STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Brighton Care Center	805 Sixth Avenue Northwest New Brighton, MN 55112

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 - 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 document review, the facility failed to ensure an allegation of potential abuse was reported timely to the State agency (SA), for 1 of 1 residents (R1) reviewed for an allegation of abuse. Findings include: R1's annual Minimum Data Set (MDS), dated [DATE], identified R1 was cognitively intact with mild depression. Diagnoses included bipolar disorder, anxiety, depression, morbid obesity, chronic pain, and arthritis. R1 required partial to moderate physical assistance with upper body dressing and substantial/maximum assistance with lower body dressing and bed mobility. R1's weight was 379 pounds, and she was free of upper and/or lower extremity range of motion impairments. R1's comprehensive care plan identified on 1/27/20, R1 was a vulnerable adult due to her living in a skilled nursing facility. Interventions directed any suspicions of abuse/neglect, or maltreatment, to be investigated and reported as necessary to the proper agencies. Review of facility form titled A Grievance report, provided on 5/23/25, identified R1 reported a grievance on 5/19/25, related to 'rough' cares and bedside manners on 5/18/25. A Date Parties Informed of Findings column showed a handwritten entry: still processing/investigating. Review of facility form titled A facility Grievance Form, dated 5/19/25, identified R1 reported to social worker (SW)-A that during dressing cares on 5/18/25, at approximately 4:30 p.m., nursing assistant (NA)-A was 'rough' and 'rude and crude.' During this, R1 informed NA-A that NA-A was rude to which NA-A responded, 'I've never been called rude before.' R1 reported her left shoulder was sore and requested that NA-A no longer work with her. The form identified there was a NA witness; however, the form did not identify which NA. The form's initial investigation/response section identified the director of nursing (DON), assistant director of nursing (ADON), and/or NA Manager ([NAME])-A would follow up with the NA. Additional form sections related to Summary of Investigation Conclusion, which was to be completed by department director/designee within 72-hours, designation if the quality concern was confirmed or not, Corrective Action Taken by the facility as a Result of the Concern, and a signature and date section for the resident, social services director, DON, and the administrator were all blank. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a provider progress note, dated 5/19/25, identified the following information: Later in the day receive[d] a phone call from nursing reporting [R1] is c/o (complaining of pain) in her shoulder after an aid[e] 'being rough taking her shirt off' and is requesting an xray [sic]. No other concerns today. Review of R1's progress notes, dated 5/18/25 through 5/27/25, lacked information related to the 5/18/25, incident and/or her 5/19/25 allegation. During an interview on 5/23/25, at 11:13 a.m., SW-A identified she was the director of social services. She stated the nursing leadership continued to work on R1's allegation. She was unaware of the status of the investigation; however, she indicated R1's shoulder x-ray was negative, and NA-A was placed on the NA agency do not return list in response to the allegation. SW-A explained she interviewed R1 about the allegation on 5/19/25, where R1 stated NA-A took off R1's dress roughly and was jerking her around. She identified R1, at times, was grievance happy, had borderline traits, and was attention seeking. SW-A identified any possible abuse claims were to be reported to the SA, especially if there was evidence of any abuse; however, she did not report R1's allegations to the SA as she did not consider R1's allegation abuse based on R1's interview. Despite this, later in the interview, SW-A stated R1's allegation should have been reported, despite no evidence, as R1 reported an allegation of rough cares, and that management was not there when the incident occurred. They should have taken R1's word for it pending their investigation. SW-A stated she would be expected to report R1's allegation within 24 hours or ideally as soon as she heard about it. During an interview on 5/23/25, at 11:29 a.m., the DON identified R1's allegation continued to be investigated. The DON stated R1's allegation was not reported to the SA as no one was hurt, along with the incident did not rise to the level of actual abuse, and R1's history related to grievances and allegations. She explained the facility utilized an abuse reporting algorithm; however, this was not utilized as R1 was not injured by the situation. R1 was content with NA-A no longer being allowed to work at the facility, and based on reports from [NAME]-A, it was her understanding R1 did not use the word rough during the interview. The DON stated she expected a SA report to be filed when there was any type of injury, within two hours of the injury. Additionally, she expected if any staff were to witness abuse, or if a resident alleged abuse, staff were to report it right away to their supervisor and the administrator. Due to this, she expected NA-B would have alerted the nurse on 5/18/25, of R1's and NA-A's interaction for an investigation to begin and administrator notification to occur right away. She confirmed she first heard about the allegation on 5/19/25. She was unable to remember the time frame she was notified. During an interview on 5/23/25, at 11:33 a.m., [NAME]-A stated any allegations of abuse were to be reported to the charge nurse and the DON immediately. Additionally, she would expect staff to report witnessed rough cares immediately to leadership. She denied any recent resident abuse allegations: however, she reported a recent event where an agency staff (NA-A) was rough with a resident (R1). This was reported to the DON right away on the morning of 5/19/25, and NA-A was placed on the due not return list. She currently was unaware of the investigation status of R1's allegation. [NAME]-A identified during her interview with R1, R1 stated NA-A pulled her shift off roughly and had a bad attitude. [NAME]-A denied R1 stated NA-A swore at her. Additionally, [NAME]-A indicated she interviewed NA-B who confirmed NA-A presented a bad attitude towards R1 and was not being gentle. [NAME]-A denied this was abuse but it was not gentle care taking. Thus, this was not reported to the SA. (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 - Few	During an interview on 5/23/25, at 11:43 a.m., the ADON stated any witnessed abuse or abuse allegation, along with the word rough being verbalized, were to be reported to the DON and the administrator right away. Upon investigation, if there were any injuries or harm identified or if the resident used the actual word abuse, then it was reported to the SA within two hours and measures were put into place which ensured resident safety. The ADON stated abuse was anything which caused injury either physically or psychosocially, such as physical and/or verbal abuse. She explained physical abuse included, but was not limited to, intentionally being rough with a resident. The ADON stated, on 5/19/25, she was updated in the morning about R1's allegation; however, she did not personally speak with R1. She explained it was hard to say if R1's allegation rose to the level of abuse that required reporting to the SA but then followed up with a statement she did not think it did. The ADON identified they conducted their own internal investigation and based on R1's history of being hard on staff, especially pool agency staff, and their placing NA-A on the do not return list, along with R1 not being bruised or injured, based on the x-ray, along with a witness, they have pretty much completed their investigation. During an interview on 5/23/25, at 12:00 p.m., R1 stated NA-A was very aggressive with her, was rough, and felt that NA-A abused her. On 5/18/25, after church around 3:30 p.m., NA-A and NA-B assisted her to remove a dress while she laid in bed. During this, NA-A took R1's arm and bent it backwards in a very quick motion while she pulled on R1's arm to get it out of the sleeve. NA-A did not allow R1 to assist. R1 told NA-A she was rough, and NA-A responded no one had ever told her she was rough before. NA-B attempted to calm R1 down as she could see the pain in my eyes. After, NA-A attempted to get R1's other arm out of the dress; however, R1 finished this by herself as NA-A continued to state, Let's get the skirt off and the rest of the clothing. As R1 started to roll over to remove the rest of the clothing, NA-A stated, in a loud tone of voice, That was a dumb thing to do bitch. After, R1 was assisted to roll the other way and the skirt was removed. In response to the incident, NA-B stated to NA-A that she had enough of NA-A and asked her to get out of the room; however, she remained and R1 had to ask her to leave, which she finally did. R1 stated this incident caused her shoulder injury and increased pain. The pain had improved but was still sore and required continued ice pack treatment despite a negative x-ray. Additionally, R1 stated she experienced nightmares that startled her awake and made her cry as she relived the experience when she slept. She denied informing staff about the nightmares. She was relieved these improved, but she was still bothered by them. (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 - Few	During an interview via telephone on 5/27/25, at 10:02 a.m., NA-B stated if she were to witness abuse she would take over and ask the other staff to leave and then she would update management and/or call the hotline. She denied ever witnessing abuse at the facility. She explained rough cares occurred when an aide was not being as gentle as they should be and rushed through the cares, such as pulling aggressively or not being as patient as they should. NA-B explained she witnessed NA-A pull on R1's dress sleeve to get it freed which I guess caused [R1] some discomfort. R1 told NA-A to be gentle but NA-B did not feel NA-A was overly rough: just pulling on the dress .like you would have to. NA-B explained the action was not necessarily rough but it was not as gentle as [R1] would have liked. She explained NA-A reported a headache, grumpy, and not feeling good where NA-A rushed the cares and was not as gentle as she should have been. She explained if she were the aide who helped in that situation, she would have maybe [done things] a little bit differently. She would have had R1 lean to the side, so she was not pulling so hard. She denied R1 instructed NA-A to leave the room. NA-B did not consider NA-A's actions as abuse and thus she did not feel this needed to be reported to the nurse but if the interaction were more aggressive, she would have reported it: it is a fine line between gentle and rough, but based on R1's body habitus and how we had to remove the dress. NA-B stated R1 commented on the situation to her after the incident and that R1 appeared to have increased shoulder pain as R1 utilized ice packs currently to the area and the incident from 5/18/25, may have caused the increased pain. During a telephone interview on 5/27/25, at 10:53 a.m., NA-A stated abuse occurred when staff were being too aggressive, among other things. If she witnessed abuse, she was to report to the supervisor immediately. NA-A stated on 5/18/25, she and NA-B assisted R1 to change into a gown. When she assisted R1 to take off her shirt, R1 told her firmly she was being rough. NA-A immediately stopped and asked R1 how she was rough. R1 did not respond. NA-B helped R1 remove the rest of the shirt and helped R1 with the gown, but she continued with the rest of the cares once NA-B left the room. NA-A explained, when she tried to pull the shirt bottom from under R1, she did not realize R1 could sit up and move as much as she did, so that when she pulled, R1 sat up, and the action used more effort than required. This caused the movement to be a quicker, jerking motion. She declined she was rough with the cares; however, she stated she maybe used more force then if I would have known she could move. During an interview on 5/27/25, at 1:46 p.m., the administrator expected staff to protect residents and report abuse within two hours, but as soon as possible. She then expected staff to contact her right away. Additionally, if rough care was reported, she expected staff to stop what they are doing, get additional assistance, and report the incident to the nurse. The administrator was updated and questioned if staff should report the incident. It was decided not to report as there was no injury; however, she directed the incident to be treated like a grievance. She denied knowledge of the status of the investigation as the grievance form was yet to be provided to her for her review and signature, but she reported involvement in the investigation conversations. Review of facility policy titled An Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, dated 2022, identified All reports of resident abuse, neglect, . are reported to local, state, and federal agencies (as required by current regulations). In addition, the administrator was to be immediately updated. Immediately was defined as within two hours of an allegation that involved abuse or resulted in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or serious bodily injury.

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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 interview and record review, the facility failed to thoroughly investigate an allegation of potential abuse for 1 of 1 residents (R1) who reported an allegation of potential abuse by staff. Findings include: R1's annual Minimum Data Set (MDS), dated [DATE], identified R1 was cognitively intact with mild depression. Diagnoses included bipolar disorder, anxiety, depression, morbid obesity, chronic pain, and arthritis. R1 required partial to moderate physical assistance with upper body dressing and substantial/maximum assistance with lower body dressing and bed mobility. R1's weight was 379 pounds, and she was free of upper and/or lower extremity range of motion impairments. R1's comprehensive care plan identified, on 1/27/20, R1 experienced an activity of daily living (ADL) self-care performance deficit related to weakness, obesity, and history of a CVA (stroke). Interventions directed setup assist of one staff for upper body dressing and two staff for lower body dressing, along with the use of bilateral half siderails for R1 to assist staff during cares. In addition, the care plan identified R1 was a vulnerable adult due to her living in a skilled nursing facility. Interventions directed any suspicions of abuse/neglect, or maltreatment, were to be investigated. Review of form titled Grievance report, provided on 5/23/25, identified R1 reported a grievance on 5/19/25, related to 'rough' cares and bedside manners on 5/18/25. A Date Parties Informed of Findings column showed a handwritten entry: still processing/investigating. Review of facility Grievance Form, dated 5/19/25, identified R1 reported to social worker (SW)-A that during dressing cares on 5/18/25, at approximately 4:30 p.m., nursing assistant (NA)-A was 'rough' and 'rude and crude.' During this, R1 informed NA-A that NA-A was rude to which NA-A responded, 'I've never been called rude before.' R1 reported her left shoulder was sore and requested that NA-A no longer work with her. The form identified there was a NA witness; however, the form did not identify the NA. The form's Initial investigation/response section identified the director of nursing (DON), assistant director of nursing (ADON), and/or NA Manager ([NAME])-A would follow up with the NA. Additional form sections related to Summary of Investigation Conclusion, which was to be completed by department director/designee within 72-hours, designation if the quality concern was confirmed or not, Corrective Action Taken by the facility as a Result of the Concern, and a signature and date section for the resident, social services director, DON, and the administrator were all blank. Review of a provider progress note, dated 5/19/25, identified the following information: Later in the day receive[d] a phone call from nursing reporting [R1] is c/o (complaining of pain) in her shoulder after an aid[e] 'being rough taking her shirt off' and is requesting an xray [sic]. No other concerns today. Review of R1's progress notes, dated 5/18/25 through 5/27/25, lacked information related to the 5/18/25, incident and/or her 5/19/25 allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's medical record lacked evidence a nursing and body/skin assessment were conducted on 5/19/25, after the allegation of rough care was expressed or that R1 was monitored to address any issues related to the incident. During an interview on 5/23/25, at 11:13 a.m., SW-A identified she was the director of social services. She stated the nursing leadership continued to work on R1's allegation. She was unaware of the status of the investigation; however, she indicated R1's shoulder x-ray was negative, and NA-A was placed on the NA agency do not return list in response to the allegation. SW-A explained she interviewed R1 about the allegation on 5/19/25, where R1 stated NA-A took off R1's dress roughly and was jerking her around. She identified R1, at times, was grievance happy, had borderline traits, and was attention seeking. SW-A did not consider R1's allegation abuse based on R1's interview; however, as management did not witness the incident, they should have taken R1's word for it pending their investigation. During an interview on 5/23/25, at 11:29 a.m., the DON identified R1's allegation continued to be investigated. The DON stated their investigation identified no one was hurt and R1's allegation did not rise to the level of actual abuse. The DON indicated R1 had a history related to grievances and allegations. R1 was content with NA-A no longer being allowed to work at the facility, and based on reports from [NAME]-A, it was her understanding R1 did not use the word rough during the interview. The DON indicated she first heard about the allegation on 5/19/25, from [NAME]-A. She was unable to remember the time frame she was notified. She stated [NAME]-A was involved in the investigation and she explained staff investigated by interviewing R1, NA-A, and NA-B; however, no additional staff were interviewed for additional insight, nor any other residents to determine any additional potential concerns related to care delivered from NA-A. The DON was unaware if the three interviews conducted were documented. The DON denied staff were educated related to the concerns addressed by the allegation and/or the investigation. During an interview on 5/23/25, at 11:33 a.m., [NAME]-A denied any recent resident abuse allegations: however, she reported a recent event where an agency staff (NA-A) was rough with a resident (R1). This was reported to the DON right away on the morning of 5/19/25, and NA-A was placed on the do not return list. She currently was unaware of the investigation status of R1's allegation. [NAME]-A identified during her interview with R1, R1 stated NA-A pulled her shirt off roughly and had a bad attitude. [NAME]-A denied R1 stated NA-A swore at her. Additionally, [NAME]-A indicated she interviewed NA-B who confirmed NA-A presented a bad attitude towards R1 and was not being gentle. [NAME]-A denied this was not abuse but it was not gentle care taking. Additionally, she denied documentation related to R1 or NA-B's interview, but she requested NA-A to email her a statement. She however, did not document her interview with NA-A. [NAME]-A denied additional staff interviews or other resident interviews. Additionally, no staff were educated related to the concerns addressed by the allegation and/or the investigation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25, at 11:43 a.m., the ADON stated abuse was anything which caused injury either physically or psychosocially, such as physical and/or verbal abuse. She explained physical abuse included, but not limited to, intentionally being rough with a resident. The ADON stated, on 5/19/25, she was updated in the morning about R1's allegation when she reviewed a voice mail R1 left her; however, she did not personally speak with R1 as others were directed to. She explained it was hard to say if R1's allegation rose to the level of abuse but then followed up with a statement she did not think it did. The ADON identified they conducted their own internal investigation and based it on R1's history of being hard on staff, especially pool agency staff, and their placing NA-A on the do not return list, along with R1 not being bruised or injured, based on the x-ray, along with a witness, they have pretty much completed their investigation. She indicated R1 and two of the aides involved were talked to; however, she did not think any additional staff or residents were interviewed despite these interviews being something that was completed when abuse was alleged. The ADON explained education was always ongoing, but no recent education was provided related to this incident that she was aware of. During an interview on 5/23/25, at 12:00 p.m., R1 stated NA-A was very aggressive with her, was rough, and felt that NA-A abused her. On 5/18/25, after church around 3:30 p.m., NA-A and NA-B assisted her to remove a dress while she laid in bed. During this, NA-A took R1's arm and bent it backwards in a very quick motion while she pulled on R1's arm to get it out of the sleeve. NA-A did not allow R1 to assist. R1 told NA-A she was rough, and NA-A responded no one had ever told her she was rough before. NA-B attempted to calm R1 down as she could see the pain in my eyes. After, NA-A attempted to get R1's other arm out of the dress; however, R1 finished this by herself as NA-A continued to state, Let's get the skirt off and the rest of the clothing. As R1 started to roll over to remove the rest of the clothing, NA-A stated, in a loud tone of voice, That was a dumb thing to do bitch. After, R1 was assisted to roll the other way and the skirt was removed. In response to the incident, NA-B stated to NA-A that she had enough of NA-A and asked her to get out of the room; however, she remained and R1 had to ask her to leave, which she finally did. R1 stated this incident caused her shoulder injury and increased pain. The pain had improved but was still sore and required continued ice pack treatment despite a negative x-ray. Additionally, R1 stated she experienced nightmares that startled her awake and made her cry as she relived the experience when she slept. She denied informing staff about the nightmares. She was relieved these improved, but she was still bothered by them. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview via telephone on 5/27/25, at 10:02 a.m., NA-B stated if she were to witness abuse she would take over and ask the other staff to leave and then she would update management and/or call the hotline. She denied ever witnessing abuse at the facility. She explained rough cares occurred when an aide was not being as gentle as they should be and rushed through the cares, such as pulling aggressively or not being as patient as they should. NA-B explained she witnessed NA-A pull on R1's dress sleeve to get it freed which I guess caused [R1] some discomfort. R1 told NA-A to be gentle but NA-B did not feel NA-A was overly rough: just pulling on the dress .like you would have to. NA-B explained the action was not necessarily rough but it was not as gentle as [R1] would have liked. She explained NA-A reported a headache, grumpy, and not feeling good where NA-A rushed the cares and was not as gentle as she should have been. She explained if she were the aide who helped in that situation, she would have maybe [done things] a little bit differently. She would have had R1 lean to the side, so she was not pulling so hard. She denied R1 instructed NA-A to leave the room. NA-B did not consider NA-A's actions as abuse and thus she did not feel this needed to be reported to the nurse but if the interaction were more aggressive, she would have reported it: it is a fine line between gentle and rough, but based on R1's body habitus and how we had to remove the dress. NA-B stated R1 commented on the situation to her after the incident and that R1 appeared to have increased shoulder pain as R1 utilized ice packs currently to the area and the incident from 5/18/25, may have caused the increased pain. During a telephone interview on 5/27/25, at 10:53 a.m., NA-A stated abuse occurred when staff were being too aggressive, among other things. If she witnessed abuse, she was to report to the supervisor immediately. NA-A stated on 5/18/25, she and NA-B assisted R1 to change into a gown. When she assisted R1 to take off her shirt, R1 told her firmly she was being rough. NA-A immediately stopped and asked R1 how she was rough. R1 did not respond. NA-B helped R1 remove the rest of the shirt and helped R1 with the gown, but she continued with the rest of the cares once NA-B left the room. NA-A explained, when she tried to pull the shirt bottom from under R1, she did not realize R1 could sit up and move as much as she did, so that when she pulled, R1 sat up, and the action used more effort than required. This caused the movement to be a quicker, jerking motion. She declined she was rough with the cares; however, she stated she maybe used more force then if I would have known she could move. During an interview via telephone on 5/27/25, at 11:56 a.m., certified nurse practitioner (CNP)-A stated she received a phone call on 5/19/25, that R1 complained of shoulder pain after an aide was too rough during cares. She explained she was updated the aide was asked to leave and the facility investigated the incident. CNP-A stated she had not heard anything since related to the investigation. During an interview on 5/27/25, at 1:46 p.m., the administrator expected staff to protect residents and when rough care was reported, she expected staff to stop what they are doing, get additional assistance, and report the incident to the nurse. Based on the initial investigation, it was decided not to report as there was no injury; however, she directed the incident to be treated like a grievance and NA-A was placed on the do not return list. She denied knowledge of the status of the investigation as the grievance form was yet to be provided to her for her review and signature, but she reported involvement in the investigation conversations. An Abuse and Neglect - Clinical Protocol, dated 2018, directed the nurse was to assess the individual and document any related findings (i.e., injury assessment, pain assessment, current behavior, past 24-hour behavior(s), etc.). Additionally, the staff and physician were to monitor the resident to address any issues regarding their medical condition, mood, and function. (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 - Few	Review of facility policy titled An Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, dated 2022, identified a section labeled Investigating Allegations. This instructed all allegations were to be thoroughly investigated. The administrator was to initiate the investigation with assistance from appropriately trained staff. The staff conducting the investigation, at a minimum, was to review documentation and evidence, the resident's medical record, interview the involved resident, the person(s) reporting the incident, any witnesses, the attending provider, staff members who have had contact with the resident during the period of the alleged incident, interview family members, and other residents whom the accused employee provided care or services to. Additionally, all events leading up to the alleged incident were to be reviewed and the investigation was to be documented completely and thoroughly. When conducting interviews, statements were obtained in writing, signed, and dated.