STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145666	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centralia Manor	1910 East McCord Rte 161 East Centralia, IL 62801

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** Based on interview and record review the facility failed to keep residents free from abuse for 2 (R1 and R3) of 3 residents reviewed for abuse in a sample of 5. This failure would cause a reasonable person to experience feelings of fear, anxiety and anger while residing in their home.Findings include:1. R2's Face Sheet documents an admission date of 12/11/25 with diagnoses including: displaced fracture of upper end of right humerus, dementia, type 2 diabetes mellitus, muscle weakness, cognitive communication deficit, candidiasis of skin and nail, pain, vitamin D deficiency, major depressive disorder, and essential hypertension. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03 indicating R2 has severe cognitive impairment.R1's Face Sheet documents an admission date of 05/15/25 with diagnoses including: Alzheimer's disease, hypokalemia, altered mental status, major depressive disorder, anxiety disorder, seizures, type 2 diabetes mellitus, dementia, and visual loss. R1's MDS dated [DATE] documents a BIMS score of 04 indicating R1 has severe cognitive impairment.R1's Care Plan documents a problem area of: behavioral symptoms with goals listed as: R1 will have a decrease in other behaviors by next review dated 03/12/26 with approaches listed as help R1 to call her friend when restless dated 06/16/25 and offer R1 a snack and drink in room or dining area dated 05/19/25, R1 will have a decrease in verbal, physical and rejection of care behaviors by next review dated 03/12/26 with an approach listed as offer independent activity supplies and setup dated 08/21/25, and R1 will have fewer episodes of exit seeking by next review dated 03/12/26 with an approach listed as invite R1 to activities of her interest dated 05/19/25.R2's Progress Note dated 1/20/26 at 10:18PM, authored by V10 (Licensed Practical Nurse/LPN) documents this writer was passing medication down the 200 hall when it was overheard from the resident next to (R2's) room saying ‘get out of bed' (R2) was heard yelling. CNA went into room to find resident in her floor near the bathroom door. She stated, ‘a man pulled me out of bed.' ROM is good except with her right arm. She doesn't want to move arm. This is the arm that she complains of often. Neuro checks were started. Resident was taken to day area and placed in a recliner. She was able to stand and pivot to get into the recliner. She was given PRN (as needed) pain medication.R2's Progress Note dated 01/22/26 at 10:23 AM documents: root cause analysis IDT (Interdisciplinary Team) met and discussed fall from 01/20 at 10:06 PM. R2 was previously in bed. Staff heard another resident (R1) in R2's room telling her to get up. R2 was then heard yelling out and observed on the floor. R2 stated, a man pulled me out of bed. Other resident (R1) was redirected back to her room. R2 was taken to the dayroom. The intervention was a room change for R1.R2's Event Report dated 01/20/26 at 10:06 PM documents event details: location of fall with resident's room marked, what was resident doing just prior to fall? documents was in her bed, why does resident think they fell? documents she said a man pulled me out of bed. The area titled, describe, if needed documents heard resident in room next to her's saying get out of bed. Then heard resident yelling. Advised CNA who went into room and (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: 145666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Centralia Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1910 East McCord Rte 161 East Centralia, IL 62801	

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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	resident was found in the floor by the bathroom door. The section titled, pain assessment contains: does resident exhibit or complain of pain related to the fall? If so, describe location with Yes marked and location as right arm, on a scale of 0-10, how does resident rate intensity of pain if able or indicate based on observation with '5' marked. The section titled, Body assessment contains: location of injury with mid back right side documented, note any injury to the head, extremities, or trunk with redness and range of motion with ROM (range of motion) painful/limited in upper extremity marked, describe, if necessary documents resident won't allow her right arm to be moved around. The section titled, Neurological Check notes: upper right extremity movement/grasps with other marked and documents won't grasp with right hand. The area titled, speech has clear-distinct, intelligible words marked. The section titled, possible contributing factors includes the question, are any the following factors present? with other marked and documents possible pulled out of bed by resident in room beside hers. The section titled, Interventions-immediate measures taken has marked: analgesics and other marked and documents placed resident in day area in recliner.R1's progress note dated 01/21/26 at 10:29 AM documents R1 is moving to room (number) due to going through the bathroom into another residents room disturbing her significantly.On 02/02/26 at 10:39 AM, R1 was interviewed and did not remember the incident with R2 and R1 started becoming agitated.On 02/09/26 at 11:20 AM, R2 was interviewed and did not remember the incident with R1.On 02/02/26 at 2:05 PM, V3 (Director of Memory Care) stated, R1's behaviors are sporadic, she can be physical, she tries to wake other residents up and almost forces them out of bed. V3 stated, R1 did pull R2 out of bed. R1 gets upset because R1 thinks other residents are in her bed so she either yells for them to get out or tries to force them out. V3 stated, R1's behaviors get the other residents frustrated and R1's behaviors get worse at night. V3 stated, R1 will tell residents to go play in traffic and to get out of her house. V3 stated, when you try to redirect R1 she will become more argumentative.On 02/02/26 at 2:33 PM, R3 stated R1 has a smart mouth.On 02/09/26 at 2:34 PM, V8 (Family) stated the facility called him and told him R2 was pulled out of bed by another resident. V8 stated, R2 fell at a different facility and fractured her arm and injured her shoulder and came to this facility for rehabilitation.On 02/09/26 at 2:45 PM, V4 (CNA) stated R2 has some verbal behaviors where she will yell out for her mother sometimes but that is about it. V4 stated, R1 has behaviors kind of all over the place but they are worse in the evening. R1 has tried to pull residents out of their beds. V4 stated, she was not working when the incident happened with R2, but she worked the shift right after and she was given report about it. V4 stated, R2 did complain she was hurting in the shoulder/arm area. V4 stated, they will try to redirect R1 but most of the time it does not work, you have to let her throw her fit and then she will go back to her room and be calmed down. V4 stated, sometimes redirection will just make the situation worse. V4 stated, R1 will sometimes swing on the staff but she has not seen her swing on any of the residents before. V4 stated, R1 has tried to pull more than one resident out of bed before. V4 stated, she caught R1 pulling R5 out of bed before, R1 had ahold of R5's ankles and was pulling her out of bed. V4 stated, V3 (Director of Memory Care) and V1 (Administrator) were aware of the situation, she reported the situation to them.On 02/09/26 at 3:07 PM, V7 (CNA) stated R1 has very triggering behaviors including: looking at her, talking with her, and R1 will come out of her room just to pick fights. R1 can be very aggressive towards staff and residents. V7 stated, V6 (CNA) was working when R1 pulled R2 out of bed. V7 stated, she has seen R1 get in bed with other residents and tell them to get out of bed. V7 stated, she will try to get R1 to go back to her room because she seems calmer there, sometimes they will have to get a nurse or someone else to help.On 02/09/26 at 3:18 PM, V8 (CNA) stated the shift R1 pulled R2 out of bed she was down in the dining room doing her charting and (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	she heard R1 screaming and then she heard R2 scream. V8 stated, she ran down there and R2 was on the floor and R1 was standing next to her. V8 stated, R2 said, that guy pulled me out of bed. V8 stated, there are residents at the facility that think R1 is a guy. V8 stated, she was told by other coworkers, R1 had halfway pulled R5 out of bed. V8 stated, R1 will threaten other residents and they will try to take her to her room and give her space to calm down. V8 stated, R1's behaviors are all over the place, it's like a flip of a switch. V8 stated, R1 was pulling R5 out of bed by her feet, but she did not see how R1 pulled R2 out of bed, if it was by her feet or her arm but R2 did have a red spot on her back that was not there when she put R2 to bed.On 02/10/26 at 4:03 PM, V3 stated the intervention after R1 pulled R2 out of bed was a room change to a private room. V3 stated she reported the incidents R1 and R2 to the administrator. 2. R3's Face Sheet documents an admission date of 10/08/25 with diagnoses including: diabetes mellitus, diarrhea, fracture of unspecified carpal bone, vitamin D deficiency, pain, muscle spasm, end stage renal disease, dementia, metabolic encephalopathy, allergic rhinitis, gastro-esophageal reflux disease, muscle weakness, and depression. R3's MDS dated [DATE] documents a BIMS score of 03 indicating R3 has severe cognitive impairment.R3's final follow-up investigation report with a date of incident of 11/02/26 at 1:45 PM documents an incident description: On 11/02/26 at approximately 1:45 PM, (V1) was notified by staff member V3 that a resident-to-resident contact incident had occurred on the memory care unit in the dining room. According to staff report, two residents were seated at adjacent dining tables. One resident (Resident A) (R1) was repeatedly speaking loudly and asking the same question. The second resident (Resident B) (R3) became visibly frustrated and poured cold coffee onto resident A (R1). Staff immediately intervened and separated both residents.On 02/02/26 at 2:05 PM, V3 stated R3 did throw coffee, but it was cold coffee onto R1 because R1 agitated her, there was no injuries and R1 was taken to her room to clean up and calm down.On 02/02/26 at 2:40 PM, R1 was interviewed and did not remember the incident with R3.On 02/02/26 at 2:44 PM, R3 was interviewed and did not remember the incident with R1.On 02/10/26 at 4:06 PM, V1 stated in the report titled, Final Follow-up Investigation report the date should be 01/02/26 and resident A is R1 and resident B is R2.R1's Progress Note documents on 01/02/2026 at 1:53 PM coffee was thrown at R1, caught R1 in the face and the right side of head. The coffee was cold and there was no redness to right side of her face or neck. R1 offers no complaint of pain or discomfort.The facility policy dated 11/28/19 titled, Abuse Prohibition and Reporting documents: to protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms.

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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 interview and record review the facility failed to report alleged abuse for 1(R2) of 3 resident reviewed for abuse allegations in a sample of 5.Findings include:R2's Face Sheet documents an admission date of 12/11/25 with diagnoses including: displaced fracture of upper end of right humerus, dementia, type 2 diabetes mellitus, muscle weakness, cognitive communication deficit, candidiasis of skin and nail, pain, vitamin D deficiency, major depressive disorder, and essential hypertension. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03 indicating R2 has severe cognitive impairment.R1's Face Sheet documents an admission date of 05/15/25 with diagnoses including: Alzheimer's disease, hypokalemia, altered mental status, major depressive disorder, anxiety disorder, seizures, type 2 diabetes mellitus, dementia, and visual loss. R1's MDS dated [DATE] documents a BIMS score of 04 indicating R1 has severe cognitive impairment.R1's Care Plan documents a problem area of: behavioral symptoms with goals listed as: R1 will have a decrease in other behaviors by next review dated 03/12/26 with approaches listed as help R1 to call her friend when restless dated 06/16/25 and offer R1 a snack and drink in room or dining area dated 05/19/25, R1 will have a decrease in verbal, physical and rejection of care behaviors by next review dated 03/12/26 with an approach listed as offer independent activity supplies and setup dated 08/21/25, and R1 will have fewer episodes of exit seeking by next review dated 03/12/26 with an approach listed as invite R1 to activities of her interest dated 05/19/25.R2's Progress Note dated 1/20/26 at 10:18PM, authored by V10 (Licensed Practical Nurse/LPN) documents this writer was passing medication down the 200 hall when it was overheard from the resident next to (R2's) room saying ‘get out of bed' (R2) was heard yelling. CNA went into room to find resident in her floor near the bathroom door. She stated, ‘a man pulled me out of bed.' ROM is good except with her right arm. She doesn't want to move arm. This is the arm that she complains of often. Neuro checks were started. Resident was taken to day area and placed in a recliner. She was able to stand and pivot to get into the recliner. She was given PRN (as needed) pain medication.R2's progress note dated 01/22/26 at 10:23 AM documents: root cause analysis IDT (interdisciplinary team) met and discussed fall from 01/20 at 10:06 PM. R2 was previously in bed. Staff heard another resident (R1) in R2's room telling her to get up. R2 was then heard yelling out and observed on the floor. R2 stated, a man pulled me out of bed. Other resident (R1) was redirected back to her room. R2 was taken to the dayroom. The intervention was a room change for R1.R2's Event Report dated 01/20/26 at 10:06 PM documents event details: location of fall with resident's room marked, what was resident doing just prior to fall? documents was in her bed, why does resident think they fell? documents she said a man pulled me out of bed. The area titled, describe, if needed documents heard resident in room next to her's saying get out of bed. Then heard resident yelling. Advised CNA who went into room and resident was found in the floor by the bathroom door.On 02/10/26 at 4:06 PM V1 stated, the incident between R1 and R2 was discussed during the IDT meeting and decided since it was not witnessed and the resident could not give a description of the event, they did not consider it a resident to resident.On 02/02/26 at 2:05 PM, V3 (Director of Memory Care) stated R1's behaviors are sporadic, she can be physical, she tries to wake other residents up and almost forces them out of bed. V3 stated, R1 did pull R2 out of bed. R1 gets upset because R1 thinks other residents are in her bed so she either yells for them to get out or tries to force them out. V3 stated, R1's behaviors get the other residents frustrated and R1's behaviors get worse at night. V3 stated, R1 will tell residents to go play in traffic and to get out of her house. V3 stated, when you try to redirect R1 she will become more argumentative.On 02/09/26 at 2:34 PM, V8 (Family) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, the facility called him and told him R2 was pulled out of bed by another resident.On 02/09/26 at 3:07 PM V7 (CNA) stated, R1 has very triggering behaviors including: looking at her, talking with her, and R1 will come out of her room just to pick fights. R1 can be very aggressive towards staff and residents. V7 stated, V6 (CNA) was working when R1 pulled R2 out of bed. V7 stated, she has seen R1 get in bed with other residents and tell them to get out of bed. V7 stated, she will try to get R1 to go back to her room because she seems calmer there, sometimes they will have to get a nurse or someone else to help.On 02/09/26 at 3:18 PM, V8 (CNA) stated the shift R1 pulled R2 out of bed she was down in the dining room doing her charting and she heard R1 screaming and then she heard R2 scream. V8 stated, she ran down there and R2 was on the floor and R1 was standing next to her. V8 stated, R2 said, that guy pulled me out of bed. V8 stated, there are residents at the facility that think R1 is a guy. V8 stated, she was told by other coworkers, R1 had halfway pulled R5 out of bed. V8 stated, R1 will threaten other residents and they will try to take her to her room and give her space to calm down. V8 stated, R1's behaviors are all over the place, it's like a flip of a switch. V8 stated, R1 was pulling R5 out of bed by her feet, but she did not see how R1 pulled R2 out of bed, if it was by her feet or her arm but R2 did have a red spot on her back that was not there when she put R2 to bed.As of 2/10/26, there has been no reports if resident to resident abuse reported to the Illinois Department of Public Health for R1 and R2 for the incident that occurred on 1/20/26.The facility policy dated 11/28/19 titled, Abuse Prohibition and Reporting documents: 2.if the matter involves alleged abuse or results in serious bodily injury, the administrator, or designee shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or serious bodily injury as soon as possible, but not more than 2 hours after the matter becomes known or no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury. 7. if the incident involves alleged abuse and substantiated evidence indicates that another resident of the facility is the perpetrator of the abuse, then the administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated.

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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** Based on interview and record review the facility failed to prevent and investigate alleged abuse for 2 (R1 and R2) of 3 residents reviewed for abuse in a sample of 5.The findings include:R1's Face Sheet documents an admission date of 05/15/25 with diagnoses including: Alzheimer's disease, hypokalemia, altered mental status, major depressive disorder, anxiety disorder, seizures, type 2 diabetes mellitus, dementia, and visual loss. R1's MDS dated [DATE] documents a BIMS score of 04 indicating R1 has severe cognitive impairment.R1's Care Plan documents a problem area of: behavioral symptoms with goals listed as: R1 will have a decrease in other behaviors by next review dated 03/12/26 with approaches listed as help R1 to call her friend when restless dated 06/16/25 and offer R1 a snack and drink in room or dining area dated 05/19/25, R1 will have a decrease in verbal, physical and rejection of care behaviors by next review dated 03/12/26 with an approach listed as offer independent activity supplies and setup dated 08/21/25, and R1 will have fewer episodes of exit seeking by next review dated 03/12/26 with an approach listed as invite R1 to activities of her interest dated 05/19/25.R1's progress note dated 10/24/25 at 12:32 AM documents: R1 approaching staff and demanding that they go away. R1 attempting to pull other residents out of bed. R1 redirected to assigned room and covered up in bed. R1 tells this nurse to go away and get rid of the others.R1's progress note dated 01/14/26 at 12:00 AM documents: R1 was observed laying in another resident's bed with no shirt on and other resident sitting on side of her bed because R1 was telling her to get out of her bed. R1 continued to argue with staff telling them to get the other resident out of her bed and out of her room.R1's progress note dated 01/21/26 at 10:29 AM documents R1 is moving to room (number) due to going through the bathroom into another residents room disturbing her significantly.R1's progress note dated 01/22/26 at 6:05 PM documents: after dinner R1 was observed in another residents bed when assisting another resident to their room. R1 argued with staff and was difficult to redirect. R1 eventually got up and went back to her room.R2's Face Sheet documents an admission date of 12/11/25 with diagnoses including: displaced fracture of upper end of right humerus, dementia, type 2 diabetes mellitus, muscle weakness, cognitive communication deficit, candidiasis of skin and nail, pain, vitamin D deficiency, major depressive disorder, and essential hypertension. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03 indicating R2 has severe cognitive impairment.R2's Progress Note dated 1/20/26 at 10:18PM, authored by V10 (Licensed Practical Nurse/LPN) documents this writer was passing medication down the 200 hall when it was overheard from the resident next to (R2's) room saying 'get out of bed' (R2) was heard yelling. CNA went into room to find resident in her floor near the bathroom door. She stated, 'a man pulled me out of bed.' ROM is good except with her right arm. She doesn't want to move arm. This is the arm that she complains of often. Neuro checks were started. Resident was taken to day area and placed in a recliner. She was able to stand and pivot to get into the recliner. She was given PRN (as needed) pain medication.R2's Progress Note dated 01/22/26 at 10:23 AM documents: root cause analysis IDT (Interdisciplinary Team) met and discussed fall from 01/20 at 10:06 PM. R2 was previously in bed. Staff heard another resident (R1) in R2's room telling her to get up. R2 was then heard yelling out and observed on the floor. R2 stated, a man pulled me out of bed. Other resident (R1) was redirected back to her room. R2 was taken to the dayroom. The intervention was a room change for R1.On 02/09/26 at 2:45 PM, V4 (CNA) stated they will try to redirect R1 but most of the time it does not work, you have to let her throw her fit and then she will go back to her room and be calmed down. V4 stated, sometimes redirection will just make the situation worse. V4 stated, R1 will sometimes swing on the staff but she has not seen her swing on any of the residents before. V4 stated, R1 has tried to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pull more than one resident out of bed before. V4 stated, she caught R1 pulling R5 out of bed before, R1 had ahold of R5's ankles and was pulling her out of bed. V4 stated, V3 (Director of Memory Care) and V1 (Administrator) were aware of the situation, she reported the situation to them.On 02/09/26 at 3:18 PM, V8 (CNA) stated the shift R1 pulled R2 out of bed she was down in the dining room doing her charting and she heard R1 screaming and then she heard R2 scream. V8 stated, she ran down there and R2 was on the floor and R1 was standing next to her. V8 stated, R2 said, that guy pulled me out of bed. V8 stated, there are residents at the facility that think R1 is a guy. V8 stated, she was told by other coworkers, R1 had halfway pulled R5 out of bed. V8 stated, R1 will threaten other residents and they will try to take her to her room and give her space to calm down. V8 stated, R1's behaviors are all over the place, it's like a flip of a switch. V8 stated, R1 was pulling R5 out of bed by her feet, but she did not see how R1 pulled R2 out of bed, if it was by her feet or her arm but R2 did have a red spot on her back that was not there when she put R2 to bed.On 02/10/26 at 4:06 PM, V1 (Administrator) stated the incident between R1 and R2 was discussed during the IDT meeting and decided since it was not witnessed and the resident could not give a description of the event, they did not consider it a resident to resident.On 02/10/26 at 4:03 PM, V3 (Director of Memory Care) stated she is not sure what the intervention was that was put in place after R1 was witnessed pulling R5 out of bed. V3 stated she reported the incidents between R1 and R5 and the incident with R1 and R2 to V1.The facility policy dated 11/28/19 titled, Abuse Prohibition and Reporting under Purpose documents To protect residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Under C. Investigation step 1 documents interviews will all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least on interviewer shall take notes. Attachment 3 of this policy titled Abuse Investigation Checklist documents If there is reasonable cause to suspect that willful abuse, neglect, and misappropriation of property have occurred, use the following checklist during investigation to assure the necessary steps are completed.