abd (abdominal) pain, no redness, swelling, or tenderness noted BS (bowel sounds) x 4 (all four quadrants) will monitor res. A witness statement dated [DATE] at 7:45 a.m. and signed by CNA #2 documented, (Resident #7) was hitting (Resident #6) in stomach. c. Nurses Notes dated [DATE] at 8:20 a.m. documented, Experiencing loose stools and vomiting. New order received Phenergan 25 mg (milligrams) IM (intramuscularly) now. Imodium 2 mg after each loose stool max (maximum) 16 mg daily. Clear liquid diet 24 hours. Chem (chemistry lab) 8 am of [DATE]. Family notified of order. Nurses Notes dated [DATE] at 3:00 p.m. documented, Resident still experiencing loose stools received new order for Lomotil 5 mg QID (four times daily) PRN (as needed) faxed to pharmacy. Call and requested stat order. Mucous membranes moist, no tenting of skin. Resident is able to keep down fluids. Nurses Notes dated [DATE] at 3:30 p.m. documented, Resident's daughters without notifying staff call EMS (Emergency Medical System). Resident transferred via ambulance. Given copy of MAR (Medication Administration Record), Face Sheet. DON (Director of Nurses) notified. Nurses Notes dated [DATE] documented, D/C (discharged) from Heritage Park per family request. d. The Emergency Department GI (Gastrointestinal) Assessment documented, [DATE] at 1628 (4:28 p.m.) the abdominal appearance- flat appearance, bowel sounds all quadrants. [DATE] at 1810 (6:10 p.m.) the abdominal appearance was rounded Symmetric audible bowel sounds soft non-tender incontinent of large amount of stool liquid brown. The Hospital Inpatient H&P (History and Physical) documented, The. (Resident #6) presents for evaluation of AMS (altered mental status) and diarrhea for 2 days .This is a new problem. This current episode started ,[DATE] hours ago. This problem has not changed since onset. Associated symptoms include somnolence and weakness. They stated that yesterday when wife visited he was sleeping. Today he would not wake up and had runny diarrhea about every 30 minutes. No documentation of fever. In ED (Emergency Department) pt (patient) was found to have elevated WBC (white blood count) 15.4 (range 3XXX,[DATE].0). The Hospital Course documented, After evaluating pt initially, I was called by RN (Registered Nurse) that pt started vomiting. Concerned about possibility of ischemic bowel. ordered CT (computerized tomography) abd (abdomen) stat. When I went back up to evaluate pt he had just vomited again and aspirated a large amount. Suctioned out fecal looking/smelling emesis. Pt likely does have ischemic bowel Discussed case with wife who has stayed the night. She states that she wants him to be comfortable and understands that there is likely nothing that can be done for him. Pt became hypoxic on 6 L (oxygen at 6 L) appears pale and dyspnea. Lungs have very coarse rales throughout. Will stop all medications other than those for pt comfort. Cancel labs, cancel CT abd. Morphine and Ativan prn. Pt's wife understands that pt's prognosis is very poor. Pt died at 2:14 a.m. Cause of death, Respiratory failure secondary to Aspiration Pneumonia secondary to Presumed ischemic bowel. 3. Resident #7 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. a. A History & Physical dated [DATE] and signed by the medical doctor documented, .admitted to (Geri-Psychiatric unit) ,[DATE] (secondary to) sexually explicit behaviors at previous nursing facility. Psych meds were not changed. Received milieu therapy. Decided he (Resident #7) needed a locked down mens unit. b. A history and physical examination [REDACTED]. Refusal of ADLs (activities of daily living). Labile mood - from smile to combative in seconds. The Psychiatric Evaluation dated [DATE] documented under Mental Status Evaluation, Attitude is poorly cooperative. Delusions, paranoid type appear to be present and as manifest in patient with defensive aggression, especially with essential care. He is having prominent anxiety again pacing, talking to unseen people. While there is no frank suicidal ideation, intent or plan, his proclivity for aggression given his severe confusion and delusional thought can contribute to morbidity and mortality to himself and others. Prognosis: Guarded given severity of dementia syndrome and underlying chronic and acute psychiatric and medical conditions. c. The Geri-Psychiatric Unit Continuing Care/Discharge Planning dated [DATE] documented, .Psychosis NOS (not otherwise specified) CAD (coronary artery disease) Dementia (with) delusions. d. The Social Services Progress Notes dated [DATE] documented, Res (Resident) returned to (facility) on [DATE] from (Geri-Psychiatric Unit). Upon return Res swung at staff. e. The Interdisciplinary Care Plan Conference Record dated [DATE] documented, .Cont (continues) to have some agitation. Action Plan: cont. to observe for behaviors. The care plan itself did not document any new interventions at this conference for

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045212**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/02/2014**
NAME OF PROVIDER OF SUPPLIER **HERITAGE PARK NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1513 SOUTH DIXIELAND RD ROGERS, AR 72756**	

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) monitoring and intervening when behaviors escalate. f. The Care Plan documented, .Focus Resident has impaired cognitive skills AEB/RT (as evidenced by/related to) BIMS (Brief Interview for Mental Status) (less than) 13, impaired memory, disorientation to person, poor or unsafe decision making, dementia Created on: [DATE].XXX[DATE] (handwritten) N.O. (new order) Risperdal (antipsychotic) 0.25 mg BID (twice daily). g. A Fall Investigation dated [DATE] documented the resident fell when he wandered into another resident's bedroom and tripped over a fall mat. Nurses Notes dated [DATE] at 10:00 a.m. documented a physician order [REDACTED]. Nurses Notes dated [DATE] at 6:10 a.m. and at 8:15 a.m. documented the resident fell twice while ambulating. Nurses Notes dated [DATE] documented the resident was seen in the emergency room due to the falls and returned to the facility at 6 p.m. and that new orders were received to discontinue the Risperdal. Nurses Notes dated [DATE] at 2:30 a.m. documented, Reported to refuse all help (with) ADLs and will become aggressively agitated. The Nurses Progress note dated for [DATE] documented, Resident was mildly combative this a.m. able to be redirected. As of [DATE], the care plan did not document any new behavior interventions despite the discontinuation of the antipsychotic medication on [DATE]. The Nurses Notes did not document anything other than attempts to redirect. h. The Quarterly MDS with an ARD of [DATE] documented the resident scored 5 (,[DATE] indicated severely impaired) on a Brief Interview for Mental Status for daily decision making; was ambulatory and required extensive assistance of 1 person for dressing and totally dependent of 1 person for personal hygiene; exhibited wandering behavior with no other behavioral issues checked; had a history of [REDACTED]. i. The Nurses Notes documented, [DATE] at 2100 (9:00 a.m.) This Nurse witnessed res (resident) walk out of his room et (and) hit another res in the stomach twice with his fist. This Nurse ran to intervene et (and) was hit as well. Res was distracted while the other res was moved out of the way .Res was re-directed back to room where he got back into bed. (The Physician) was notified et no N.O. (new orders) were received at this time. The DON notified. Family wife notified. Q (every) 15 minute checks started to monitor res (resident). The Incident Report Investigation Behavioral Outburst-Assault of Another Resident or Staff Member dated [DATE] at 9:00 p.m. documented, Res (resident) came out of room et struck another res. (Resident #6) who was walking by (punched him in the stomach) x 2.Has a similar type of incident occurred in the past? (circle only one choice below). (d circled) At least one other time within the past week. Who or what do you think might have precipitated this incident (triggers): Other resident (up) by room making noise et trying to get in his room most likely was why he got (up) and was agitated. Could the incident have been anticipated or avoided? If so how? .Unknown. Res has hx (history) of these behaviors et can act out (at) any given moment. Could such an incident be avoided in the future? If so how?. Yes monitor this resident closely when ambulating in hall (with) other residents when agitated. The witness statement dated [DATE] at 9:00 p.m. and signed by CNA #1 documented, (Resident #7) walk up to (Resident #6) and punched him in the stomach. Then he walked towards me and trying to hit me and anybody that he came close too. As of [DATE], the care plan did not document any new interventions related to the triggers documented on the Incident Report Investigation. j. Nurses Notes dated [DATE] at 10:00 a.m. documented, Res showing aggressive behavior et being combative (with) staff. Physician notified et N.O. received for Risperdal 0.25 mg po (by mouth) . k. The Incident Report Investigation Behavioral Outburst-Assault of Another Resident or Staff Member dated [DATE] at 7:45 a.m. documented, Resident became combative (and) began hitting CNAs (and) another Resident (Resident #6). Res 1:1 (one on one supervision). Nurses Notes dated [DATE] at 6:00 p.m. documented, (Incident occurred at 7:45 a.m.) Resident became combative (and) aggressive. While walking down the hallway he hit another resident (Resident #6) in the stomach. He also attacked the CNA hitting the CNA(CNA #2) in the face leaving a black eye. The CNA called for help. Upon entering the unit RN (Registered Nurse #1) attempted to give Resident po (by mouth) pain med (medication) and was attacked by resident. Dr. (Doctor) notified and orders given for Ativan IM 1 mg. Med was given. Resd (resident) calmed a little but remained combative against staff. (Physician) Ordered Psych Eval (Evaluation)(Geri-Psych) came and evaluated resident and accepted him in the program. Waiting for POA (Power of Attorney) to consent that Resd (resident) will be transported to (Geri-Psych). There was no indication that resident was still receiving one-on-one supervision. There was no documentation in the Nurses Notes until the next day. Nurses Notes dated [DATE] at 6:30 a.m. documented, Resident calm (and) cooperative this morning (no) further behavior issues this shift. There was no indication that resident was still receiving one-on-one supervision. Nurses Notes dated [DATE] at 11:05 a.m. and 1:06 p.m. did not mention one-on-one supervision. Nurses Notes at 3:25 p.m. documented the resident was taken to the Geri-Psychiatric Unit. l. The Resident Safety Check Form dated [DATE] documented, 7:45 (a.m.) One on One (checked). Q (every) 15 minute check (checked). 11:00 (a.m.) Q 30 min (minutes) check (checked), (1:00 p.m.) Q 1 hour check (checked)*Please initial below at the time the check was completed. By initialing you are verifying that the safety check was completed. Please note a one-on-one indicates that the assigned person is with the resident constantly. The Resident Safety Check was initialed as completed with last hourly initial at 3:00 p.m. There was no further documentation of frequent monitoring. There was no documented Resident Safety Check form for [DATE]. m. Staff interviews were conducted regarding the Men's Secure Unit: 1) On [DATE] at 4:05 p.m., CNA #1 was asked if she had worked the Secure Unit. The CNA stated, Yes, I have worked on the Men's Unit. The CNA was asked if she was aware of any incidents regarding resident to resident aggression. The CNA stated, Yes, (Resident #7) came out of his room and hit (Resident #6) repeatedly in the abdomen, 2 or 3 times. The CNA was asked when the incident occurred. The CNA stated, Right after breakfast ([DATE]) I told him not to hit (Resident #6). (Resident #7) stated it's not hurting him. Then (Resident #7) hit me in the face. He slapped me 3 times that day. The CNA was asked how she got help. The CNA stated, I didn't leave the unit but I had to go to the door (the door is located at the end of the hall) and open the door and yell for help. The CNA was asked if they had anything other than yelling for help on the secure unit. The CNA stated that they had walky talkies but they weren't working and they had not worked for some time. The CNA stated, The Nurse came in and attempted to give (Resident #7) medication and he slapped it out of her hand and bent her hand back and slapped her in the face. The CNA was asked how she protected (Resident #6). The CNA stated that the nurse gave (Resident #7) medication that calmed him down. The CNA was asked if (Resident #7) had been aggressive and hit before. The CNA stated, Yes, he had hit staff but not residents as far as I know. The CNA was asked how many staff worked on the Men's Secure Unit. The CNA stated, One, there is a float that also works the Women's Secure Unit, (the census for the Women's secure unit is 13). The CNA was asked how often the float came to help. The CNA stated that it varied. The CNA was asked, If you are in a room caring for a resident, how do you know what is going on with the other residents. The CNA stated, You listen for them. 2) On [DATE] at 10:00 a.m., CNA #3 stated that she worked at the facility for 1 year and had been working on the Women's Secure Unit. The CNA was asked if she had worked the Men's Secure Unit. The CNA stated, Yes. The CNA was asked, Did you have any problems with aggressive residents? The CNA stated, Yes with (Resident #7). He came out of his room and slapped me and then went back in his room. She was asked when this occurred. The CNA stated, It's been a while. The CNA was asked if she had seen any resident hit another resident. The CNA stated, No. 3) On [DATE] at 12:20 p.m., CNA #4 and #5 both stated that (Resident #7) was aggressive at times and had hit a resident in the stomach, but had not witnessed the incident. CNA #5 stated that (Resident #7) did raise his hand to hit her, but CNA talked to him and he put his hand down. 4) On [DATE] at 4:05 p.m., Licensed Practical Nurse (LPN) #1 stated, I have worked at the facility for 5 years. The LPN stated that she had not witnessed (Resident #7) hit a resident, but had heard of the resident hitting staff and (Resident #6). The LPN stated, It was in May or June can't remember the exact date, but I assessed (Resident #6) and there was no redness or pain. The LPN was asked what the procedure was for the secure unit with an aggressive resident. The LPN stated, The residents are monitored 1-on-1 until one hour after they receive medication. 5) On [DATE] at 11:20 a.m., RN #2 stated that he was the weekend supervisor and worked one day a week on the cart (medication). RN #2 was asked if he had observed any incident with aggressive residents on the secure unit. RN #2 stated, Yes, (Resident #7) has been known to hit staff and I was told he hit a resident. I have not witnessed him hitting another resident. RN #2 was asked if there were any other residents that were aggressive on the Men's Secure Unit. The RN stated, (Resident #11) had a history of [REDACTED]. RN #2 was asked how the staff get help when they are on the unit. RN #2 stated, We have walky talkies but they haven't worked for over a couple of weeks. The RN was asked if the Administrator was aware. The RN stated, I don't know, the former DON was (aware). At 11:30 a.m., the RN received a phone call and stated that (Resident #7) was coming back to the facility. 6) On [DATE] at 10:22 a.m., the Administrator and DON were asked how the staff communicated on the Secure Units when they needed help. The DON stated that they have a button that they can push. When told that interviews with staff indicated they go to the door and yell for help and that on [DATE] with the resident-to-resident incident CNA #2 had to go to the door and yell for help which meant that she had to walk away from the residents, the Administrator stated, I was not aware the walky talkies were not functioning. o. On [DATE] at 10:36 a.m., the Administrator was asked when she started working at the facility. The Administrator stated, The afternoon of [DATE]. The Administrator was asked if she was aware of the incident that occurred with Resident #7. She stated, I was not told that day, I was told the next day on [DATE]. The Administrator was asked what steps did the facility take to protect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045212**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/02/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE PARK NURSING CENTER	**1513 SOUTH DIXIELAND RD ROGERS, AR 72756**

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) the resident. The Administrator stated, I would have to check that was my first day. The Administrator was asked if she had checked to see if there had been any other incidents regarding Resident #7. The Administrator stated, No. The Administrator was asked if there were any other incidents regarding Resident-to-Resident altercation. The Administrator stated, I didn't know he had hit a resident, I was aware of him hitting a CNA. The Administrator was asked if she had read the Incident report. The Administrator stated, No. The Administrator was shown a copy of the Incident report dated [DATE]. The Administrator was asked if Resident #7 was going to be coming back to the facility. The Administrator stated, Eventually he will. The Administrator was asked if she had checked the other incidents regarding Resident #7. The Administrator stated, No. p. Resident #7 was readmitted to the facility on [DATE] at 12:30 p.m. At 12:45 p.m., the Surveyor entered the Men's Secure Unit. There was only one staff member on the Men's Secure Unit. The resident was sitting on the couch covered with a blanket. CNA #6 went to the door to the secure until and yelled for someone to bring the resident his lunch tray. At 12:47 p.m. the resident's lunch tray was brought to the secure unit. The resident was not placed on 1-on-1 as soon as he was admitted . The Resident Safety Check form dated [DATE] was checked, there were initials on the 12:30 p.m. and the 12:45 p.m. slots the Resident #7 was on 1-on-1 starting at 12:30 p.m. RN #2 was asked whose initials were in the 12:30 slot indicating that Resident #7 had been on 1-on-1 starting at 12:30 p.m. The RN stated, I signed it when I admitted him back to the unit. The RN was asked if he stayed with the resident for the first 15 minutes. The RN stated, No. The RN was asked, When you signed the form are you saying that you stayed with the resident for the first 15 minutes? The RN stated, I shouldn't have signed the form. The RN was asked when did the 1-on-1 actually start as there was only one CNA on the Men's Secure Unit at 12:47 p.m. The RN stated, CNA #5 was supposed to be back there. There was an initial in the 12:45 p.m. slot and the RN was asked if the CNA was on the unit at 12:45 p.m. The RN stated that the CNA did not get to the Men's Secure Unit around 12:55 p.m. On [DATE] At 1:15 p.m., the Administrator and the Director of Nurses were asked what plans had been developed related to Resident #7's aggressive behaviors toward staff/residents when he returned to the facility. The DON stated, I was not aware that (Resident #7) was returning to the facility until he was already in the facility. The DON stated, We will get a Psych consult with (agency) and will have q 15 minutes checks to check the level of function and we plan on initiating a Plan of Care for Behaviors, see if we can find what the triggers are, we can't restrain him. The DON stated, We are still working on our plans. 4. The facility removed the Immediate Jeopardy on [DATE] at 4:36 p.m. and reduced the scope/severity to H when the following plan of removal was implemented: 1. The resident in question, upon his return to the facility, was immediately placed on one-on-one supervision by a certified staff member for seven days and then the Director of Nursing will reassess the further need for one-on-one intervention. 2. A new order of Zyprexa was initiated for the resident in question during his recent geri-psych hospitalization . 3. New walkie-talkies were purchased on [DATE] at 3:15 p.m. by facility for staff members working on the dementia units. The new walkie-talkies were given immediately to the staff members working on the dementia units and the B-Hall and C-Hall nurse upon arrival at 3:30 p.m. on [DATE]. A front office staff member went to buy new batteries to replace the old batteries in the walkie-talkies not working on [DATE]. 4. Charts and care plans of residents with behaviors were reviewed by the MDS Coordinator on [DATE] to ensure appropriate interventions were in place. 5. Re-education initiated by Director of Nursing/Designee on [DATE] with staff members prior to coming to work the designated shift and with staff members returning back to work from vacation or leave of absence on the following: a. Separate residents involved in altercation immediately. b. Place residents on on-on-one supervision immediately following an altercation. c. Document the one-on-one supervision on the approved facility form. d. Continue the one-on-one supervision until a more permanent intervention is in place and the DON directs to remove the one-on-one supervision e. One-on-one refers to staff being placed with resident for close observation. 6. The Plan of Action will be monitored for on-going compliance by the Director of Nursing/Designee daily for seven days and then will be re-reviewed by the Interdisciplinary Team for further monitoring.