

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2022
NAME OF PROVIDER OR SUPPLIER GEORGETOWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 MAPLECREST ROAD, FORT WAYNE, , 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00384061. Complaint IN00384061 - Substantiated. State deficiencies related to the allegations are cited at R0064. Survey date: July 7, 2022 Facility number: 013463 Residential Census: 152 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 11, 2022	R 0000			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his	R 0064	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an	07/07/2022	

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FORM APPROVED

OMB NO. 0938-0391

or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.

Based on interview and record review the facility failed to ensure resident property was protected from loss for 5 of 152 residents reviewed. (Resident B, Resident C, Resident E, Resident F, Resident G)

Findings include:

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Resident B's record review began on 7/7/22 at 2:29 PM. Diagnoses included chronic obstructive pulmonary disease, hypertension, anemia, rheumatoid arthritis, protein-calorie malnutrition, colostomy, and atherosclerotic heart disease.

Resident C's record review began on 7/7/22 at 2:39 PM. Diagnoses included hypertension.

Resident E's record review began on 7/7/22 at 2:49 PM. Diagnoses included osteoporosis, arthritis, osteoarthritis, hypertension, and degenerative lumbar stenosis.

Resident F's record review began on 7/7/22 at 2:59 PM. Diagnoses included heart disease, aortic stenosis,

admission on the part of Georgetowne Place as to the accuracy of the surveyors' findings or the conclusions drawn therefrom.

Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

1. C.N.A. 1 was terminated immediately upon learning of the thefts and was fully terminated prior to 7.7.22. The stolen property of Resident B and Resident C were found

arthritis, renal insufficiency, conductive hearing loss, left ear, and diabetes mellitus.

Resident G's record review began on 7/7/22 at 3:10 PM. Diagnoses included acute on chronic congestive heart failure, atrial fibrillation with rapid ventricular response, hypertension, and obstructive sleep apnea.

A review of a document titled, Assisted Living & Memory Care Resident Incident Report, filed on 6/27/22, indicated the date of the incident was unknown. The resident involved was Resident B and the reporting employee was the Executive Director (ED). There were no witnesses. The type of incident was theft. The document indicated Resident B opened her nightstand and found it in disarray. Resident B had a ring box containing two valuable rings, the rings were not in box. Resident B did not know when she saw them last or when she had last opened the nightstand drawer. An attached document indicated, upon investigation, the ED learned on approximately 5/1/22, one of Resident B's caregivers, a friend, had taken the rings to her house to keep them safe while Resident B had outpatient surgery. The friend indicated she returned the rings to the box on an unspecified date.

and returned prior to 7.7.22. Property of residents E and F could not be located. Property of Resident G was not found to be among items taken by C.N.A 1.

2. Community will continue to background check all intended hires per state and company policy. Background check results are reviewed by Business Director and Executive Director before hire and placed in employee file.

3. Community requested bids from security company to place cameras throughout the hallways and parking lot to help insure the security of resident belongings. Bids received 7.11.22. Maintenance Director and Executive Director will follow up on bids for security cameras by 8.31.22.

4. Prior to 7.7.22 and on 7.7.22 notifications were sent out to residents and families of residents alerting them to the thefts which allowed for any other missing items to be identified. No further missing items have been reported. Executive Director is responsible for managing any reports of missing items. Executive Director will counsel residents on securing valuables at lease signing and annually through

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Resident B had hospice caregivers and did not receive services from the community staff.

A police report with the control number 22F067677 was reviewed. The report indicated Resident B's caregivers, niece and friend, were notified on 6/27/22 at 9:30 PM of the theft.

An Indiana State Department of Health Survey Report System Incident Form, indicated the incident was reported to the Indiana State Department of Health (ISDH) on 6/28/22 at 12:10 PM by the ED. The incident date was 6/27/22 at 12:01PM. The Resident involved was Resident B. The staff involved was Certified Nurse Aide (C.N.A.) 1. A description of the incident indicated, on 6/27/22, Resident B reported 2 rings missing from the nightstand in her bedroom. She could not pinpoint an exact date as she had not been in the drawer for 6 to 8 weeks. While looking for an appointment card, Resident B found the contents of the drawer in disarray (disorganized) and the ring box was empty. Immediate action taken indicated family was contacted to ensure they had not taken the rings. The family indicated they did not have the rings. They had put them in the drawer on approximately 5/1/22. The family contacted police who

printed notification.

5. All staff will continue to receive in-servicing and training per state and company guidelines regarding resident abuse and resident rights. Executive Director and Wellness Director are responsible to insure this training is completed upon hire and annually thereafter.

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came to facility & did a report. Preventive measures indicated the family was advised to keep valuables in a floor safe in the room or a safe deposit box outside the community. Follow up added indicated the police returned on 6/28/22 at 10:30 AM, had found Resident B's rings at a coin/jewelry store in Ft Wayne. The rings were sold at the store on 6/23/22 by C.N.A 1. The Detective indicated C.N.A. 1 frequently sold jewelry items to pawn or gold brokers. No other losses were reported by other residents at that time. The ED was trying to determine if other residents were missing jewelry items.

An email, sent by the ED to the Detective on 6/28/22 at 4:35PM, indicated when the ED checked with a Resident D, the resident was rumored to have a missing ring. The resident believed the ring slipped off into the trash. This occurred during the period of time being investigated. The ED spoke with the Director of Housekeeping (DH), to see if the DH knew which residents had valuables. The DH indicated a Housekeeper 2 was told by a clerk at a local pawn shop, C.N.A. 1 sold stuff at the shop all the time.

A document, handwritten by the ED during a conversation with the Detective on 6/29/22, contained a list of items and

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dates sold by C.N.A. 1 to various pawn shops. The dates of sale ranged from 3/30/21 to 6/23/22. The list included a class ring, with initials, tanzanite, sold on 4/12/22, and indicated the ring belonged to Resident C.

An Email from the Detective to the ED, sent on 6/30/22 at 2:28 PM, indicated the class ring was found intact and he forwarded pictures to Resident C's daughter for identification. An Email from the Det to the ED dated 6/30/22 at 5:19 PM, indicated Resident C's daughters identified the class ring as her mother's.

On 7/1/22, an update to the Incident 43 Form indicated, on 6/30/22, the continued investigation found another ring sold at the pawn/jewelry shop by C.N.A.1. The item belonged to Resident C. Staff continued to match identifiable jewelry with residents. Resident C had not reported jewelry missing. On 7/1/22, Resident E and Resident F reported missing approximately \$250 cash. The money went missing between 6/24/22 & 7/1/22, an exact date could not be pinpointed. Staff were unable to complete details due to Resident E & Resident F not being available. Staff would continue search & investigation on 7/5/22. Report indicated the couple did not want police

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called.

On 7/6/22 at 2PM, in a monthly meeting with residents, the ED mentioned the thefts and spoke about securing valuables. At approximately 4:30 PM, Resident G reported 2 rings missing She had kept the rings in a box in her underwear drawer for 10 years, never looked at them, she had no date to determine loss. Resident G provided an appraisal with a description of rings. The information was forwarded to the Detective. On 7/7/22, the Detective emailed photos of rings sold by the C.N.A.1 that could possibly be Resident G's. Resident G indicated none of the rings in the photo were hers.

A review of C.N.A. 1's employee file indicated a background check had been completed. The file contained 2 reference checks, job description, new hire orientation check list, C.N.A orientation check list, Substance Abuse Policy & Acknowledgement, Resident Rights Know Your Rights under Federal Nursing Home Regulations, ACT on Alzheimer's Alzheimer Disease Curriculum Module I-Disease Description: Alternative Version, ACT on Alzheimer's Alzheimer Disease Curriculum Module II-Demographics, Abuse Prevention Policy. Documents were signed by C.N.A 1's and

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dated 3-22-22.

An interview was conducted with the ED on 7/7/22 at 9:38 AM. The ED indicated an incident of misappropriation was reported on Monday, 6/27/22. There was a 6-week window involved. Resident B had not seen her rings since 5/1/22. Resident B saw them, after she had surgery, when a friend brought them back and put them in a nightstand drawer. On 6/25/22, when Resident B looked in the drawer, it was in disarray and the rings were missing. The ED indicated Resident B kept things neat. The ED notified Resident B's caregivers, niece & friend. The ED indicated she contacted the facility's insurance company regarding the incident. On 6/27/22, a police officer spoke with Resident B. Resident B gave photos of the missing rings to the police officer. That officer provided the information & photo to the Detective who does theft investigations. The Detective took the photos & sent them to area pawn shops on 6/27/22. On 6/28/22 at 10:30 AM, the Detective received a call from a Pawn Shop indicating they had the rings. The Detective brought Resident B's rings to the facility on 6/30/22. The rings were returned to Resident B at approximately 1PM by the Detective and the ED. The ED

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indicated she spoke with Resident E and Resident F on 7/1/22. They reported \$250 cash missing, 2 envelopes with "hair & tip money" & cash from a wallet. They used the money last on 6/24/22 at Resident E's hair appointment. Resident E had changed her purse, then hung it on the bathroom door. On Wednesday, 6/29/22, she took her wallet out for a doctor's appointment, needed her insurance card, did not notice if envelopes were there and the envelopes had been loose in her purse. She did not look for the cash in her wallet. On Friday, 7/1/22, Resident E noticed all the cash was missing when she went for hair appointment. The ED indicated C.N.A. 1 worked on 6/24/22. The ED indicated she & the Business Director went to Resident E & Resident F's room to see if they could locate the missing cash as some residents put money in places & forget where they put it. The ED indicated a brief search was made since the residents were present. The ED indicated no money was found. The ED indicated she held monthly meetings with the residents, the last was on 7/6/22 at 2pm. Approximately 40 residents attended, including Resident B. The ED discussed resident council minutes, new happenings within the building, residents were able to ask

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questions. At that meeting, she mentioned that some items had been stolen but recovered, and a staff member had been terminated. Residents were given recommendations on how to keep things safe.

In an interview, on 7/7/22 at 10:20 AM, the Director of Nursing (DON) indicated C.N.A. 1 worked last on 6/24/22. He was scheduled to work 2nd shift on 6/28/22 but she called him & told him not to come in, but did not give an explanation.

In an interview on 7/7/22 at 10:58 AM, Resident B indicated she was leaving for appointment soon, so could not talk long. She indicated she had 2 missing rings, did not know when they had been taken, but had been returned. Resident B indicated she did not want to give details. She had reported the missing rings to the ED, then the police. She had pictures of the jewelry, which the police officer took with them. The rings were found at 10:30 am, the Resident did not remember the day, and the police found out who took them. The Detective returned the rings. Resident B indicated the ED was helpful. The resident indicated she spoke with her family. She indicated it was "wonderful the way it turned out".

On 7/7/22 at 11:24 AM,

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Resident G, indicated she found 2 diamond rings were missing, her diamond & her mother's diamond ring. She received an email from the ED which told of instances happening, warned residents to care for valuables. She looked for her rings, but the box that had contained the rings was empty. Resident G indicated her daughter went with her and they spoke to the staff, around 4PM or shortly after. She was told that the missing items were being investigated. Resident G's daughter told her the rings were stolen. Resident G indicated she did not feel it was the facility's fault. She indicated she had not had anything missing previously. Resident G indicated that she felt the facility was handling situation well. Resident G indicated she could not wear the rings, but she was upset due to the sentimental value of the rings.

In an interview on 7/7/22 at 3:25 PM, with Resident E and Resident F, Resident E spoke, Resident F listened but indicated he agreed with his wife's explanation of events. Resident E indicated that she kept money for her hair appointments & tips in 2 bank envelopes in her purse. She indicated that she had 2 purses she switched back & forth. She indicated that she had her hair done on Fridays. Resident E

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indicated she had 1 wallet that she moved to the purse she would be using. She indicated that she had approximately \$250 in cash in her purse. She indicated she usually kept her purse in the bedroom closet. She indicated that she returned from an appointment last on 6/29/22, she had taken just her wallet with her, then put her wallet in her purse & hung her purse on the bedroom door. She indicated she did not look inside her purse after returning from the appointment until 7/1/22 when she was leaving for her hair appointment, about 9:30 AM. When she looked in her purse to get her money envelopes, she did not find them. She looked in her other purse & did not see the envelopes. Her credit cards & insurance cards were out of place but still in the wallet. No credit cards missing. Resident E indicated she told her husband about the missing money. Resident F gave her money for her hair appointment. Resident E indicated the ED & Business Manager came up to look for the lost money. "Sometimes us older folks don't remember where we put things". She indicated she had not looked in her purse from Wednesday night until Friday morning when she went for her hair appointment. Both Residents indicated that they did not receive any assistance from

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certified nurse aides on staff at the facility. Housekeeping staff came in to clean on Wednesday, but she had her purse with her at that time.

This state citation is related to complaint IN00384061.

Based on interview and record review the facility failed to ensure resident property was protected from loss for 5 of 152 residents reviewed. (Resident B, Resident C, Resident E, Resident F, Resident G)

Findings include:

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Resident B's record review began on 7/7/22 at 2:29 PM. Diagnoses included chronic obstructive pulmonary disease, hypertension, anemia, rheumatoid arthritis, protein-calorie malnutrition, colostomy, and atherosclerotic heart disease.

Resident C's record review began on 7/7/22 at 2:39 PM. Diagnoses included hypertension.

Resident E's record review began on 7/7/22 at 2:49 PM. Diagnoses included osteoporosis, arthritis, osteoarthritis, hypertension, and degenerative lumbar stenosis.

Resident F's record review

began on 7/7/22 at 2:59 PM.
Diagnoses included heart disease, aortic stenosis, arthritis, renal insufficiency, conductive hearing loss, left ear, and diabetes mellitus.

Resident G's record review began on 7/7/22 at 3:10 PM
Diagnoses included acute on chronic congestive heart failure, atrial fibrillation with rapid ventricular response, hypertension, and obstructive sleep apnea.

A review of a document titled, Assisted Living & Memory Care Resident Incident Report, filed on 6/27/22, indicated the date of the incident was unknown. The resident involved was Resident B and the reporting employee was the Executive Director (ED). There were no witnesses. The type of incident was theft. The document indicated Resident B opened her nightstand and found it in disarray. Resident B had a ring box containing two valuable rings, the rings were not in box. Resident B did not know when she saw them last or when she had last opened the nightstand drawer. An attached document indicated, upon investigation, the ED learned on approximately 5/1/22, one of Resident B's caregivers, a friend, had taken the rings to her house to keep them safe while Resident B had outpatient

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surgery. The friend indicated she returned the rings to the box on an unspecified date. Resident B had hospice caregivers and did not receive services from the community staff.

A police report with the control number 22F067677 was reviewed. The report indicated Resident B's caregivers, niece and friend, were notified on 6/27/22 at 9:30 PM of the theft.

An Indiana State Department of Health Survey Report System Incident Form, indicated the incident was reported to the Indiana State Department of Health (ISDH) on 6/28/22 at 12:10 PM by the ED. The incident date was 6/27/22 at 12:01PM. The Resident involved was Resident B. The staff involved was Certified Nurse Aide (C.N.A.) 1. A description of the incident indicated, on 6/27/22, Resident B reported 2 rings missing from the nightstand in her bedroom. She could not pinpoint an exact date as she had not been in the drawer for 6 to 8 weeks. While looking for an appointment card, Resident B found the contents of the drawer in disarray (disorganized) and the ring box was empty. Immediate action taken indicated family was contacted to ensure they had not taken the rings. The family indicated they did not have the

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rings. They had put them in the drawer on approximately 5/1/22. The family contacted police who came to facility & did a report. Preventive measures indicated the family was advised to keep valuables in a floor safe in the room or a safe deposit box outside the community. Follow up added indicated the police returned on 6/28/22 at 10:30 AM, had found Resident B's rings at a coin/jewelry store in Ft Wayne. The rings were sold at the store on 6/23/22 by C.N.A 1. The Detective indicated C.N.A. 1 frequently sold jewelry items to pawn or gold brokers. No other losses were reported by other residents at that time. The ED was trying to determine if other residents were missing jewelry items.

An email, sent by the ED to the Detective on 6/28/22 at 4:35PM, indicated when the ED checked with a Resident D, the resident was rumored to have a missing ring. The resident believed the ring slipped off into the trash. This occurred during the period of time being investigated. The ED spoke with the Director of Housekeeping (DH), to see if the DH knew which residents had valuables. The DH indicated a Housekeeper 2 was told by a clerk at a local pawn shop, C.N.A. 1 sold stuff at the shop all the time.

A document, handwritten by the

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ED during a conversation with the Detective on 6/29/22, contained a list of items and dates sold by C.N.A. 1 to various pawn shops. The dates of sale ranged from 3/30/21 to 6/23/22. The list included a class ring, with initials, tanzanite, sold on 4/12/22, and indicated the ring belonged to Resident C.

An Email from the Detective to the ED, sent on 6/30/22 at 2:28 PM, indicated the class ring was found intact and he forwarded pictures to Resident C's daughter for identification. An Email from the Det to the ED dated 6/30/22 at 5:19 PM, indicated Resident C's daughters identified the class ring as her mother's.

On 7/1/22, an update to the Incident 43 Form indicated, on 6/30/22, the continued investigation found another ring sold at the pawn/jewelry shop by C.N.A.1. The item belonged to Resident C. Staff continued to match identifiable jewelry with residents. Resident C had not reported jewelry missing. On 7/1/22, Resident E and Resident F reported missing approximately \$250 cash. The money went missing between 6/24/22 & 7/1/22, an exact date could not be pinpointed. Staff were unable to complete details due to Resident E & Resident F not being available. Staff would

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continue search & investigation on 7/5/22. Report indicated the couple did not want police called.

On 7/6/22 at 2PM, in a monthly meeting with residents, the ED mentioned the thefts and spoke about securing valuables. At approximately 4:30 PM, Resident G reported 2 rings missing She had kept the rings in a box in her underwear drawer for 10 years, never looked at them, she had no date to determine loss. Resident G provided an appraisal with a description of rings. The information was forwarded to the Detective. On 7/7/22, the Detective emailed photos of rings sold by the C.N.A.1 that could possibly be Resident G's. Resident G indicated none of the rings in the photo were hers.

A review of C.N.A. 1's employee file indicated a background check had been completed. The file contained 2 reference checks, job description, new hire orientation check list, C.N.A orientation check list, Substance Abuse Policy & Acknowledgement, Resident Rights Know Your Rights under Federal Nursing Home Regulations, ACT on Alzheimer's Alzheimer Disease Curriculum Module I-Disease Description: Alternative Version, ACT on Alzheimer's Alzheimer Disease Curriculum Module

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II-Demographics, Abuse Prevention Policy. Documents were signed by C.N.A 1's and dated 3-22-22.

An interview was conducted with the ED on 7/7/22 at 9:38 AM. The ED indicated an incident of misappropriation was reported on Monday, 6/27/22. There was a 6-week window involved. Resident B had not seen her rings since 5/1/22. Resident B saw them, after she had surgery, when a friend brought them back and put them in a nightstand drawer. On 6/25/22, when Resident B looked in the drawer, it was in disarray and the rings were missing. The ED indicated Resident B kept things neat. The ED notified Resident B's caregivers, niece & friend. The ED indicated she contacted the facility's insurance company regarding the incident. On 6/27/22, a police officer spoke with Resident B. Resident B gave photos of the missing rings to the police officer. That officer provided the information & photo to the Detective who does theft investigations. The Detective took the photos & sent them to area pawn shops on 6/27/22. On 6/28/22 at 10:30 AM, the Detective received a call from a Pawn Shop indicating they had the rings. The Detective brought Resident B's rings to the facility on 6/30/22. The rings were

returned to Resident B at approximately 1PM by the Detective and the ED. The ED indicated she spoke with Resident E and Resident F on 7/1/22. They reported \$250 cash missing, 2 envelopes with "hair & tip money" & cash from a wallet. They used the money last on 6/24/22 at Resident E's hair appointment. Resident E had changed her purse, then hung it on the bathroom door. On Wednesday, 6/29/22, she took her wallet out for a doctor's appointment, needed her insurance card, did not notice if envelopes were there and the envelopes had been loose in her purse. She did not look for the cash in her wallet. On Friday, 7/1/22, Resident E noticed all the cash was missing when she went for hair appointment. The ED indicated C.N.A. 1 worked on 6/24/22. The ED indicated she & the Business Director went to Resident E & Resident F's room to see if they could locate the missing cash as some residents put money in places & forget where they put it. The ED indicated a brief search was made since the residents were present. The ED indicated no money was found. The ED indicated she held monthly meetings with the residents, the last was on 7/6/22 at 2pm. Approximately 40 residents attended, including Resident B. The ED discussed resident			
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council minutes, new happenings within the building, residents were able to ask questions. At that meeting, she mentioned that some items had been stolen but recovered, and a staff member had been terminated. Residents were given recommendations on how to keep things safe.

In an interview, on 7/7/22 at 10:20 AM, the Director of Nursing (DON) indicated C.N.A. 1 worked last on 6/24/22. He was scheduled to work 2nd shift on 6/28/22 but she called him & told him not to come in, but did not give an explanation.

In an interview on 7/7/22 at 10:58 AM, Resident B indicated she was leaving for appointment soon, so could not talk long. She indicated she had 2 missing rings, did not know when they had been taken, but had been returned. Resident B indicated she did not want to give details. She had reported the missing rings to the ED, then the police. She had pictures of the jewelry, which the police officer took with them. The rings were found at 10:30 am, the Resident did not remember the day, and the police found out who took them. The Detective returned the rings. Resident B indicated the ED was helpful. The resident indicated she spoke with her family. She indicated it was "wonderful the way it turned

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out".

On 7/7/22 at 11:24 AM, Resident G, indicated she found 2 diamond rings were missing, her diamond & her mother's diamond ring. She received an email from the ED which told of instances happening, warned residents to care for valuables. She looked for her rings, but the box that had contained the rings was empty. Resident G indicated her daughter went with her and they spoke to the staff, around 4PM or shortly after. She was told that the missing items were being investigated. Resident G's daughter told her the rings were stolen. Resident G indicated she did not feel it was the facility's fault. She indicated she had not had anything missing previously. Resident G indicated that she felt the facility was handling situation well. Resident G indicated she could not wear the rings, but she was upset due to the sentimental value of the rings.

In an interview on 7/7/22 at 3:25 PM, with Resident E and Resident F, Resident E spoke, Resident F listened but indicated he agreed with his wife's explanation of events. Resident E indicated that she kept money for her hair appointments & tips in 2 bank envelopes in her purse. She indicated that she had 2 purses

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she switched back & forth. She indicated that she had her hair done on Fridays. Resident E indicated she had 1 wallet that she moved to the purse she would be using. She indicated that she had approximately \$250 in cash in her purse. She indicated she usually kept her purse in the bedroom closet. She indicated that she returned from an appointment last on 6/29/22, she had taken just her wallet with her, then put her wallet in her purse & hung her purse on the bedroom door. She indicated she did not look inside her purse after returning from the appointment until 7/1/22 when she was leaving for her hair appointment, about 9:30 AM. When she looked in her purse to get her money envelopes, she did not find them. She looked in her other purse & did not see the envelopes. Her credit cards & insurance cards were out of place but still in the wallet. No credit cards missing. Resident E indicated she told her husband about the missing money. Resident F gave her money for her hair appointment. Resident E indicated the ED & Business Manager came up to look for the lost money. "Sometimes us older folks don't remember where we put things". She indicated she had not looked in her purse from Wednesday night until Friday morning when she went for her hair

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appointment. Both Residents indicated that they did not receive any assistance from certified nurse aides on staff at the facility. Housekeeping staff came in to clean on Wednesday, but she had her purse with her at that time.

This state citation is related to complaint IN00384061.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE