STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation, the facility failed to implement their policy on abuse regarding reporting and investigation of an allegation of abuse for one of 3 sampled resident (#51). The deficient practice could result in residents not protected from further abuse. Findings include:-Resident #17 (alleged perpetrator) was readmitted to the facility on [DATE], with diagnoses of dementia, history of traumatic brain injury, anxiety disorder, major depressive disorder, history of transient ischemic attack, and cerebral infarction.A care plan revised on August 12, 2025 revealed the resident had behavior problems consisting of eating other resident's food, wandering, refusing care, and being sexually inappropriate. Interventions included administering medications as ordered, removing from situations and explaining why the behavior is inappropriate/unacceptable. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident had no cognitive impairment. A late entry Nurse Practitioner (NP/staff #500) note dated January 10, 2026 included staff reported that resident #17 exhibited sexual inappropriate behaviors with another resident. The note included a staff member saw the hands of resident #17 inside the back of the pants of the other resident (#51); and that, both residents were kissing each other. The documentation included that resident #17 was a registered s** o*******; and that, there was an incident where resident #17 was talking loudly on his portable phone in the lounge area, making sexually explicit comments, including asking about breast size and making sexual remarks. It also included that when staff attempted to redirect resident #17, the resident becomes upset and continues the behavior. Per the documentation, the facility was notified of the staff report and staff were instructed to continue monitoring the situation closely. The late entry behavior note dated January 15, 2026 revealed that at approximately 10:15 a.m. the resident walked by a female peer and pretended to touch the female resident's cheek. Per the documentation, the CNA (certified nursing assistant reminded resident #17 not to touch peers and the resident walked away. A NP note dated January 21, 2026 included that upon review of the camera footage by the Director of Nursing, it was determined that the staff's initial report was inaccurate. Per the documentation, the hands of resident #17 was not inside the pants of another resident (#51); but rather, both residents were holding hands. The documentation also included that on one occasion, resident #17 placed his hand on the thigh of resident #51. -Resident #51 (alleged victim) was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, dementia, bipolar disorder, obsessive compulsive behavior, anxiety disorder, and Alzheimer's disease. A care plan revised on August 12, 202, revealed the resident had a communication problem related to impaired cognition and a hearing deficient, had an alteration in neurological status related to a diagnosis of neurocognitive disorder, and, had impaired cognitive function/dementia or impaired thought processes related to dementia and Alzheimer's disease. Interventions included anticipating and meeting needs, and encouragement to continue stating thoughts even if there (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

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is difficulty, administering medications as ordered and monitoring for side effects and interventions, and, to face the resident when speaking, make eye contact with the resident, reduce distractions, keep routine consistent and try to provide consistent care givers to decrease confusion.The MDS assessment dated [DATE], revealed the resident had a BIMS score of 00, which indicated resident had severe cognitive impairment. Review of the clinical record revealed no documentation of an incident between resident #51 and another resident (#17) on January 10, 2026. Despite documentation, there was no evidence found in the clinical record and facility documentation that the incident between resident #17 and #51 were reported to the State Agency (SA), Ombudsman and law enforcement.There was also no evidence that the incident was thoroughly investigated and the results of the investigation was reported to the SA within 5 working days of the incident. On January 21, 2026, at 10:10 a.m., an interview was conducted with the Assistant Director of Nursing (ADON/staff #230) who stated that she was aware of the report that someone saw resident #17 put his hands down the pants of a female resident (#51); however, the ADON stated that she was not aware of who saw this incident. The ADON said that the incident was reported to the Director of Nursing (DON/staff #200) and the Administrator (staff #250); and that, she heard the camera footage was reviewed and she was told that the residents were just holding hands. The ADON further stated that she did not review the camera footage herself. In an interview conducted with the DON (staff #200) and the Administrator (staff #250) on January 21, 2026 at 1:50 p.m., the DON stated that he was made aware by a staff that resident #17 placed his hands down a female resident's pants; however, he was unable to recall which staff member reported the incident. He stated the allegation was discussed in the facility's IDT (interdisciplinary team) meeting; and that, the video camera footage was reviewed by himself and the Administrator (staff #250). The DON stated the video footage showed that both residents were sitting, the hand of the female resident was on the thigh of resident #17; and that, the hand of resident #17 was on the back of the female resident. The DON stated the incident was investigated and was unsubstantiated because resident #17 has a behavior of being sexually inappropriate; and, this incident was a behavior and not abuse. Further, the DON said that this was also the reason why the incident was not reported to the SA. Regarding their investigation, he and the Administrator determined that investigation was not needed because the incident happened in the behavior unit. The Administrator stated the video footage of the incident was no longer available for review because their system auto deletes in 72 hours. Despite admitting to reviewing the video footage of the incident, both the Administrator and the DON stated that they do not know who the female resident that was involved with this incident. The Administrator stated that the intent to cause harm would constitute abuse. The DON stated that it would only be considered abuse if the psychiatric provider says that it is. He also said that there was no preventive measures in place for resident #17 because being sexually inappropriate was a behavior of resident #17. An interview was conducted with a Certified Medical Assistant (CMA/staff #220) and Certified Nursing Assistant (CNA/staff #227) on January 21, 2026 at 2:46 p.m. Both staff #220 and #227 stated they heard about the incident regarding with resident #17 putting his hands down the pants of resident #51 but they did not witness the incident.A telephone interview was conducted with the Nurse Practitioner (NP/staff #500), on January 21, 2026 at 3:18 p.m. The NP stated that he wrote the note on January 10, 2026 because staff reported to him that resident #17 had his hands down a female resident's pants; however, he did not witness the incident. The NP stated that he did not review the video footage of the incident but the DON called and told him what the DON saw on the footage; and that, he had to write another note in case anything went to court. The NP stated that this was the reason why he wrote the NP note on January 21, 2026. Review of the facility's policy on Resident (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated January 1, 2024, included that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility; local/state ombudsman; adult protective services (where state law provides jurisdiction in long-term care); and law enforcement officials. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. All allegations are thoroughly investigated. The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction. The individual conducting the investigation as a minimum:a. Reviews the documentation and evidence;b. Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;c. Observes the alleged victim, including his or her interactions with staff and other residents;d. Interviews the person(s) reporting the incident;e. Interviews any witnesses to the incident;f. Interviews the resident (as medically appropriate) or the resident's representative;g. Interviews the resident's attending physician as needed to determine the resident's condition;h. Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;i. Interviews the resident's roommate, family members, and visitors;j. Interviews other residents to whom the accused employee provides care or services;k. Reviews all events leading up to the alleged incident; andl. Documents the investigation completely and thoroughly.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation, the facility failed to ensure that an allegation of abuse for one of 3 sampled residents (#51) was reported to the State Agency, Ombudsman and law enforcement and failed to report the results of the investigation to the State Agency within 5 working days of the incident as required. The deficient practice could result in abuse not being reported and residents not protected from further abuse.Findings include: -Resident #17 (alleged perpetrator) was readmitted to the facility on [DATE], with diagnoses of dementia, history of traumatic brain injury, anxiety disorder, major depressive disorder, history of transient ischemic attack, and cerebral infarction.A care plan revised on August 12, 2025 revealed the resident had behavior problems consisting of eating other resident's food, wandering, refusing care, and being sexually inappropriate. Interventions included administering medications as ordered, removing from situations and explaining why the behavior is inappropriate/unacceptable. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident had no cognitive impairment. A late entry Nurse Practitioner (NP/staff #500) note dated January 10, 2026 included staff reported that resident #17 exhibited sexual inappropriate behaviors with another resident. The note included a staff member saw the hands of resident #17 inside the back of the pants of the other resident (#51); and that, both residents were kissing each other. The documentation included that resident #17 was a registered s** o*******; and that, there was an incident where resident #17 was talking loudly on his portable phone in the lounge area, making sexually explicit comments, including asking about breast size and making sexual remarks. It also included that when staff attempted to redirect resident #17, the resident becomes upset and continues the behavior. Per the documentation, the facility was notified of the staff report and staff were instructed to continue monitoring the situation closely. The late entry behavior note dated January 15, 2026 revealed that at approximately 10:15 a.m. the resident walked by a female peer and pretended to touch the female resident's cheek. Per the documentation, the CNA (certified nursing assistant reminded resident #17 not to touch peers and the resident walked away. A NP note dated January 21, 2026 included that upon review of the camera footage by the Director of Nursing, it was determined that the staff's initial report was inaccurate. Per the documentation, the hands of resident #17 was not inside the pants of another resident (#51); but rather, both residents were holding hands. The documentation also included that on one occasion, resident #17 placed his hand on the thigh of resident #51. -Resident #51 (alleged victim) was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, dementia, bipolar disorder, obsessive compulsive behavior, anxiety disorder, and Alzheimer's disease. A care plan revised on August 12, 202, revealed the resident had a communication problem related to impaired cognition and a hearing deficient, had an alteration in neurological status related to a diagnosis of neurocognitive disorder, and, had impaired cognitive function/dementia or impaired thought processes related to dementia and Alzheimer's disease. Interventions included anticipating and meeting needs, and encouragement to continue stating thoughts even if there is difficulty, administering medications as ordered and monitoring for side effects and interventions, and, to face the resident when speaking, make eye contact with the resident, reduce distractions, keep routine consistent and try to provide consistent care givers to decrease confusion.The MDS assessment dated [DATE], revealed the resident had a BIMS score of 00, which indicated resident had severe cognitive impairment. Review of the clinical record revealed no documentation of an incident between resident #51 and another resident (#17) on January 10, 2026. Despite documentation, there was no evidence (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found in the clinical record and facility documentation that the incident between resident #17 and #51 were reported to the State Agency (SA), Ombudsman and law enforcement.There was also no evidence that the results of the investigation was reported to the State Agency within 5 working days of the incident.On January 21, 2026, at 10:10 a.m., an interview was conducted with the Assistant Director of Nursing (ADON/staff #230) who stated that she was aware of the report that someone saw resident #17 put his hands down the pants of a female resident (#51); however, the ADON stated that she was not aware of who saw this incident. The ADON said that the incident was reported to the Director of Nursing (DON/staff #200) and the Administrator (staff #250); and that, she heard the camera footage was reviewed and she was told that the residents were just holding hands. The ADON further stated that she did not review the camera footage herself. In an interview conducted with the DON (staff #200) and the Administrator (staff #250) on January 21, 2026 at 1:50 p.m., the DON stated that he was made aware by a staff that resident #17 placed his hands down a female resident's pants; however, he was unable to recall which staff member reported the incident. He stated the allegation was discussed in the facility's IDT (interdisciplinary team) meeting; and that, the video camera footage was reviewed by himself and the Administrator (staff #250). The DON stated the video footage showed that both residents were sitting, the hand of the female resident was on the thigh of resident #17; and that, the hand of resident #17 was on the back of the female resident. The DON stated the incident was investigated and was unsubstantiated because resident #17 has a behavior of being sexually inappropriate; and, this incident was a behavior and not abuse. Further, the DON said that this was also the reason why the incident was not reported to the SA. Regarding their investigation, he and the Administrator determined that investigation was not needed because the incident happened in the behavior unit. The Administrator stated the video footage of the incident was no longer available for review because their system auto deletes in 72 hours. Despite admitting to reviewing the video footage of the incident, both the Administrator and the DON stated that they do not know who the female resident that was involved with this incident. The Administrator stated that the intent to cause harm would constitute abuse. The DON stated that it would only be considered abuse if the psychiatric provider says that it is. He also said that there was no preventive measures in place for resident #17 because being sexually inappropriate was a behavior of resident #17. An interview was conducted with a Certified Medical Assistant (CMA/staff #220) and Certified Nursing Assistant (CNA/staff #227) on January 21, 2026 at 2:46 p.m. Both staff #220 and #227 stated they heard about the incident regarding with resident #17 putting his hands down the pants of resident #51 but they did not witness the incident.A telephone interview was conducted with the Nurse Practitioner (NP/staff #500), on January 21, 2026 at 3:18 p.m. The NP stated that he wrote the note on January 10, 2026 because staff reported to him that resident #17 had his hands down a female resident's pants; however, he did not witness the incident. The NP stated that he did not review the video footage of the incident but the DON called and told him what the DON saw on the footage; and that, he had to write another note in case anything went to court. The NP stated that this was the reason why he wrote the NP note on January 21, 2026. Review of the facility's policy on Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated January 1, 2024, included that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility; local/state ombudsman; adult protective services (where state law provides jurisdiction in long-term care); and law enforcement officials. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. The follow-up investigation report will provide as much information as possible at the time ofsubmission of the report. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

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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** Based on clinical record review, interviews, and facility policy review the facility failed to ensure an allegation of abuse for one of 3 sampled residents (#51) was thoroughly investigated. The deficient practice could result in appropriate corrective action not taken to protect residents from further abuse.Findings include: -Resident #17 (alleged perpetrator) was readmitted to the facility on [DATE], with diagnoses of dementia, history of traumatic brain injury, anxiety disorder, major depressive disorder, history of transient ischemic attack, and cerebral infarction.A care plan revised on August 12, 2025 revealed the resident had behavior problems consisting of eating other resident's food, wandering, refusing care, and being sexually inappropriate. Interventions included administering medications as ordered, removing from situations and explaining why the behavior is inappropriate/unacceptable. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident had no cognitive impairment. A late entry Nurse Practitioner (NP/staff #500) note dated January 10, 2026 included staff reported that resident #17 exhibited sexual inappropriate behaviors with another resident. The note included a staff member saw the hands of resident #17 inside the back of the pants of the other resident (#51); and that, both residents were kissing each other. The documentation included that resident #17 was a registered s** o*******; and that, there was an incident where resident #17 was talking loudly on his portable phone in the lounge area, making sexually explicit comments, including asking about breast size and making sexual remarks. It also included that when staff attempted to redirect resident #17, the resident becomes upset and continues the behavior. Per the documentation, the facility was notified of the staff report and staff were instructed to continue monitoring the situation closely. The late entry behavior note dated January 15, 2026 revealed that at approximately 10:15 a.m. the resident walked by a female peer and pretended to touch the female resident's cheek. Per the documentation, the CNA (certified nursing assistant reminded resident #17 not to touch peers and the resident walked away. A NP note dated January 21, 2026 included that upon review of the camera footage by the Director of Nursing, it was determined that the staff's initial report was inaccurate. Per the documentation, the hands of resident #17 was not inside the pants of another resident (#51); but rather, both residents were holding hands. The documentation also included that on one occasion, resident #17 placed his hand on the thigh of resident #51. -Resident #51 (alleged victim) was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, dementia, bipolar disorder, obsessive compulsive behavior, anxiety disorder, and Alzheimer's disease. A care plan revised on August 12, 202, revealed the resident had a communication problem related to impaired cognition and a hearing deficient, had an alteration in neurological status related to a diagnosis of neurocognitive disorder, and, had impaired cognitive function/dementia or impaired thought processes related to dementia and Alzheimer's disease. Interventions included anticipating and meeting needs, and encouragement to continue stating thoughts even if there is difficulty, administering medications as ordered and monitoring for side effects and interventions, and, to face the resident when speaking, make eye contact with the resident, reduce distractions, keep routine consistent and try to provide consistent care givers to decrease confusion.The MDS assessment dated [DATE], revealed the resident had a BIMS score of 00, which indicated resident had severe cognitive impairment. Review of the clinical record revealed no documentation of an incident between resident #51 and another resident (#17) on January 10, 2026. Despite documentation, there was no evidence found in the clinical record and facility documentation that the incident was thoroughly investigated and the results of the investigation was reported to the SA within 5 working days of the incident. On January 21, 2026, at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:10 a.m., an interview was conducted with the Assistant Director of Nursing (ADON/staff #230) who stated that she was aware of the report that someone saw resident #17 put his hands down the pants of a female resident (#51); however, the ADON stated that she was not aware of who saw this incident. The ADON said that the incident was reported to the Director of Nursing (DON/staff #200) and the Administrator (staff #250); and that, she heard the camera footage was reviewed and she was told that the residents were just holding hands. The ADON further stated that she did not review the camera footage herself. In an interview conducted with the DON (staff #200) and the Administrator (staff #250) on January 21, 2026 at 1:50 p.m., the DON stated that he was made aware by a staff that resident #17 placed his hands down a female resident's pants; however, he was unable to recall which staff member reported the incident. He stated the allegation was discussed in the facility's IDT (interdisciplinary team) meeting; and that, the video camera footage was reviewed by himself and the Administrator (staff #250). The DON stated the video footage showed that both residents were sitting, the hand of the female resident was on the thigh of resident #17; and that, the hand of resident #17 was on the back of the female resident. The DON stated the incident was investigated and was unsubstantiated because resident #17 has a behavior of being sexually inappropriate; and, this incident was a behavior and not abuse. Further, the DON said that this was also the reason why the incident was not reported to the SA. Regarding their investigation, he and the Administrator determined that investigation was not needed because the incident happened in the behavior unit. The Administrator stated the video footage of the incident was no longer available for review because their system auto deletes in 72 hours. Despite admitting to reviewing the video footage of the incident, both the Administrator and the DON stated that they do not know who the female resident that was involved with this incident. The Administrator stated that the intent to cause harm would constitute abuse. The DON stated that it would only be considered abuse if the psychiatric provider says that it is. He also said that there was no preventive measures in place for resident #17 because being sexually inappropriate was a behavior of resident #17. An interview was conducted with a Certified Medical Assistant (CMA/staff #220) and Certified Nursing Assistant (CNA/staff #227) on January 21, 2026 at 2:46 p.m. Both staff #220 and #227 stated they heard about the incident regarding with resident #17 putting his hands down the pants of resident #51 but they did not witness the incident.A telephone interview was conducted with the Nurse Practitioner (NP/staff #500), on January 21, 2026 at 3:18 p.m. The NP stated that he wrote the note on January 10, 2026 because staff reported to him that resident #17 had his hands down a female resident's pants; however, he did not witness the incident. The NP stated that he did not review the video footage of the incident but the DON called and told him what the DON saw on the footage; and that, he had to write another note in case anything went to court. The NP stated that this was the reason why he wrote the NP note on January 21, 2026. Review of the facility's policy on Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated January 1, 2024, included that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. All allegations are thoroughly investigated. The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The administrator provides supporting documents and evidence related (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the alleged incident to the individual in charge of the investigation. Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction. The individual conducting the investigation as a minimum:a. Reviews the documentation and evidence;b. Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident;c. Observes the alleged victim, including his or her interactions with staff and other residents;d. Interviews the person(s) reporting the incident;e. Interviews any witnesses to the incident;f. Interviews the resident (as medically appropriate) or the resident's representative;g. Interviews the resident's attending physician as needed to determine the resident's condition;h. Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;i. Interviews the resident's roommate, family members, and visitors;j. Interviews other residents to whom the accused employee provides care or services;k. Reviews all events leading up to the alleged incident; andl. Documents the investigation completely and thoroughly.