STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145914	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

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 -** Immediate jeopardy **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 protect and supervise a dependent, dementia female (R1) resident from sexual assault by an oriented, ambulatory male (R3) resident which resulted in an Immediate Jeopardy on 5/20/20. This failure affected one resident (R1) of 3 residents reviewed for sexual abuse in the sample of 3 residents. R3 is an oriented ambulatory male resident who placed his penis into R1's mouth who is not capable of consent. As result, an immediate jeopardy was identified. This past non-compliance occurred from 5/20/20 to 5/22/20. The Immediate Jeopardy began on 5/20/20 when R3 placed his penis in R1's mouth and was identified on 6/24/20. V2 (Director of Nursing), V10 (Regional Director) and V12 (Regional Director of Operations) were notified of the Immediate Jeopardy on 7/28/20 at 3:58 PM in the absence of the facility's administrator. The immediate jeopardy was removed 5/22/20 when R1 and R3 were transferred out of the facility and the facility took steps to ensure other residents were safe from sexual abuse. The finding include: According to the quarterly MDS (Minimum Data Set), dated 4/9/20, R1 is a [AGE] year old, ambulatory female who has severe cognition loss per the brief interview mental score (BIMS) of 01. R1 has been a resident in the facility since 7/27/18, with [DIAGNOSES REDACTED]. The MDS, dated [DATE], documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R1 is no longer in the facility, and never returned after the 5/22/20 per MDS, nurses' notes, and interviews. According to the quarterly MDS, dated [DATE], R3 is an oriented, [AGE] year old ambulatory male who was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS, dated [DATE], documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R3 is no longer in the facility and never returned after 5/22/20 per MDS, nurses' notes, and interviews. On 6/24/20 at 11 AM, V2 (Director of Nursing) stated that R1 and R3 are no longer in the facility. The following staff interviews were conducted regarding the sexual abuse involving R1 and R3. On 6/24/20 at 11:24 AM, V1 (Administrator/Abuse Coordinator) stated she received the allegation from V4 (Dementia Coordinator/Psychiatric Rehabilitation Service Counselor/PRSC) who received the allegation from V3 (Certified Nurse Aide/CNA). V1 says that V3 was walking by, it was the shift change around 3:30 PM on 5/20/20, when V3 says she saw R3 (male resident) with his privates in R1's mouth (female). V1 says she had V3 demonstrate the assault, and V3 demonstrated R3 having leg/foot on bed and jiggling his privates in front of R1. R1 was seated on her bed. V1 stated that both residents have dementia and denied it happened. On 6/24/20 at 4:10 PM, V3 (CNA) stated she was doing her rounds on May 20th at 2:45 PM, normally works 3 to 11 shift; it was a Wednesday when she saw R3 on R1's bed with his penis in her mouth. V3 stated that R1 was seated upright in the bed, due to Gastrostomy Tube infusing, and was dressed in a hospital gown. V3 stated that R3 was kneeling on the bed with his penis in R1's mouth. When she asked what was going on, R3 stopped, got off bed, put his penis in pants, and zipped his pants. V3 told R3 that he would be reported, and R3 stated, I know. V3 went to the nurses' station and telephoned the receptionist and asked for the administrator. Receptionist asked why, and was told of the assault. Receptionist stated that V9 (Social Service Director/Psychiatric Rehabilitation Service Director) would come to the 3rd floor for report. V3 says that she saw V4 (PRSC) and told her of the assault. V3 stated that R3 was removed and placed at the nurses' station and monitored, then moved to 2nd floor. R3 told V4 that R1 is his girlfriend, which is untrue. V3 says that R3 has behavior of masturbating in his room. V3 stated she reported the sexual assault the same day she saw it, and was adamant it was a Wednesday, the 20th of May. V3 stated that on her way out of facility, she went to V1 (administrator) and asked if she was aware of R3's assault, and V1 replied yes. V3 stated the floor is for dementia residents, but there are alert, oriented residents on the floor also. On 6/25/20 at 11:11 AM, V4 (PRSC) stated it happened on 5/20/20 between 2:30 PM to 3 PM, when V3 (Certified Nurse Aide) came to her and stated R3 was standing in front of R1 in her room with his penis out in his hand and in R1's mouth. V4 stated that V3 then stated she was not sure if penis was in her mouth. Asked why her statement was written up 5/24/20, 4 days after the event, V4 stated she was going out of town and left the facility before writing up the statement. V4 stated she only provided a statement, and was not interviewed about the incident. V4 stated it was the administrator who made the decision to send R3 to the 2nd floor and not out of the facility immediately. V4 stated when R3 was admitted to the facility he was very confused so he was put on the 3rd floor, a closed unit. But during his stay, he presented as oriented times three, and knowing right from wrong. V4 stated she did the BIMS for the 5/19/20 MDS, and admits that she did it quite early in the morning, and R3 was a little groggy waking up. V4 stated he had trouble recalling the 3 words; could only recall 2 words. She was his assigned PRSC, and stated not to be aware of R3's behavior of masturbating. On 6/25/20 at 1:01 PM, V5 (R3's sister) stated that R3 has been in and out of psychiatric facilities his whole life. V5 stated R3 was living in assisted living prior to going to this nursing home. While he was in assisted living, he was not taking care of himself, and had poor hygiene and staying in the bed. R3 was sent to the hospital; it was the hospital staff who informed her of R3's masturbation behavior. V5 stated that R3 is not a bad person but a mentally ill person. Stated that R3 was put on the closed unit because he was so confused and weak. After a couple of months, he started to improve mentally and physically. V5 stated that R3 is oriented and knows right from wrong. Stated she was contacted by a female staff member who told V5 that R3 was being sent to the hospital (2 days after the incident) for inappropriate behavior. V5 stated she needed to press the staff member to say what was inappropriate. Staff member told V5, R3 was having sex with a female. V5 stated she did not understand why this was an issue if both adults are consenting. V5 stated that R3 told her that R1 was his friend. On 6/25/20 at 1:45 PM, V6 (CNA) stated that R3 could hold a conversation with staff. R3 is usually pleasant and walks the unit or stays in his room. She stated she heard from other C.N.A.s about R3's masturbation but never witnessed it herself. On 6/25/20 at 5:45 PM, V8 (Psychiatric Nurse Practitioner) stated she conducted a telemedicine call with a nurse and V9 (SSD/PRSD) on 5/20/20 at 3 PM. (minutes after the sexual assault). V8 stated there was no mention of any sexual assault by R3. V8 stated that R3 is grossly oriented : meaning he is oriented by 3 to 4 spheres. V8 stated that R3 knew the difference of right and wrong. R3 knows who he is, where he is, he can recall details from the past and present. V8 stated her biggest problem is the nurses do not document. A resident will voice an issue that the nurses are aware of, but they fail to document it. Nurses will say they informed the social service department. It makes no sense for the Social Service to document it when the nurses know of it first-hand. It makes it difficult for her to do the job. V8 stated she never heard of any masturbation issue or any issues from the nurses about R3. V8 stated that R3 is now residing in a psych nursing home. On 6/26/20 at 12:30 PM, V11 (Registered Nurse) stated she heard from the aides about R3's masturbation behavior, but she never witnessed it herself. The facility's policy labeled ABUSE PREVENTION PROGRAM documents this facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, agency staff, family members, legal guardians, friends or other individuals. The surveyor confirmed by interview and record review the facility took the following actions to correct the

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) non-compliance: 1. R1 and R3 are no longer in the facility as of 5/22/20. 2. On 6/19/20, all residents were screened and assessed to determine any factors that would contribute to residents being at risk or abuse. The residents' care plans have been updated as needed. 3. On 6/19/20, the facility identified potential perpetrators that exhibit inappropriate behaviors on 6/19/20. The residents' care plans have been reviewed and updated as needed. 4. The facility's Quality Assessment and Assurance Committee reviewed the facility's policy and no changes were made. 5. Staff were re-educated on, but limited to, the facility Abuse Policy and Procedures. The re-education emphasized identifying abuse and providing a safe environment. The re-education provided return verbalization and understanding. This education was completed by Regional Nurse Consultant, Doctor of Nurse Practice, Regional Director of Operations and Licensed Social Worker. This was initiated on 6/19/20 and completed 7/15/20. 6. Administrator and Assistant Administrator were terminated on 7/24/20. 7. The Q.A. (Quality Assurance) audit tool was developed. An audit will be conducted by the Regional Director of Operations to ensure the administrator is reporting abuse timely per the Abuse Policy on a quarterly basis. 8. Any future allegations of abuse will be reported to IDPH immediately. 9. Staff will be in-serviced monthly on Abuse Protocol by the administrator or D.O.N on a yearly basis or as needed.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review, the facility failed to report an allegation of sexual abuse to the Department for 1 (R1) of 3 residents reviewed for abuse in the sample of 3 residents. This failure has the potential to affect 166 residents residing in the facility. The findings include: On 6/24/20 at 11:24 AM, V1 (Administrator/Abuse Coordinator) stated she received the sexual abuse allegation from V4 (Dementia Coordinator/Psychiatric Rehabilitation Service Counselor/PRSC) who received the allegation from V3 (Certified Nurse Aide/CNA) on 5/20/20. On 6/24/20 at 4:10 PM, V3 (CNA) stated she reported the sexual assault the same day it happened to V1 (administrator). V3 stated she was on her way out of facility when she went to V1's office and asked if she was aware of R3's sexual assault, and V1 replied yes. V3 stated the floor is for dementia residents but there are alert, oriented residents on the floor also. On 6/25/20 at 9:52 AM , V1 (administrator) stated she failed to report allegation of sexual assault immediately to the Department, to the resident representatives, and the attending physician for R1 and R3. V1 stated she knows she should have notified the Department on 5/20/20, day of incident, and should have transferred R1 and R3 on 5/20/20 to a hospital. V1 stated she was the one to write up the staff interviews, along with V10 (Regional Director) and failed to date, and obtain signatures and titles of staff V1 stated she failed to write up R1's and R3's statement, but stated that both residents denied sexual assault happened. V1 stated she also failed to document V3's demonstration of the assault. On 7/23/20 at 3:30 PM, V1 stated that there are 166 residents who reside in the facility. Review of the Department's received incidents/abuse allegations show there is no abuse allegation from 5/20/20 reported by this facility. The facility's policy labeled ABUSE PREVENTION PROGRAM documents : If you suspect ABUSE, separate alleged perpetrator and assure all residents' safety. Notify the administrator and the director of nursing immediately. Complete incident report immediately. Do not leave building until above is completed. Fax report to the Illinois Department of Public Health immediately. Under the investigation portion of the policy : All incidents, allegation or suspicion of abuse against a resident will be documented and result in an investigation. The charge nurse must complete an incident report and obtain a written, signed and dated statement from person reporting the incident. A completed copy of the incident report and written statements from witnesses will be provided to Administrator within 24 hours of the occurrence. Any incident that involves a crime toward a resident will be reported with in 2 hours of the incident to the State, to the resident representative, to the attending physician and any law enforcement when it is sexual abuse of a resident by another resident.
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** Based on interview and record review, the facility failed to do a complete investigation, failed to interview all parties involved, failed to take reasonable steps to preserve evidence of the alleged assault, failed to obtain physician's order for hospital transfer, failed to notify the physician and resident representative immediately after the assault, failed to send both residents for hospital examination following the assault, and failed to follow the facility's abuse Policy for two residents (R1, R3) of 3 residents reviewed for sexual abuse in the sample of 3 residents and has the potential to affect all 166 residents residing in the facility. The findings include: R1 is a [AGE] year old, ambulatory female who has severe cognition loss per the Brief Interview Mental Score (BIMS) of 01 in the quarterly MDS (Minimum Data Set), dated 4/9/20. R1 has been a resident in the facility since 7/27/18 with [DIAGNOSES REDACTED]. The MDS, dated [DATE], documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R1 is no longer in the facility and never returned after the 5/22/20 per MDS, nurses' notes, and interviews. R3 is an oriented, [AGE] year old ambulatory male who was admitted to the facility on [DATE], per the quarterly MDS, dated [DATE]. R3's [DIAGNOSES REDACTED]. The MDS, dated [DATE], documents discharged with return anticipated. Nothing documented that resident went to hospital. There is no physician order to send to hospital. R3 is no longer in the facility and never returned after 5/22/20 per MDS, nurses' notes, and interviews. On 6/24/20 at 11:24 AM, V1 (Administrator/Abuse Coordinator) stated she received the allegation from V4 (Dementia Coordinator/Psychiatric Rehabilitation Service Counselor/PRSC) who received the allegation from V3 (Certified Nurse Aide/CNA). V1 says that V3 was walking by, it was the shift change around 3:30 PM on 5/21/20, when V3 says she saw R3 (male resident) with his privates in R1's mouth (female). V1 says she had V3 demonstrate the assault, and V3 demonstrated R3 having leg/foot on bed and jiggling his privates in front of R1. R1 was seated on her bed. V1 stated that both residents have dementia and denied it happened. On 6/24/20 at 4:10 PM, V3 (CNA) she was doing her rounds on May 22nd at 2:45 PM, normally works 3 to 11 shift, it was a Wednesday, when she saw R3 on R1's bed with his penis in her mouth. V3 stated that R1 was seated upright in the bed, due to Gastrostomy Tube infusing, and was dressed in a hospital gown. V3 stated that R3 was kneeling on the bed with his penis in R1's mouth. When she asked what was going on, R3 stopped, got off bed, put his penis in pants, and zipped his pants. V3 told R3 that he would be reported. V3 went to the nurses' station and telephoned the receptionist and asked for the administrator. Receptionist asked why, and was told of the assault. Receptionist stated that V9 (Social Service Director/Psychiatric Rehabilitation Service Director) would come to the 3rd floor for report. V3 says that she saw V4 (Psychiatric Rehabilitation Service Counselor/PRSC) and told her of the assault. V3 stated that R3 was removed and placed at the nurses' station and monitored, then moved to 2nd floor. R3 told V4 that R1 is his girlfriend, which is untrue. V3 says that R3 has behavior of masturbating in his room. V3 stated she reported the sexual assault same day she saw it, and was adamant it was a Wednesday. Told her that Wednesday is the 20th. V3 stated she must of written the wrong date in cell phone, but it was a WEDNESDAY. V3 stated that on her way out of facility, she went to V1 (administrator) and asked if she was aware of R3's assault and V1 replied yes. V3 stated the floor is for dementia residents but there are alert, oriented residents on the floor also. V3 was never interviewed by administration. On 6/25/20 at 11:11 AM, V4 (PRSC) stated it happened on 5/20/20, between 2:30 PM to 3 PM, when V3 (Certified Nurse Aide) came to her and stated R3 was standing in front of R1 in her room with his penis out in his hand and in R1's mouth. V4 stated that V3 then stated she was not sure if penis was in her mouth. Asked why her statement was written up 5/24/20, 4 days after the event, V4 stated she was going out of town and left the facility before writing up the statement. V4 stated she only provided a statement and was not interviewed about the incident. Stated it was the administrator who made the decision to send R3 to the 2nd floor and not out of the facility immediately. V4 stated when R3 was admitted to the facility he was very confused so put on the 3rd floor, a closed unit. But during his stay he presented as oriented times three, and knowing right from wrong. V4 stated she did the BIMS for the 5/19/20 MDS, and admits that she did it quite early in the morning, and R3 was a little groggy waking up. V4 stated he had trouble recalling the 3 words, could only recall 2 words. She was his assigned PRSC and stated not to be aware of R3's behavior of masturbating. On 6/25/20 at 9:52 AM , V1 (administrator) stated she failed to report allegation of sexual assault immediately to the Department, to the resident representatives, and the attending physician for R1 and R3. V1 stated she knows she should have notified the Department on 5/20/20, day of incident, and should have transferred R1 and R3 on 5/20/20 to a hospital. V1 stated she was the one to write up the staff interviews along with V10 (Regional Director) and failed to date, and obtain signatures and titles of staff. V1 stated V2 (Director of Nursing) did the assessments on R1 and R3 after the sexual assault. V1 stated she failed to write up R1's and R3's statements, but both

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) denied sexual assault happened. V1 stated she also failed to document V3's demonstration of the assault. On 7/23/20 at 3:30 PM, V1 stated that there are 166 residents who reside in the facility. The incident reports were incomplete and inaccurate with notifying (date and time) the resident representative and attending physician, R3's cognition not documented, and no conclusion of the incident report. Both residents remained in the facility after the sexual assault for 2 days. There is no date on incident report as to when it was completed. The incident report was not faxed to regional office. Review of the facility's abuse investigation was lacking interviews with R1, R3; incomplete interviews that lacked dates, titles and signatures. No follow up or conclusion for the assault. V1 presented a fax sheet indicating that the initial investigation was supposedly sent to the regional office 2 days after the assault. The final report which lacked a conclusion was sent to the regional office supposedly on 5/27/20, six working days after the sexual assault. The fax for the final investigation was suspect. A police report was provided with no date on it as to when the report was filled out. The Police Report only has time of assault. Review of the Department's received incidents/abuse allegations showed there is no abuse allegation related to the 5/20/20 sexual assault reported by this facility. The facility failed to report this 5/20/20 abuse allegation and failed to do a thorough or any investigation. The facility's policy labeled ABUSE PREVENTION PROGRAM documents : If you suspect ABUSE, separate alleged perpetrator and assure all residents' safety. Notify the administrator and the director of nursing immediately. Complete incident report immediately. Do not leave building until above is completed. Fax report to the Illinois Department of Public Health immediately. Under the investigation portion of the policy : All incidents, allegation or suspicion of abuse against a resident will be documented and result in an investigation. The charge nurse must complete an incident report and obtain a written, signed and dated statement from person reporting the incident. A completed copy of the incident report and written statements from witnesses will be provided to Administrator within 24 hours of the occurrence. The final report will be completed in 5 working days with a conclusion of the investigation based on facts. Any investigation that concludes abuse against a resident will be reviewed by the Quality Assurance Performance Improvement Committee for possible changes in facility practices to ensure that similar events do not occur again. As part of the social history and the MDS assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behavior that might lead to conflict. Any incident that involves a crime toward a resident will be reported with in 2 hours of the incident to the State, to the resident representative, to the attending physician and any law enforcement when it is sexual abuse of a resident by another resident. The Abuse Policy documents Abuse allegations involving one resident upon another resident will be reported to I.D.P.H. The investigator will submit a final report of the conclusion of the investigation in writing within 5 working days of the incident. The final investigation report shall contain the following: * Name, Age, [DIAGNOSES REDACTED]. * The original allegation (note day, time, location, the specific allegation, by whom, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries. * Facts determined during the process of the investigation, review of medical record and interview of witnesses * Conclusion of the investigation based on known facts * If there is a police report, attach the police report * Attach a summary of all interviews conducted, with the names, addresses, phone numbers and willingness to testify of all witnesses. Upon receiving information concerning a report of abuse, the administrator will request a Social Service representative to monitor resident's feelings concerning the incident as well as the resident's reaction to her involvement in the investigation. The Social Service Representative will provide a written report of her findings in the resident's medical record. The administrator shall review the findings of the investigation and determine if further training or other corrective action is needed to prevent future occurrences.The facility failed to follow their Abuse Policy.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on interview and record review, the facility's administrator failed to follow the facility's Abuse Policy when she failed to report and investigate an allegation of sexual abuse when notified by a staff member, failed to obtain/preserve any evidence from the crime, and failed to take any actions for 2 days. This failure has the potential to affect all 166 residents residing in the facility. The findings include: On 6/24/20 at 11:24 AM, V1 (Administrator/Abuse Coordinator) stated she received the sexual abuse allegation from V4 (Dementia Coordinator/Psychiatric Rehabilitation Service Counselor/PRSC) who received the allegation from V3 (Certified Nurse Aide/CNA). On 6/24/20 at 4:10 PM, V3 (CNA) stated she reported the sexual assault the same day it happened to V1 (administrator). V3 stated she was on her way out of facility when she went to V1's office and asked if she was aware of R3's sexual assault, and V1 replied yes. V3 stated the floor is for dementia residents but there are alert, oriented residents on the floor also. On 6/25/20 at 9:52 AM , V1 (administrator) stated she failed to report allegation of sexual assault immediately to the Department, to the resident representatives, and the attending physician for R1 and R3. V1 stated she knows she should have notified the Department on 5/20/20, day of incident, and should have transferred R1 and R3 on 5/20/20 to a hospital. V1 stated she was the one to write up the staff interviews, along with V10 (Regional Director), and failed to date, and obtain signatures and titles of staff V1 stated she failed to write up R1's and R3's statements, but stated that both residents denied sexual assault happened. V1 stated she also failed to document V3's demonstration of the assault. On 7/23/20 at 3:30 PM, V1 stated that there are 166 residents who reside in the facility. Review of the facility's abuse investigation was lacking interviews with R1, R3; incomplete interviews that lacked dates, titles and signatures. No follow up or conclusion for the assault. The initial investigation was supposedly sent to the regional office 2 days after the assault. The final report which lacked a conclusion was supposedly sent to the regional office on 5/27/20, six working days after the sexual assault. A police report was provided with no date on it as to when the report was filled out. Police Report only has time of assault. Review of the Department's received incidents/abuse allegations showed there is no abuse allegation related to the 5/20/20 sexual assault reported by this facility. The facility failed to report this 5/20/20 abuse allegation and failed to do an investigation. The facility's policy labeled ABUSE PREVENTION PROGRAM documents : If you suspect ABUSE, separate alleged perpetrator and assure all residents' safety. Notify the administrator and the director of nursing immediately. Complete incident report immediately. Do not leave building until above is completed. Fax report to the Illinois Department of Public Health immediately. Under the investigation portion of the policy : All incidents, allegation or suspicion of abuse against a resident will be documented and result in an investigation. The charge nurse must complete an incident report and obtain a written, signed and dated statement from person reporting the incident. A completed copy of the incident report and written statements from witnesses will be provided to Administrator within 24 hours of the occurrence. Any incident that involves a crime toward a resident will be reported with in 2 hours of the incident to the State, to the resident representative, to the attending physician and any law enforcement when it is sexual abuse of a resident by another resident. This was not done. Upon receiving information concerning a report of abuse, the administrator will request a Social Service representative to monitor resident's feelings concerning the incident as well as the resident's reaction to her involvement in the investigation. The Social Service Representative will provide a written report of her findings in the resident's medical record. The administrator shall review the findings of the investigation and determine if further training or other corrective action is needed to prevent future occurrences.The facility failed to follow their Abuse Policy.