STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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** 19152 Based on interview and record review, the facility's staff failed to ensure one of three sampled residents (Resident A) was free from physical abuse. The facility failed to: 1. Ensure staff members supervised residents' smoking activity to prevent physical altercations and abuse, per the facility's policy titled Smoking Policy. Residents A and B were left unsupervised on the Grove Unit (a locked unit were residents with more aggressive behavior, elopement/exit seeking [leaving without permission] resided and where CPI [crisis prevention intervention] trained staff were available to handle critical behaviors) smoking patio during a smoking activity. Resident B physically assaulted Resident A, which resulted in an injury to Resident A's right index finger. This deficient practice resulted in an unwitnessed physical assault/abuse on Resident A by Resident B, who grabbed Resident A's right hand and pulled his finger resulting in a fractured (broken bone) finger and placed other residents at risk for potential physical abuse. Findings: During a review of Resident A's Admission Records (Face Sheet), the Face Sheet indicated Resident A was initially admitted to the facility on [DATE], and last readmitted on [DATE] with diagnoses including bipolar disorder (a mental illness characterized by periods of elevated mood and periods of depression). During a review of Resident A's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/1/2021, the MDS indicated Resident A was able to make independent decisions that were consistent and reasonable. According to the MDS, Resident A required limited one-person physical assistance from staff for locomotion (moving) on and off the unit but did not walk in his room or the corridor. The MDS indicated Resident A had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of his lower extremities (left leg). During a review of Resident A's Physician's Orders dated 10/6/2021, the physician's orders indicated for the resident to receive Seroquel (anti-psychotic medication) tablet 50 milligrams ([mg] unit of measurement), give 100 mg twice a day related to (r/t) bipolar disorder manifested by (m/b) delusions and making false accusations toward staff and peers. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	During a review of Resident A's Nursing Progress Note (NPN), dated 1/17/2022 and timed at 10:45 p.m., the NPN indicated Resident A approached Licensed Vocational Nurse 1 (LVN 1) and reported that while he was smoking on the patio, Resident B asked him if he could have a light. The NPN indicated Resident A told Resident B No, and Resident B grabbed Resident A's right hand and jerked it sideways. Resident A's right index finger was noted with swelling and stiff to touch, and Resident A complained of pain of 10 on a scale of 1-10 (10 indicating extreme pain) and was unable to move the affected finger. Resident A's physician was called, and an order was obtained for an x-ray (a photographic or digital image of the body part internal composition) of the right hand. During a review of Resident A's Physician Order, dated 1/17/2022, the order indicated to obtain a STAT (immediate) x-ray of Resident A's right hand. During a review of Resident A's x-ray Report, dated 1/18/2022, the x-ray report indicated Resident A had an acute (recent) oblique (slanting/twisted) second proximal (the part of the body that is closer to the center of the body than another part) phalanx (a bone of the finger or toes) fracture with mild displacement (loss of bone alignment). During a review of Resident A's Physician Progress Note (PPN), dated 1/19/2022, the PPN indicated Resident A had a swollen hand with a splint (a device used for holding a part of the body stable to decrease pain and prevent further injury) on the right index finger (the second digit of the hand). During a review of Resident B's Admission Records (Face Sheet), the Face Sheet indicated Resident B was initially admitted to the facility on [DATE] and last readmitted on [DATE]with diagnoses including alcohol abuse, history of traumatic brain injury and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) bipolar type. During a review of Resident B's MDS assessment, dated 12/14/2021, the MDS indicated Resident B's cognitive skills for daily decision-making were moderately impaired. The MDS indicated Resident B required limited one-person physical assistance from staff to walk in his room and down the corridors and on/off the unit. During a review of Resident B's physician orders, the physician's orders indicated the following: 1. Risperdal (antipsychotic medication) tablet 3 milligram (mg) every 12 hours related to (r/t) schizoaffective disorder, bipolar type m/b disorganized thought process. 2. Seroquel tablet 600 mg at bedtime r/t schizoaffective disorder, bipolar type m/b responding to internal stimuli (unseen; i.e. voices etc. with a response) and talking to self. During a review of Resident B's NPN, dated 1/17/2021 and timed at 10:56 p.m., the NPN indicated LVN 2 was informed by a charge nurse (unnamed), Resident B grabbed Resident A's hand because Resident A refused to give Resident B a light for his cigarette when he asked. During a review of the facility's Investigative Report (IR) dated 1/18/2022 and timed at 9:30 a.m., the IR indicated Resident A stated he was outside smoking a cigarette in the patio unattended at approximately 9:30 p.m., on 1/17/2022. Resident A stated Resident B approached him and asked for a cigarette. Resident A stated No to Resident B became angry and grabbed Resident A's right wrist and pulled Resident A's right index finger sideways. (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	During a telephone interview on 4/15/2022 at 3:13 p.m., the Director of Nursing (DON) stated after reviewing LVN 1's nursing notes dated 1/17/2022, she found a certified nursing assistant (CNA 1) was mentioned by LVN 1 in his notes. The DON stated she called LVN 1 and LVN 1 stated CNA 1 was supervising the smoking patio but was pulled away on an emergency and that was when the altercation happened between Residents A and B. During a telephone interview on 4/24/2022 at 7:13 p.m., Registered Nurse Supervisor 1 (RNS 1) stated, the last smoking hour for the residents was at 8:30 p.m. and based on the slowest smoker the smoking break typically last approximately, 30 minutes. RNS 1 stated the smoking hours are usually followed so residents have consistency. RNS 1 stated he did not know who was assigned to the smoking patio but was told it was CNA 1. During a telephone interview on 4/25/2022 at 12:09 p.m., CNA 1 stated the night of the incident (1/17/2022) between Residents A and B he was assigned to the patio area. CNA 1 stated there were approximately four residents who were either smoking or lingering around the patio after they finished smoking. CNA 1 stated he heard a resident hollering across the hallway and ran to that area to make sure no one was hurt. CNA 1 stated when he returned to the smoking patio, Residents A and B were close to each other, but he was not aware there had been an incident between them until LVN 1 asked him if he had seen anything. CNA 1 stated when he is assigned to monitor the smoking patio, he monitors the residents for safety to make sure there are no resident-to-resident altercations, falls, and/or smoking related accidents. CNA 1 stated the residents who were on the smoking patio were not being aggressive and he had no reason to believe any of them would become aggressive so when he heard the other resident holler out his priority was to make sure that resident was okay. CNA 1 stated the last official smoking time was at 8:30 p.m., but even after the last smoking time they allow residents to smoke and monitor them until the end of the shift. During a telephone interview on 4/25/2022 at 12:51 p.m., Licensed Vocational Nurse 1 (LVN 1) stated he was passing medication the night of the altercation on 1/17/2022, when Resident A approached him and stated he missed his smoking break. LVN 1 stated he had cigarettes on him and gave one to Resident A who went to the smoking patio to smoke. LVN 1 stated later, Resident A came to him pointing at his right hand and stated Resident B grabbed his hand. LVN 1 stated Resident A's finger was hard and swollen and Resident A was in a lot of pain. LVN 1 stated he asked CNA 1 what happened, and CNA 1 told him he was not on the patio and did not witness the altercation between Residents A and B. LVN 1 stated he was not sure if the facility was short-staffed that night but stated CNA 1 left the patio and should have stayed on the smoking patio where he was assigned to monitored and supervise. During a review of the Grove Smoking Schedule Times, the schedule indicated resident's smoking times were at 6:30 a.m., 8:30 a.m., 1:45 p.m., 3:30 p.m., 6:30 p.m., and 8:30 p.m. During a review of the facility's policy and procedure (P/P), dated 10/24/2017 and titled, Smoking Policy, the P/P indicated the purpose was to respect residents' choice to smoke and to maintain a safe and healthy environment to both smokers and non-smokers. The P/P indicated designated supervised smoking schedule will be discussed with the residents and posted in the facility and all smoking sessions will be supervised by the facility's staff members. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P/P for abuse, revised in 3/2018 and titled, Abuse Prohibition and Prevention, the P/P indicated each resident had the right to be free from abandonment, mental/emotional, isolation, involuntary seclusion, verbal, physical, financial, sexual, neglect, and misappropriation of property.

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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 - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19152 Based on interview and record review, the facility's nursing staff failed to conduct a complete investigation of physical altercation occurred between residents for two of three sampled residents (Residents A and B). This deficient practice resulted in the facility not exploring all aspects of physical altercation between residents before making a determination about the incident and had the potential for altercation reoccurrence. Findings: During a review, Resident A's Admission Records indicated Resident A was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident A's had diagnosis of bipolar disorder (a mental illness characterized by periods of elevated mood and periods of depression). During review, a Minimum Data Set (MDS) a standardizes assessment a care screening tool, dated 12/1/2021 indicated Resident A was able to make independent decisions that were consistent and reasonable. The MDS indicated Resident A required limited one-person physical assist for locomotion on and off the unit but did not walk in his room or the corridor. According to the MDS Resident A had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of his lower extremities. During a review of the Nurses Progress Notes dated 1/17/2022 and timed at 10:45 p.m., the notes indicated Licensed Vocational Nurse 1 (LVN 1) was approached by Resident A who reported that while he was smoking on the outside patio, Resident B asked him if he could have a light. The notes indicated Resident A told Resident B no, and Resident B grabbed Resident A's right hand and jerked his index finger sideways. Resident A's right index finger was noted with swelling, it was stiff and hard to touch. Resident A complained of pain of a 10 on a scale of 1-10 (10 indicating extreme pain) and was unable to move the affected finger. Resident A's physician was called, and an order was obtained for an x-ray. During a review, a Physician's Order dated 1/17/2022, indicated to obtain a STAT (immediate) X-ray on Resident A's right hand. During a review, a Radiology Report, dated 1/18/2022, indicated Resident A had an acute (recent) oblique (slanting) 2nd proximal the part of the body that is closer to the center of the body than another part, phalanx (a bone of the finger or toe) fracture with mild displacement (loss of bone alignment). During a review, Physician Progress Notes, dated 1/19/2022, indicated Resident A had right index finger swollen with a splint. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review, Resident B's Admission Records indicated Resident B was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident B had diagnoses including alcohol abuse, history of traumatic brain injury and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) bipolar type. During a review, Resident B's MDS dated [DATE], indicated Resident B's cognitive skills for daily decision-making were moderately impaired. The MDS indicated Resident B required limited one-person physical assist to walk in his room and down the corridors and on/off the unit. During a review, Progress Notes (nursing) dated 1/17/2021 and timed at 10:56 p.m., indicated LVN 2 was informed by a charge nurse that Resident B grabbed Resident A's hand because Resident A refused to give Resident B a light when he asked. During a review, the Investigative Documents indicated the facility's investigation of the altercation between Residents A and B did not include interviews with staff assigned to monitor Resident A and Resident B on the smoking patio. The facility's investigation did not include interviews with the charge nurse assigned to the residents or the RN who oversaw the unit. During a telephone interview on 4/15/2022, at 3:13 p.m., and after reviewing Resident A and Resident B's progress notes, the Director of Nursing (DON) stated she discovered a certified nursing assistant (CNA 1) was mentioned by LVN 1 in his progress notes. The DON stated she called LVN 1 and was told by that CNA 1 was supervising the smoking patio but got pulled away on a different emergency and that was when the altercation happened between Resident B and Resident B. The DON stated she did not conduct the investigation and was not sure why the staff were not interviewed. During an interview on 4/24/2022, at 7:13 p.m., Registered Nurse Supervisor 1 (RN 1) stated he documented in the Progress Notes what occurred the night of Resident A and Resident B's altercation. RN 1 stated he contacted the director of nursing (DON) to let her know about the incident, but no one had ever interviewed him or taken his statement about what occurred. During a telephone interview on 4/25/2022, at 12:09 p.m., Certified Nursing Assistant 1 (CNA 1) stated the night of the altercation incident between Resident A and Resident B on 1/17/2022, he was assigned to the patio area. CNA 1 stated there were approximately 3-4 residents who were either smoking or lingering around after they finished smoking. CNA 1 stated he heard a resident hollering and ran to that area to make sure no one was hurt. CNA 1 stated when he returned to the smoking patio Resident A and Resident B were near each other, but he was not aware there had been an incident between them until the charge nurse ([LVN 1] Licensed Vocational Nurse) asked him if he had seen anything. CNA 1 stated the only person who asked him about the incident was LVN 1, no one else asked him what happened where he was or took his statement. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/25/2026, at 12:51 p.m., LVN 1 stated he was passing medication on 1/17/2022, on the night of the incident, when Resident A approached him and said he missed his smoking break. LVN 1 stated he had cigarettes on him and gave one to Resident A who went to the smoking patio to smoke. LVN 1 stated later Resident A came to him pointing at his hand and said Resident grabbed his hand. LVN 1 stated Resident A's finger was hard and swollen and he was in a lot of pain. LVN 1 stated he asked CNA 1 what happened, and CNA 1 told him there was an emergency across the hall that he went to assist in, and he did not witness the altercation between Resident A and Resident B. LVN 1 stated he was not sure if they were short staffed that night, but CNA 1 left to assist and should have stayed with his assignment on the smoking patio. LVN 1 stated he was asked to write a statement regarding the incident, but he was busy and thought his progress notes would be sufficient, so he did not make a statement. LVN 1 stated other than being asked to write a statement no one ever interviewed him. During a review of facility's Policy and Procedure (P/P), titled Abuse Prohibition and Prevention, Reporting Reasonable Suspicion of a Crime in the Facility dated 3/2018 indicated, under section titled Investigation, all incidents of suspected or alleged abuse will be promptly investigated by the assigned staff. The investigation and report shall include: reviews of all relevant documentation, review of the resident's medical record to determine events preceding the alleged incident, interviews the person making the report, interview any witnesses to the alleged incident and others that may have additional information, interview the facility staff members who have had contact with the resident during the period of the alleged incident, interviews other residents to who the accused employee provides care or services, reviews all events leading up to the alleged incident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19152 Based on interview and record review, the facility failed to provide supervision to ensure residents in the Behavioral Unit of the facility named Grove Unit (a locked unit with residents who had more aggressive behaviors) were free from harm and had a crisis prevention intervention (CPI) trained staff present required to handle the critical behaviors for two of three sampled residents (Residents A and B). Residents A and B, who had behavioral problems, were left on the patio during a smoking activity unsupervised and Resident B physically assaulted Resident A by pulling his finger back. This deficient practice resulted in physical altercation between Residents A and B occurred during the time when the residents were not supervised. Resident B grabbed Resident A's right hand and pulled his finger resulting in a fractured (broken bone) right index finger. This deficient practice placed other residents at risk for potential physical abuse when residents are left unsupervised. Findings: During a review of Resident A's Admission Records (Face Sheet), the Face Sheet indicated Resident A was initially admitted to the facility on [DATE], and last readmitted on [DATE] with diagnoses including bipolar disorder (a mental illness characterized by periods of elevated mood and periods of depression). During a review of Resident A's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/1/2021, the MDS indicated Resident A was able to make independent decisions that were consistent and reasonable. According to the MDS, Resident A required limited one-person physical assistance from staff for locomotion (moving) on and off the unit but did not walk in his room or the corridor. The MDS indicated Resident A had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of his lower extremities (left leg). During a review of Resident A's Physician's Orders dated 10/6/2021, the physician's orders indicated for the resident to receive Seroquel (anti-psychotic medication) tablet 50 milligrams ([mg] unit of measurement), give 100 mg twice a day related to (r/t) bipolar disorder manifested by (m/b) delusions and making false accusations toward staff and peers. During a review of Resident A's Nursing Progress Note (NPN), dated 1/17/2022 and timed at 10:45 p.m., the NPN indicated Resident A approached Licensed Vocational Nurse 1 (LVN 1) and reported that while he was smoking on the patio Resident B asked him if he could have a light. The NPN indicated Resident A told Resident B No, and Resident B grabbed Resident A's right hand and jerked it sideways. Resident A's right index finger was noted with swelling and stiff to touch, and Resident A complained of pain of 10 on a scale of 1-10 (10 indicating extreme pain) and was unable to move the affected finger. Resident A's physician was called, and an order was obtained for an x-ray (a photographic or digital image of the body part internal composition) of the right hand. During a review of Resident A's Physician Order, dated 1/17/2022, the order indicated to obtain a STAT (immediate) x-ray of Resident A's right hand. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident A's x-ray Report, dated 1/18/2022, the x-ray report indicated Resident A had an acute (recent) oblique (slanting/twisted) second proximal (the part of the body that is closer to the center of the body than another part) phalanx (a bone of the finger or toes) fracture with mild displacement (loss of bone alignment). During a review of Resident A's Physician Progress Note (PPN), dated 1/19/2022, the PPN indicated Resident A had a swollen hand with a splint (a device used for holding a part of the body stable to decrease pain and prevent further injury) on the right index finger (the second digit of the hand). During a review of Resident B's Admission Records (Face Sheet), the Face Sheet indicated Resident B was initially admitted to the facility on [DATE] and last readmitted on [DATE]with diagnoses including alcohol abuse, history of traumatic brain injury and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions) bipolar type. During a review of Resident B's MDS assessment, dated 12/14/2021, the MDS indicated Resident B's cognitive skills for daily decision-making were moderately impaired. The MDS indicated Resident B required limited one-person physical assistance from staff to walk in his room and down the corridors and on/off the unit. During a review of Resident B's physician orders, the physician's orders indicated the following: 1. Risperdal (antipsychotic medication) tablet 3 milligram (mg) every 12 hours related to (r/t) schizoaffective disorder, bipolar type m/b disorganized thought process. 2. Seroquel tablet 600 mg at bedtime r/t schizoaffective disorder, bipolar type m/b responding to internal stimuli (unseen, i.e. voices etc. with a response) and talking to self. During a review of Resident B's NPN, dated 1/17/2021 and timed at 10:56 p.m., the NPN indicated LVN 2 was informed by a charge nurse (unnamed), Resident B grabbed Resident A's hand because Resident A refused to give Resident B a light for his cigarette when he asked. During a review of the facility's Investigative Report (IR) dated 1/18/2022 and timed at 9:30 a.m., the IR indicated Resident A stated he was outside smoking a cigarette in the patio unattended at approximately 9:30 p.m., on 1/17/2022. Resident A stated Resident B approached him and asked for a cigarette. Resident A stated No to Resident B became angry and grabbed Resident A's right wrist and pulled Resident A's right index finger sideways. During a telephone interview on 4/15/2022 at 3:13 p.m., the Director of Nursing (DON) stated after reviewing LVN 1's nursing notes dated 1/17/2022, she found a certified nursing assistant (CNA 1) was mentioned by LVN 1 in his notes. The DON stated she called LVN 1 and LVN 1 stated CNA 1 was supervising the smoking patio but was pulled away on an emergency and that was when the altercation happened between Residents A and B. During a telephone interview on 4/24/2022 at 7:13 p.m., Registered Nurse Supervisor 1 (RNS 1) stated, the last smoking hour for the residents was at 8:30 p.m. and based on the slowest smoker the smoking break typically last approximately, 30 minutes. RNS 1 stated the smoking hours are usually followed so residents have consistency. RNS 1 stated he did not know who was assigned to the smoking patio but was told it was CNA 1. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/25/2022 at 12:09 p.m., CNA 1 stated the night of the incident (1/17/2022) between Residents A and B he was assigned to the patio area. CNA 1 stated there were approximately four residents who were either smoking or lingering around the patio after they finished smoking. CNA 1 stated he heard a resident hollering across the hallway and ran to that area to make sure no one was hurt. CNA 1 stated when he returned to the smoking patio, Residents A and B were close to each other, but he was not aware there had been an incident between them until LVN 1 asked him if he had seen anything. CNA 1 stated when he is assigned to monitor the smoking patio, he monitors the residents for safety to make sure there are no resident-to-resident altercations, falls, and/or smoking related accidents. CNA 1 stated the residents who were on the smoking patio were not being aggressive and he had no reason to believe any of them would become aggressive so when he heard the other resident holler out his priority was to make sure that resident was okay. CNA 1 stated the last official smoking time was at 8:30 p.m., but even after the last smoking time they allow residents to smoke and monitor them until the end of the shift. During a telephone interview on 4/25/2022 at 12:51 p.m., LVN 1 stated he was passing medication the night of the altercation on 1/17/2022, when Resident A approached him and stated he missed his smoking break. LVN 1 stated he had cigarettes on him and gave one to Resident A who went to the smoking patio to smoke. LVN 1 stated later, Resident A came to him pointing at his right hand and stated Resident B grabbed his hand. LVN 1 stated Resident A's finger was hard and swollen and Resident A was in a lot of pain. LVN 1 stated he asked CNA 1 what happened, and CNA 1 told him he was not on the patio and did not witness the altercation between Residents A and B. LVN 1 stated he was not sure if the facility was short-staffed that night but stated CNA 1 left the patio and should have stayed on the smoking patio where he was assigned. During a review of the Grove Smoking Schedule Times, the schedule indicated resident's smoking times were at 6:30 a.m., 8:30 a.m., 1:45 p.m., 3:30 p.m., 6:30 p.m., and 8:30 p.m. During a review of the facility's policy and procedure (P/P), dated 10/24/2017 and titled, Smoking Policy, the P/P indicated the purpose was to respect residents' choice to smoke and to maintain a safe and healthy environment to both smokers and non-smokers. The P/P indicated designated supervised smoking schedule will be discussed with the residents and posted in the facility and all smoking sessions will be supervised by the facility's staff members.