

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2012
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00114426 and IN00115545 completed on 9-11-12, which resulted in unrelated deficiencies cited.</p> <p>Complaint IN00114426 -- Corrected.</p> <p>Complaint IN00115545 -- Corrected.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: November 13 and 14, 2012</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey Team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 103 SNF: 9 Total: 112</p> <p>Census payor type: Medicare: 9 Medicaid: 96 Other: 7 Total: 112</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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	<p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/15/12 Cathy Emswiller RN</p>				

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a resident's personal monies were not taken by a facility staff member without the resident's permission for 1 of 3 resident's reviewed for misappropriation of funds in a sample of 3. (Resident A)</p> <p>Findings include:</p> <p>A copy of a state-reportable incident was provided by the Director of Nursing on 11-13-12 at 11:22 a.m. This document indicated on the evening of 11-6-12, the resident had placed her purse with approximately \$470.00 in her wallet lying on her bed when she went to supper, time not indicated. Upon return to her room, she found the purse on the floor and shortly thereafter, found all but \$84.00 missing. It indicated this information was reported to the Social Services Designee (SSD) on 11-7-12, time not indicated nor by whom it was reported. The SSD interviewed the resident and contacted the local police department. Arrangements were made for the police representative to</p>	F0224	<p>F224 SS=D</p> <p>PROHIBIT MISTREATMENT /NEGLECT/MISAPPROPRATIO N</p> <p>1. Resident A was seen by psych services to assist with psychological management for loss of personal property. (Attachment A) The CNA is no longer employed at Jennings Healthcare Center</p> <p>2. All residents exercising their right to keep sums of money in their possession have the potential to be affected. Residents are advised upon admission not to keep large sums of money on them. Residents were interviewed by the Social Service Designee to determine if any sums of money have been misappropriated and not reported. There were no additional reports.</p> <p>3. Facility staff re educated by the Director of Clinical Services/designee on Policy Regarding Abuse, Investigation of Abuse, and Reporting of Abuse</p>	11/23/2012			

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	<p>interview the resident on 11-7-12 and 3 staff who had access to the resident the previous evening. The 3 staff were asked to go to the police station. It indicated CNA #1 "then confessed to stealing the money. Police handling legalities...[name of CNA #1] stated to the police that she would repay the money to [name of resident A]." The facility immediately terminated CNA #1. This document indicated this report was emailed to ISDH on 11-8-12 at 8:56 a.m. by the SSD.</p> <p>In interview with the SSD on 11-13-12 at 11:35 a.m., she indicated LPN #1 and Resident #A reported the event of the missing monies to her about the same time, estimated at around 9:00 a.m. on 11-7-12. She indicated she also had received a written note which indicated she should speak with Resident #A on the same morning. She indicated she was uncertain if LPN #1 had informed the next shift, the night shift, of the missing money and was uncertain if this information had been shared with the on-call staff the evening before. She indicated when she spoke with LPN #1, she learned the resident did not inform LPN #1 until late on the evening shift of 11-6-12. She indicated she began the investigation immediately upon receiving the information of the money being missing. She indicated she was surprised</p>		<p>timely. (Attachment B). At the next Resident council meeting the Social Service Designee /Designee will discuss the importance of depositing their monies in the business office. 25 % of resident population will be interviewed by the Social Service Designee/Designee monthly to determine resident's ability to understand and identification of abuse and reporting abuse. Re education provided as indicated.</p> <p>4. Director of Clinical Services/Designee will interview 10% of interviewable residents monthly to determine resident's ability to understand how to identify abuse and how to report abuse. Any findings will be brought to monthly RMQI committee for review and development of action plan to ensure resident's personal monies are not taken by a facility staff member without the resident's permission.</p> <p>5. 11/23/2012</p>				

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	<p>when she learned CNA #1 had confessed to taking the money to the police officer.</p> <p>In interview with LPN #1 on 11-13-12 at 2:03 p.m., she indicated Resident #A told her she had some money missing between 9:30 p.m. and 10:00 p.m. on 11-6-12. She indicated the resident indicated she had \$320.00 of which she had given a family member money to buy some items for her and resulted in her having \$304.00 remaining. She indicated the resident had found her purse was not in its usual place as it was found on the floor. She indicated the resident indicated "the aides had told her it had fallen on the floor and that's where it was found." She indicated the resident "sounded like it was missing, not taken. I didn't even think about looking in her room because she said it was missing." She indicated shortly afterwards, CNA #1 and CNA #2 told her that Resident #A had told her she had about \$100.00 missing. LPN #1 indicated she did share this information with the next shift nurse about missing money for Resident #A, but did not share the information with the Shift Supervisor, LPN #2, nor did she contact the SSD who was identified by the SSD as the abuse point of contact until the following morning. She indicated she called the SSD on 11-7-12 between 7:50 a.m. and 8:00 a.m. to inform her of Resident #A's</p>			

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	<p>report of missing money.</p> <p>In interview with Resident #A on 11-13-12 at 2:35 p.m. she indicated she had left her purse on her bed on the evening of 11-6-12 when she went to the dining room for supper. She indicated she thought her purse would be safe in her room. She indicated she had between \$200.00 and \$300.00 in her purse at the time. She indicated when she returned to her room, she found her purse lying in the far side of the bed on the floor, near her night stand. She indicated a family member had called her regarding needing a car part and she then went to count her money and found the money missing. She indicated she called 2 other family members to find out if they might have stopped by and obtained money from her purse. She indicated both indicated they had not done so. She indicated she later that evening informed LPN #1 of the missing money. She indicated LPN #1 offered to call the police to report the missing money, but Resident #A decided she did not want that done at that time. She indicated the following morning, on 11-7-12, the SSD came to her "and took a report and contacted the police." She indicated a police officer took a report and she later learned one of the facility CNA's had taken the money and had told the police she would repay the money.</p>			
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	<p>She indicated she has not received any repayment of the money to date. She indicated she should not have kept so much money in the facility.</p> <p>Review of Resident #A's clinical record on 11-13-12 at 2:58 p.m. indicated was cognitively intact according to the most recent Minimum Data Set assessment, dated 10-9-12.</p> <p>A copy of a document entitled, "Abuse Prevention Program and Reporting Policy," with a revision date of 3/11, was provided by the Assistant Director of Nursing on 11-13-12 at 10:33 a.m. This policy indicated, "The facility prohibits the mistreatment, neglect, and abuse of resident/patients and misappropriation of resident/patient property by anyone...Employees are appropriately screened and trained to prevent abuse. Each employee is responsible to report any suspected abuse. Each incident will be investigated, and required reporting completed."</p> <p>3.1-28(a)</p>						

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the</p>	F0225	F 225 SS=D	11/23/2012			

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	<p>facility failed to ensure a staff member immediately reported a suspected misappropriation of a resident's monies to the administrator, or designee. The delay in reporting of approximately 10 hours of the suspected misappropriation resulted in delayed investigation of the event and subsequent delayed reporting to the Indiana State Department of Health's (ISDH) Long Term Care Division within 24 hours. This deficient practice affected 1 of 3 residents reviewed for misappropriation of property in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>A copy of a state-reportable incident was provided by the Director of Nursing on 11-13-12 at 11:22 a.m. This document indicated on the evening of 11-6-12, the resident had placed her purse with approximately \$470.00 in her wallet lying on her bed when she went to supper, time not indicated. Upon return to her room, she found the purse on the floor and shortly thereafter, found all but \$84.00 missing. It indicated this information was reported to the Social Services Designee (SSD) on 11-7-12, time not indicated nor by whom it was reported. The SSD interviewed the resident and contacted the local police department. Arrangements were made for the police representative to</p>		<p>INVESTIGATE/REPORT ALLEGATIONS OF ABUSE</p> <p>1. Resident A was seen by psych services to assist with psychological management for loss of personal property. (Attachment A) The CNA is no longer employed at Jennings Healthcare Center</p> <p>2. All residents exercising their right to keep sums of money in their possession have the potential to be affected. Residents are advised upon admission not to keep large sums of money on them. Residents were interviewed by the Social Service Designee to determine if any sums of money have been misappropriated and not reported. There were no additional reports.</p> <p>3. Facility staff re educated by the Director of Clinical Services/designee on Policy Regarding Abuse, Investigation of Abuse, and Reporting of Abuse timely. (Attachment B). At the next Resident council meeting the Social Service Designee /Designee will discuss the importance of depositing their monies in the business office. 25 % of resident population will be interviewed by the Social Service Designee/Designee monthly to determine resident's ability to understand and identification of abuse and reporting abuse. Re education provided as indicated.</p>				

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	<p>interview the resident on 11-7-12 and 3 staff who had access to the resident the previous evening. The 3 staff were asked to go to the police station. It indicated CNA #1 "then confessed to stealing the money. Police handling legalities...[name of CNA #1] stated to the police that she would repay the money to [name of resident A]." The facility immediately terminated CNA #1. This document indicated this report was emailed to ISDH on 11-8-12 at 8:56 a.m. by the SSD.</p> <p>In interview with the SSD on 11-13-12 at 11:35 a.m., she indicated LPN #1 and Resident #A reported the event of the missing monies to her about the same time, estimated at around 9:00 a.m. on 11-7-12. She indicated she also had received a written note which indicated she should speak with Resident #A on the same morning. She indicated she was uncertain if LPN #1 had informed the next shift, the night shift, of the missing money and was uncertain if this information had been shared with the on-call staff the evening before. She indicated when she spoke with LPN #1, she learned the resident did not inform LPN #1 until late on the evening shift of 11-6-12. She indicated she began the investigation immediately upon receiving the information of the money being missing. She indicated she was surprised</p>		<p>4. Director of Clinical Services/Designee will interview 10% of interviewable residents monthly to determine resident's ability to understand how to identify abuse and how to report abuse. Any findings will be brought to monthly RMQI committee for review and development of action plan to ensure resident's personal monies are not taken by a facility staff member without the resident's permission.</p> <p>5. 11/23/2012</p>	

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	<p>when she learned CNA #1 had confessed to taking the money to the police officer.</p> <p>In interview with LPN #1 on 11-13-12 at 2:03 p.m., she indicated Resident #A told her she had some money missing between 9:30 p.m. and 10:00 p.m. on 11-6-12. She indicated the resident indicated she had \$320.00 of which she had given a family member money to buy some items for her and resulted in her having \$304.00 remaining. She indicated the resident had found her purse was not in its usual place as it was found on the floor. She indicated the resident indicated "the aides had told her it had fallen on the floor and that's where it was found." She indicated the resident "sounded like it was missing, not taken. I didn't even think about looking in her room because she said it was missing." She indicated shortly afterwards, CNA #1 and CNA #2 told her that Resident #A had told her she had about \$100.00 missing. LPN #1 indicated she did share this information with the next shift nurse about missing money for Resident #A, but did not share the information with the Shift Supervisor, LPN #2, nor did she contact the SSD who was identified by the SSD as the abuse point of contact until the following morning. She indicated she called the SSD on 11-7-12 between 7:50 a.m. and 8:00 a.m. to inform her of Resident #A's</p>			

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	<p>report of missing money.</p> <p>In interview with Resident #A on 11-13-12 at 2:35 p.m. she indicated she had left her purse on her bed on the evening of 11-6-12 when she went to the dining room for supper. She indicated she thought her purse would be safe in her room. She indicated she had between \$200.00 and \$300.00 in her purse at the time. She indicated when she returned to her room, she found her purse lying in the far side of the bed on the floor, near her night stand. She indicated a family member had called her regarding needing a car part and she then went to count her money and found the money missing. She indicated she called 2 other family members to find out if they might have stopped by and obtained money from her purse. She indicated both indicated they had not done so. She indicated she later that evening informed LPN #1 of the missing money. She indicated LPN #1 offered to call the police to report the missing money, but Resident #A decided she did not want that done at that time. She indicated the following morning, on 11-7-12, the SSD came to her "and took a report and contacted the police." She indicated a police officer took a report and she later learned one of the facility CNA's had taken the money and had told the police she would repay the money.</p>			

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	<p>She indicated she has not received any repayment of the money to date. She indicated she should not have kept so much money in the facility.</p> <p>Review of Resident #A's clinical record on 11-13-12 at 2:58 p.m. indicated was cognitively intact according to the most recent Minimum Data Set assessment, dated 10-9-12.</p> <p>Review of LPN #1's facility inservice training record indicated she had received inservice education on the topic of "Abuse/Abuse Prohibition" on 12-28-11 and 8-31-12.</p> <p>Review of CNA #1's employee record indicated she had received inservice education on the topic of "Abuse/Abuse Prohibition" most recently on 8-31-12. A document entitled, "Employee Coaching Plan-Level 2" indicated, "Police questioning revealed CNA admitting to taking money from resident." The document indicated CNA #1 was terminated with an effective date of 11-9-12. This document was signed by the Director of Nursing and CNA #1 on 11-9-12.</p> <p>A copy of a document entitled, "Abuse Prevention Program and Reporting Policy," with a revision date of 3/11, was</p>						

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	<p>provided by the Assistant Director of Nursing on 11-13-12 at 10:33 a.m. This policy indicated, "The facility prohibits the mistreatment, neglect, and abuse of resident/patients and misappropriation of resident/patient property by anyone...Employees are appropriately screened and trained to prevent abuse. Each employee is responsible to report any suspected abuse. Each incident will be investigated, and required reporting completed." Under the sub-heading of "Training," the policy indicated, "Provide training for new employees through orientation and with ongoing training programs. Training will include, but not be limited to:...Identification of abuse, neglect, mistreatment, and misappropriation of property...How to investigate and report incidents of abuse, neglect, mistreatment, and misappropriation of property..." Under the sub-heading of "Identification," the policy indicated, "...Instruct staff, resident/patient, family, and visitor, to report immediately, with fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Initiate an <i>Incident/Accident Report</i> immediately upon identification of actual or suspected abuse, neglect, mistreatment, and/or misappropriation of property..." This document continued with a secondary</p>			

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	<p>policy, entitled, "Abuse Prevention Program & Reporting Policy." This document indicated, "...Notify the Shift Supervisor immediately if suspected abuse, neglect, mistreatment or misappropriation of property occurs. Report the incident immediately to the Administrator, and Director of Nursing. Notify the appropriate State agency(s) immediately by fax or telephone after identification of the alleged/suspected incident. Initiate process according to State-specified regulations..."</p> <p>3.1-28 (c)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure a staff member implemented facility policies regarding the immediate reporting of a suspected misappropriation of a resident's monies to the administrator, or designee. This deficient practice affected 1 of 3 residents reviewed for misappropriation of property in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>A copy of a state-reportable incident was provided by the Director of Nursing on 11-13-12 at 11:22 a.m. This document indicated on the evening of 11-6-12, the resident had placed her purse with approximately \$470.00 in her wallet lying on her bed when she went to supper, time not indicated. Upon return to her room, she found the purse on the floor and shortly thereafter, found all but \$84.00 missing. It indicated this information was reported to the Social Services Designee (SSD) on 11-7-12, time not indicated nor by whom it was reported. The SSD interviewed the resident and contacted the</p>	F0226	<p>F226 SS=D DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES 1.Resident A was seen by psych services to assist with psychological management for loss of personal property. (Attachment A) The CNA is no longer employed at Jennings Healthcare Center 2.All residents exercising their right to keep sums of money in their possession have the potential to be affected. Residents are advised upon admission not to keep large sums of money on them. Residents were interviewed by the Social Service Designee to determine if any sums of money have been misappropriated and not reported. There were no additional reports. 3. Facility staff re educated by the Director of Clinical Services/designee on Policy Regarding Abuse, Investigation of Abuse, and Reporting of Abuse timely. (Attachment B). At the next Resident council meeting the Social Service Designee /Designee will discuss the importance of depositing their monies in the business office. 25 % of resident population will be</p>	11/23/2012	

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	<p>local police department. Arrangements were made for the police representative to interview the resident on 11-7-12 and 3 staff who had access to the resident the previous evening. The 3 staff were asked to go to the police station. It indicated CNA #1 "then confessed to stealing the money. Police handling legalities...[name of CNA #1] stated to the police that she would repay the money to [name of resident A]." The facility immediately terminated CNA #1. This document indicated this report was emailed to ISDH on 11-8-12 at 8:56 a.m. by the SSD.</p> <p>In interview with the SSD on 11-13-12 at 11:35 a.m., she indicated LPN #1 and Resident #A reported the event of the missing monies to her about the same time, estimated at around 9:00 a.m. on 11-7-12. She indicated she also had received a written note which indicated she should speak with Resident #A on the same morning. She indicated she was uncertain if LPN #1 had informed the next shift, the night shift, of the missing money and was uncertain if this information had been shared with the on-call staff the evening before. She indicated when she spoke with LPN #1, she learned the resident did not inform LPN #1 until late on the evening shift of 11-6-12. She indicated she began the investigation immediately upon receiving</p>		<p>interviewed by the Social Service Designee/Designee monthly to determine resident's ability to understand and identification of abuse and reporting abuse. Re education provided as indicated. 4. Director of Clinical Services/Designee will interview 10% of interviewable residents monthly to determine resident's ability to understand how to identify abuse and how to report abuse. Any findings will be brought to monthly RMQI committee for review and development of action plan to ensure resident's personal monies are not taken by a facility staff member without the resident's permission. 5. 11/23/2012</p>	

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	<p>the information of the money being missing. She indicated she was surprised when she learned CNA #1 had confessed to taking the money to the police officer.</p> <p>In interview with LPN #1 on 11-13-12 at 2:03 p.m., she indicated Resident #A told her she had some money missing between 9:30 p.m. and 10:00 p.m. on 11-6-12. She indicated the resident indicated she had \$320.00 of which she had given a family member money to buy some items for her and resulted in her having \$304.00 remaining. She indicated the resident had found her purse was not in its usual place as it was found on the floor. She indicated the resident indicated "the aides had told her it had fallen on the floor and that's where it was found." She indicated the resident "sounded like it was missing, not taken. I didn't even think about looking in her room because she said it was missing." She indicated shortly afterwards, CNA #1 and CNA #2 told her that Resident #A had told her she had about \$100.00 missing. LPN #1 indicated she did share this information with the next shift nurse about missing money for Resident #A, but did not share the information with the Shift Supervisor, LPN #2, nor did she contact the SSD who was identified by the SSD as the abuse point of contact until the following morning. She indicated she called the</p>			

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	<p>SSD on 11-7-12 between 7:50 a.m. and 8:00 a.m. to inform her of Resident #A's report of missing money.</p> <p>In interview with Resident #A on 11-13-12 at 2:35 p.m. she indicated she had left her purse on her bed on the evening of 11-6-12 when she went to the dining room for supper. She indicated she thought her purse would be safe in her room. She indicated she had between \$200.00 and \$300.00 in her purse at the time. She indicated when she returned to her room, she found her purse lying in the far side of the bed on the floor, near her night stand. She indicated a family member had called her regarding needing a car part and she then went to count her money and found the money missing. She indicated she called 2 other family members to find out if they might have stopped by and obtained money from her purse. She indicated both indicated they had not done so. She indicated she later that evening informed LPN #1 of the missing money. She indicated LPN #1 offered to call the police to report the missing money, but Resident #A decided she did not want that done at that time. She indicated the following morning, on 11-7-12, the SSD came to her "and took a report and contacted the police." She indicated a police officer took a report and she later learned one of the facility</p>						

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	<p>CNA's had taken the money and had told the police she would repay the money. She indicated she has not received any repayment of the money to date. She indicated she should not have kept so much money in the facility.</p> <p>Review of Resident #A's clinical record on 11-13-12 at 2:58 p.m. indicated was cognitively intact according to the most recent Minimum Data Set assessment, dated 10-9-12.</p> <p>Review of LPN #1's facility inservice training record indicated she had received inservice education on the topic of "Abuse/Abuse Prohibition" on 12-28-11 and 8-31-12.</p> <p>Review of CNA #1's employee record indicated she had received inservice education on the topic of "Abuse/Abuse Prohibition" most recently on 8-31-12. A document entitled, "Employee Coaching Plan-Level 2" indicated, "Police questioning revealed CNA admitting to taking money from resident." The document indicated CNA #1 was terminated with an effective date of 11-9-12. This document was signed by the Director of Nursing and CNA #1 on 11-9-12.</p> <p>A copy of a document entitled, "Abuse</p>			

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	<p>Prevention Program and Reporting Policy," with a revision date of 3/11, was provided by the Assistant Director of Nursing on 11-13-12 at 10:33 a.m. This policy indicated, "The facility prohibits the mistreatment, neglect, and abuse of resident/patients and misappropriation of resident/patient property by anyone...Employees are appropriately screened and trained to prevent abuse. Each employee is responsible to report any suspected abuse. Each incident will be investigated, and required reporting completed." Under the sub-heading of "Training," the policy indicated, "Provide training for new employees through orientation and with ongoing training programs. Training will include, but not be limited to:...Identification of abuse, neglect, mistreatment, and misappropriation of property...How to investigate and report incidents of abuse, neglect, mistreatment, and misappropriation of property..." Under the sub-heading of "Identification," the policy indicated, "...Instruct staff, resident/patient, family, and visitor, to report immediately, with fear of reprisal, any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property. Initiate an <i>Incident/Accident Report</i> immediately upon identification of actual or suspected abuse, neglect, mistreatment, and/or</p>			

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	<p>misappropriation of property..." This document continued with a secondary policy, entitled, "Abuse Prevention Program & Reporting Policy." This document indicated, "...Notify the Shift Supervisor immediately if suspected abuse, neglect, mistreatment or misappropriation of property occurs. Report the incident immediately to the Administrator, and Director of Nursing. Notify the appropriate State agency(s) immediately by fax or telephone after identification of the alleged/suspected incident. Initiate process according to State-specified regulations..."</p> <p>3.1-28(a)</p>			