STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146062	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center Home Hispanic Elderly	1401 North California Chicago, IL 60622

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50728 Based on interview and record review, the facility failed to report 4 separate allegations of abuse/neglect to the state survey agency. This failure has the potential to affect 5 residents (R1, R2, R5, R6, and R7) reviewed. Findings include: 1. R1's Admission Record documents in part the following diagnosis: rheumatoid arthritis, hypertension, alcohol abuse, ascites. R1's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview for mental status score of 15, indicating that R1 is cognitively intact. R2's Admission Record documents in part the following diagnosis: bacterial intestinal infection, schizophrenia, unspecified dementia without behavioral disturbance. R2 no longer resides in the facility. R2's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview for mental status score of 2, indicating that R2 has severe cognitive impairment. Record review of grievance form dated 2/27/24 indicates that R1 stated to V4 (MDS Nurse, Licensed Practical Nurse), I was in bed a resident came in my room and closed the door grabbed my arms I pushed (R2) away & (R2) fell to the floor. I called downstairs & informed the receptionist asking for help and that administration was notified, as well as the social services/nursing departments. 2. R7's Admission Record documents in part of encephalopathy, congestive heart failure, type 2 diabetes mellitus, and unspecified dementia without behavioral disturbance. R7 is no longer a resident in the facility. R7's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview of mental status summary score of 11, indicating R7 is cognitively impaired. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of grievance form dated 5/30/2024 documents in part that R7 alleged that a CNA (certified nursing assistant) yelled at (R7) and was rough with (R7) when (R7) asked to be changed. (R7) said this happened 5/29 at around 8 PM. and Action (steps taken to resolve issue): spoke with CNA (illegible, scribble) and resident Resident stated (R7) does not like (R7's) CNA. CNA sent to another floor. The form documents a signature from the administrator (undated) acknowledging the incident. 3. R6's Admission Record documents in part a diagnosis of type 2 diabetes, sepsis, obesity, major depressive disorder recurrent, and colostomy status. R6's Minimum Data Set, dated dated dated [DATE] documents in part that that R6 has a brief interview of mental status summary score of 15, indicating that R6 is cognitively intact and that R6 is dependent on facility staff for toileting/ostomy care. Record review of facility grievance form dated 6/4/2024, documents in part that R6 stated that, (R6) asked nurse on the floor to help (R6) empty colostomy bag. Nurse replied by saying no, you can do it yourself. (R6) said (R6) tried, but the contents of the bag fell on the floor, nurse came in yelling you did that on purpose. The grievance form documents a signature from the administrator on 6/4/2024, acknowledging the incident. 4. Record review of R5's Admission Record documents in part the following diagnosis including: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, congestive heart failure, major depressive disorder. Record review of R5's Minimum Data Set documents in part a brief interview of mental status summary score of 12, indicating R5 has cognitive impairment. Record review of facility grievance form dated 7/25/24 documents that V16 (R5's family member) feels charge nurse was disrespectful towards (R5), yelling at (R5) making demands to stay in your room Also reports the ADON (V3- Assistant Director of Nursing) was equally disrespectful when V3 attempted to intervene in the original situation. Also states that the charge nurse slammed the door on (V16's) face and neglected the other residents. The form documents a signature from the administrator (V1) (undated) acknowledging the incident. On 8/26/24 at 1:19 V5 (Assistant Administrator) affirmed that V5 was the administrator and abuse prevention coordinator at the time of the grievances from 2/27/24, 5/30/24 and 6/4/2024. V5 affirmed that the grievance forms contained potential allegations of abuse. V5 stated that an investigation should have been completed for the allegations and reporting should have been completed to the state survey agency. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 2:03 PM, V1 (Administrator) confirmed that V1 is the abuse prevention coordinator for the facility. V1 stated that all potential allegations of abuse and neglect must be investigated, and findings must be sent to the public health department. V1 affirmed that the signature on the grievance form indicates that V1 was aware of the incident that occurred on 7/25/24. V1 stated that V1 could not remember all the specifics of what had occurred and would have to check. At this time, surveyor presented the additional grievances from 2/27/24, 5/30/24, and 6/4/24. V1 affirmed that all the grievances presented contained potential abuse/neglect allegations and should have been reported to the state survey agency. V1 stated that allegations of abuse and neglect need to be reported to the department within 2 hours, and that a complete final investigation needs to be sent to the department within 5 working days. On 8/28/24 at 10:42 AM, V1 stated that V1 received education on the abuse prevention policy on hire. V1 stated that no further investigation has occurred into the allegations brought to V1's attention on the grievance forms presented on 8/26/24 at 2:03 PM. When surveyor asked why no further action has been taken to investigate the allegations, V1 stated, those were before my time. On 8/29/24 at 2:00 PM, surveyor inquired if V1 had completed any reporting to the department regarding the grievance forms presented on 8/26/24 at 2:03 PM. V1 replied, no. Record review of facility provided policy titled ABUSE PREVENTION PROGRAM- POLICY documents in part, .Investigation procedures: regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion or exploitation, the investigation will consist of: Completion of a written report on the status of the investigation within 24 hours of the occurrence or as soon as possible, but no more than 2 hours, if the events that cause the suspicion result in serious bodily injury or involve an allegation of abuse; the initial report shall include: the name of the resident allegedly harmed; when the allegation was received; The time and date of the alleged incident; Who was notified and when; And the steps the Residence has taken in response to the allegation, including the steps to protect the resident . The Abuse Coordinator will summarize the investigation in a final written incident report .After reviewing the final report, the administrator or designee will submit a copy of the final report to the Department of Public Health within five working days of the occurrence. The administrator or designee will also notify the resident's representative of the results of the investigation.

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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 - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to thoroughly investigate four separate incidents involving allegations of resident-to-resident physical abuse, verbal and physical abuse or neglect by a Licensed Practical Nurse (LPN) and Certified Nursing Assistant (CNA). The facility also failed to separate the residents from the alleged perpetrator(s). These failures affected 5 residents (R1, R2, R5, R6, and R7) and has the potential for abuse and neglect to further occur, affecting all 119 residents residing in the facility. Findings include: Record review of facility census for 8/26/24 documents 119 residents reside in the facility. 1. R1's Admission Record documents in part the following diagnosis: rheumatoid arthritis, hypertension, alcohol abuse, ascites. R1's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview for mental status score of 15, indicating that R1 is cognitively intact. R2's Admission Record documents in part the following diagnosis: bacterial intestinal infection, schizophrenia, unspecified dementia without behavioral disturbance. R2 no longer resides in the facility. R2's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview for mental status score of 2, indicating that R2 has severe cognitive impairment. Record review of R1's progress notes dated 2/27/2024 documents in part that a resident was seen standing at the foot of R1's bed, that R1 was yelling at the resident, and that the resident was removed from R1's room. Additionally, R1's progress notes document later in the day that R1 reported an incident to V4 (MDS Coordinator, Licensed Practical Nurse), who completed an assessment for injury. No documentation was noted that states R1's resident representative or physician was notified. On 8/26/24 at 12:17 PM, R1 stated that on the 27th, R2 had entered R1's room and closed the door. R1 recalled that R1 began yelling to have R2 leave R1's room and R2 did not leave so R1 had pressed R1's call light. R1 stated that R2 began trying to hit R1 and grabbed R1's arms. R1 explained that R1 struggled and continued screaming until R1 was able to push R2 to the ground. R1 stated that R1 called the receptionist at the front desk using R1's phone because the call light was not being answered. R1 recalled that the receptionist called V14 (Admissions Director) who was the assistant administrator to help R1. R1 stated that as R2 began getting up, R1 grabbed a boot that was within reach of R1's bed, began swinging it to ward off R2, and continued yelling. R1 stated that V14 (Admissions Director) came into R1's room and removed R2 from R1's room. R1 stated that no staff followed up on the incident to see what happened and stated, the facility never reports abuse. R1 stated that R1 confided in V4 later that day regarding the physical altercation from R2 because the other staff won't help me (R1), but V4 will. R1 stated that R1 always felt unsafe and afraid because R2 would repeatedly stand behind R1's curtain and watch R1. R1 affirmed that R1 told staff many times about R2's behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/26/24 at 1:19 PM, V5 (Assistant Administrator) stated that V5 was the administrator and abuse prevention coordinator at the time of the incident (2/27/24). V5 denied any knowledge of the incident but recalled that R2 was a wanderer and would often go in other resident's rooms. V5 affirmed that this incident was not investigated. On 8/26/24 at 1:46 PM, V4 reviewed progress notes from 2/27/24 and recalled that R1 had asked to speak with V4 regarding the incident that occurred in the morning. V4 told R1 that V4 was not aware of any incidents and R1 told V4 that R2 had come into R1's room and was grabbing (R1's) wrists so R1 had pushed R2 to the ground. V4 stated that V4 immediately assessed R1 for injury and no obvious injuries were noted at the time. V4 affirmed that V4 told V5 about the incident and documented the incident in a grievance form. On 8/28/24 at 12:03 PM, V14 (Admissions Director) stated that V14 was the assistant administrator at the time of the incident. V14 recalled the incident from 2/27/24 and stated that V14 found R2 standing at the foot of R1's bed. V14 stated that V14 escorted R2 out of the room and that R1 was screaming at (R2). V14 stated that R1 did not want to talk to V14 after the incident occurred. V14 denied knowledge of R2 grabbing R1. Record review of grievance form dated 2/27/24 indicates that R1 stated to V4, I was in bed a resident came in my room and closed the door grabbed my arms I pushed (R2) away & (R2) fell to the floor. I called downstairs & informed the receptionist asking for help and that administration was notified, as well as the social services/nursing departments. 2. R7's Admission Record documents in part of encephalopathy, congestive heart failure, type 2 diabetes mellitus, and unspecified dementia without behavioral disturbance. R7 no longer resides in the facility. R7's Minimum Data Set, dated dated dated [DATE] documents in part a brief interview of mental status summary score of 11, indicating R7 is cognitively impaired. Record review of grievance form dated 5/30/2024 documents in part that R7 alleged that a CNA (certified nursing assistant) yelled at (R7) and was rough with (R7) when (R7) asked to be changed. (R7) said this happened 5/29 at around 8 PM. and Action (steps taken to resolve issue): spoke with CNA (illegible, scribble) and resident Resident stated (R7) does not like (R7's) CNA. CNA sent to another floor. The form documents a signature from the administrator (undated) acknowledging the allegation. On 8/26/24 at 1:19 V5 (Assistant Administrator) affirmed that V5 was the administrator and abuse prevention coordinator at the time of the allegation. V5 could not recall the incident that occurred on 5/30/24 or the CNA that was the perpetrator of the allegation. V5 reviewed the grievance log and affirmed that was V5's signature is noted on the form, affirming review of the allegation. V5 stated that the form documents a potential allegation of physical and verbal abuse. V5 affirmed that this incident should have been investigated to identify which CNA was involved and if the incident was substantiated. V5 affirmed that by not completing an investigation to identify the perpetrator, reassigning a potential perpetrator to another unit, and not removing the perpetrator from the facility, all residents may be placed at risk for being abused. V5 could not give a reason why this allegation was not investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/26/24 at 3:25 PM, V2 (Director of Nursing) stated that V4 was aware of the incident and stated that V4 talked to R7 and R7 only wanted this one particular CNA to care for (R7). V2 stated that V2 couldn't figure out which CNA R7 was talking about, so V2 switched all the assignments of the CNAs. Surveyor inquired as to why this action is contradictory to the action V2 had written on the grievance form (as the grievance form identifies a singular, unnamed CNA, not all CNAs), and V2 stated, I don't know, that's just what I did. V2 affirmed that the grievance could have potentially contained an allegation of physical and mental abuse and should have been formally investigated. V2 denied any knowledge of a formal abuse investigation being completed. V2 affirmed that by moving staff around without knowing who the perpetrator of the allegation was could have exposed all other residents of the facility to the perpetrator. On 8/27/24 at 11:33 AM, V11 (Social Services Assistant) stated that V11 remembered the incident regarding R7 and affirmed that R7 disclosed the allegation to V11. V11 stated that V11 remembers R7 being anxious about the incident during rounds on 5/30/24 and stated that a CNA handled R7 roughly and yelled at R7. V11 stated that R7 did not disclose who the CNA was. V11 stated that the allegation could have potentially been mental and/or physical abuse. V11 affirmed that V11 told V5 and V2 about the incident immediately. 3. R6's Admission Record documents in part a diagnosis of type 2 diabetes, sepsis, obesity, major depressive disorder recurrent, and colostomy status. R6's Minimum Data Set, dated dated dated [DATE] documents in part that that R6 has a brief interview of mental status summary score of 15, indicating that R6 is cognitively intact and that R6 is dependent on facility staff for toileting/ostomy care. Record review of facility grievance form dated 6/4/2024, documents in part that R6 stated that, (R6) asked nurse on the floor to help (R6) empty colostomy bag. Nurse replied by saying no, you can do it yourself. (R6) said (R6) tried, but the contents of the bag fell on the floor, nurse came in yelling you did that on purpose. The grievance form documents a signature from the administrator on 6/4/2024, acknowledging the incident. On 8/26/24 at 1:19 V5 (Assistant Administrator) affirmed that V5 was the administrator and abuse prevention coordinator at the time of the incident. V5 reviewed the grievance log and affirmed that was V5's signature is noted on the form, affirming review of the allegation. V5 recalled the incident and remembered talking to V13 (Licensed Practical Nurse) about the incident and V13 stated that R6 could do R6's ostomy independently. V5 stated that the form documents a potential allegation of mental abuse due to V13 yelling at the resident. V5 affirmed that this incident should have been fully investigated to substantiate if mental abuse occurred. V5 affirmed that by not completing an investigation to substantiate the abuse, residents are placed at risk of further abuse. V5 could not give a reason why the allegation was not investigated. On 8/27/24 at 10:46 AM, R6 could recall the incident from 6/4/2024 and stated that the nurse who yelled at R6 was here right now. R6 named V13 (Licensed Practical Nurse). R6 stated that V13 refused to change R6's ostomy which made R6 feel really bad. R6 stated that on that day, V13 was really bitching at me about my ostomy but could not remember fully if V13 was yelling or not. R6 affirmed that R6 was unable to change R6's ostomy bag without assistance because (R6's) breasts are too large and I (R6) need assistance with holding them up to have both hands for my colostomy bag. R6 stated that staff regularly refuse to care for R6's ostomy and refuse to help in changing R6's ostomy. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 11:33 AM, V11 (Social Services Assistant) stated that V11 remembered the incident regarding R6 and affirmed that R6 disclosed the allegation to V11. V11 stated that V11 remembers R6 was upset and R6 stated that V13 was yelling at R6 and refused to change the ostomy bag which caused the contents to spill all over the floor. V11 affirmed that yelling may be abuse. V11 stated that V11 documented the incident on the grievance form and immediately told both V2 and V5. V11 stated that V11 was unaware of any further follow up that occurred after the incident. On 8/27/24 at 12:23 PM, V13 (Licensed Practical Nurse) did not recall the incident on 6/4/2024 and R6. V13 recalled that V6 was a new ostomy patient and had difficulty keeping the ostomy on. V13 stated that V13 would regularly instruct R6 to do R6's own ostomy care so R6 could do it when R6 was at home. V13 denied yelling at R6 and stated that V13 changes R6's ostomy if R6 asks. V13 denied any knowledge of the grievance and affirmed that the facility did not follow up with V13 about the grievance. V13 affirmed that no investigation was completed and that V13 was not suspended. 4. Record review of R5's Admission Record documents in part the following diagnosis including: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, congestive heart failure, major depressive disorder. Record review of R5's Minimum Data Set documents in part a brief interview of mental status summary score of 12, indicating R5 has cognitive impairment. Record review of facility grievance form dated 7/25/24 documents that V16 (R5's family member) feels charge nurse was disrespectful towards (R5), yelling at (R5) making demands to stay in your room Also reports the ADON (V3- Assistant Director of Nursing) was equally disrespectful when V3 attempted to intervene in the original situation. Also states that the charge nurse slammed the door on (V16's) face and neglected the other residents. The form documents a signature from the administrator (V1) (undated) acknowledging the incident. On 8/26/24 at 2:03 PM, V1 (Administrator) confirmed that V1 is the abuse prevention coordinator for the facility. V1 stated that all potential allegations of abuse and neglect must be investigated, and findings must be sent to the public health department. V1 affirmed that the signature on the grievance form indicates that V1 was aware of the incident that occurred on 7/25/24. V1 stated that V1 could not remember all the specifics of what had occurred and would have to check. At this time, surveyor presented the additional grievances from 2/27/24, 5/30/24, and 6/4/24. V1 affirmed that all the grievances presented contained potential abuse/neglect allegations and should have been investigated. On 8/26/24 at 2:23 PM, V12 (Social Services Director) confirmed that V12 was the staff member that completed the complaint form with V16. V12 recalled that V16 was very upset because V13 had yelled at R5, and that the other staff were equally as rude. V12 stated that V16 was very specific in what V16 wanted written on the grievance form. V12 affirmed that the grievance form contained allegations of potential mental abuse and neglect. V12 stated that V12 told both V1, V2, and V5 immediately about the complaint but did not remember if there was a formal abuse investigation completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 11:06 AM, R5 stated that R5 could recall V13 yelling at R5 when R5 was in the elevator that day but couldn't remember what V13 said. R5 recalled V13 not helping R5 exit the elevator and stated that R5 told V16 about the incident and that was why V16 was mad. R5 denied ever being interviewed by staff or any further follow up about the behavior by V13. R5 affirmed that V13 was still assigned to take care of R5 after the incident had occurred. On 8/27/24 at 11:39 AM, V3 (Assistant Director of Nursing) did not recall witnessing V13 yell at R5. V3 stated that V1 talked to V3 after the incident and told V1 that there was a fire drill occurring at the time and that V13 would not allow R5 to leave the room. V3 was unaware of any allegation of neglect by V16. On 8/27/24 at 12:23 PM, V13 (Licensed Practical Nurse) recalled the incident occurring with R5 and V16. V13 stated that there was a fire drill occurring and that V16 wanted to take R5 out of the building. V13 stated that V13 refused to let them leave, as the fire drill could have been real and told them to wait in R5's room. V13 stated that V16 refused to wait, so V13 got V3 (Assistant Director of Nursing) to intervene. V13 denied yelling at R5 or V13. V13 denied that V1 or any other staff member asked or counseled V13 about the situation. V13 affirmed that no further investigation occurred about the incident and that V13 was not suspended. V13 denied ever neglecting any resident. On 8/28/24 at 10:42 AM, V1 stated that V1 received education on the abuse prevention policy on hire. V1 recalled the incident occurring on 7/25/24 and stated that V1 talked to V3 about the incident but did not complete an investigation. V1 denied speaking to V16 about the incident and stated (V16) is in the building all the time. Surveyor asked why V1 had not followed up with V16 about the incident if V16 is in the building regularly, and V1 stated that the incident was done and that V1 had already talked to V3 about it. V1 denied interviewing V13, R5, other staff assigned to care for R5, and other residents that were potentially in the vacinity during the incident. V1 denied ever suspending V13 pending investigation. V1 stated that talking to only V3 was a thorough enough investigation into the incident. Surveyor asked what specifically the neglect allegation was about, and V1 stated that V1 didn't know and that it probably was just one of those things family members say all the time when they are mad. V1 affirmed there was no investigation into the allegation of neglect and affirmed that if an investigation was completed, the facility may specifically know what the allegation of neglect was pertaining to. V1 stated that no further investigation has occurred into the allegations brought to V1's attention on the grievance forms presented on 8/26/24 at 2:03 PM. When surveyor asked why no further action has been taken to investigate the allegations, V1 stated, those were before my time, I didn't think I had to investigate them. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of facility provided policy titled ABUSE PREVENTION PROGRAM - POLICY documents in part, .Investigation procedures: regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion or exploitation, the investigation will consist of: Completion of a written report on the status of the investigation within 24 hours of the occurrence or as soon as possible, but no more than 2 hours, if the events that cause the suspicion result in serious bodily injury or involve an allegation of abuse; the initial report shall include: the name of the resident allegedly harmed; when the allegation was received; The time and date of the alleged incident; Who was notified and when; And the steps the Residence has taken in response to the allegation, including the steps to protect the resident. Interview of the person(s) reporting the incident; interview of the alleged victim, if interviewable; Interview of the alleged perpetrator; interview of the witnesses to the incident, if any, which includes visitors to the facility; interview of the alleged victims roommate if appropriate and if interviewable; interview of staff members having contact with the alleged victim and alleged perpetrator during the period of the alleged incident; If the alleged perpetrator is an employee, interview of the other residents the alleged perpetrator provided care on the same shift as the alleged incident; if the alleged perpetrator is an employee, interview of other employees that worked the same shift of the alleged incident; if the alleged perpetrator is an employee a review of the personnel file to check for references background check and documentation of orientation and training; where appropriate or indicated, an interview with the residents attending physician or psychiatrist; review of the medical records of any residents involved in the occurance, including care plans and medications; If applicable, obtain address, phone number and Social Security number of the accused employee. Review of all additional circumstances surrounding the incident, including video footage, if available . physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment . Proceed with investigation procedures and interviews. Determine if an allegation of physical abuse was because of a willful action, i.e., hitting, slapping, pinching, kicking, or corporal punishment, or if the allegation was because of accidental improper handling . Mental abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident; mocking, insulting, or ridiculing; yelling or hovering over a resident, with the intent to intimidate; threats of deprivation; and isolation . neglect means the failure to provide or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident . Determine what goods or services were not provided to the resident based upon the allegation; Determine what physical harm, mental anguish, mental illness or deterioration in the resident's physical or mental condition resulted based upon the failure to provide goods and services; and determine if the goods or services were not provided because of a pattern of deliberate negligence, carelessness, or indifference . Anonymous reports will also be thoroughly investigated . VI. Internal Investigation of Abuse, Neglect, or Misappropriation Allegations and Response 1. All incidents will be documented, whether or not abuse occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect or misappropriation will result in an abuse investigation.