

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2022	
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 IN00386865 Complaint IN00386865 - Substantiated. State Residential Finding related to the allegations is cited at R0064. Survey date: September 27, 2022 Facility number: 013463 Residential Census: 149 These State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on October 5, 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	R 0064	This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not			09/28/2022	

and theft. The administrator or his 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's property was protected from theft for 1 of 3 residents reviewed. (Resident M)

Findings include:

Review of Resident M's records began on 9/27/2022 at P.M. Diagnoses included, but were not limited to, hypertension, allergic rhinitis, insomnia, GERD (Gastroesophageal Reflux Disease), anxiety and hyperlipidemia.

On 9/27/2022 at 10:16 A.M., the facility provided a list of residents and identified Resident M as alert and interviewable.

On 9/27/2022 at 3:00 P.M., an interview with the receptionist indicated Resident M was out of the facility with family. The resident was not able to be interviewed.

Review of the facility's incident report indicated the Administrator reported the incident date was on 7/29/2022 at 9:01 A.M. and involved Resident M. The description of

constitute an 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.

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the incident indicated Resident M reported missing money, \$60.00 cash and 2 diamond rings. The investigation began and the resident indicated they had last seen the rings and money on Tuesday, 7/26/2022. Resident M indicated they had been in their room continuously, from 7/26/2022 until the evening of Thursday 7/28/2022, when they went to the dining room for dinner (7/28/22). On the morning of Friday, 7/29/2022, the resident went to get their cash for a hair appointment and noticed the money was missing. Resident M's apartment was searched by the Administrator and the Business Office Manager and the items were not found. Resident M's family was notified and wanted to search the apartment themselves. It was confirmed on Sunday, 7/31/2022, in the afternoon the items were missing. Through the investigation the facility determined a new employee, CNA 1, was the likely suspect. Through the investigation interviews, another staff said they witnessed CNA 1 going through another resident's dresser drawers on 7/27/2022. An investigation interview with another resident found CNA 1 looking at things under their bed on the evening of 7/31/2022. CNA 1 was terminated immediately on 8/1/2022. The facility notified Law Enforcement. The facility found,

· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

· How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

· What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;

· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?; and

· By the date the systemic changes will be completed.

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through Law Enforcement Detective 1, it was determined CNA 1 was a frequent seller of jewelry to pawn shops and they were searching his recent sales for the missing rings.

Tag:
R 064

1.
On August 1, 2022, CNA 1 was terminated.

2.
The Community will continue to background check all prospective new hires per state regulations and Company policy. In addition, all background check results are reviewed by Business Director and Executive Director before hire and the results of background checks are placed in employee file.

3.
Notifications were sent to residents and families in July 2022 and August 2022 to alert them to security issue and to provide guidance on securing their belongings while residing in the Community.

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Review of an investigation interview on Friday 7/29/2022 with Resident M indicated on Tuesday 7/26/2022 in the afternoon, they had a family member at their apartment to install a safe. Resident M and the family member seen the money and rings at that time. The items were not put in the safe at that time because the ring boxes were too large to fit in the safe. They were going to get bags to put the items into and put them in the small wall mounted safe. The rings and cash were kept in a middle drawer of a dresser which was angled in the corner of the bedroom. The ring boxes and wallet were stored under clothing in the drawer. They had not left their apartment for meals on 7/26/2022 and 7/27/2022. On 7/28/2022, they left their apartment to go to dinner. On 7/29/2022, they went to get the money to go to the salon and noticed the money and rings were gone. Resident M, described the missing rings as: a gold ring with one center diamond with sapphires and diamonds around it and the other ring had a round diamond on a gold band.

Review of the investigation interview indicated QMA 2 reported on Wednesday, 7/27/2022 between 4:30 P.M. to 5:00 P.M., she was going to an apartment on the 2nd floor with

4. The Executive Director or designee will continue to discuss security with residents and their families at lease signing and, at a minimum, annually thereafter both verbally and in writing. In October 2022 cameras were installed in all resident hallways to assist in deterring theft. In addition, the Executive Director and Wellness Director will be responsible for ensuring staff are in-serviced and trained per state regulations and Company policy on resident abuse and resident rights. Training is to be completed upon hire and annually thereafter.

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a resident. By the elevator, they stopped to introduce themselves to new residents (a married couple) to the facility and indicated they were going to dinner. CNA 1 was standing behind them near the elevator. The couple told them which apartment they lived in. QMA 2 indicated after taking the resident she was with, back to their apartment, she walked by the new couples apartment and noticed the door was ajar. QMA 2 indicated she looked in the new couples apartment and seen CNA 1 closing the bottom drawer on a short dresser and continued over to a tall dresser's top drawer. QMA 2 indicated she overheard CNA 1 speaking to himself, saying, "where is it." QMA 2 had reported the incident to lead, QMA 3, who then reported it to the Director of Nursing (DON).

Review of the investigation interview with another resident indicated one day during the week of 7/25/2022, CNA 1 had knocked softly on her door then entered the room without an invitation to come in. The resident asked CNA 1 why he was there. CNA 1 stated he was new and was just checking in on everyone and then he left the room. The resident indicated they always kept the door locked and a key was required to open the door. The resident further indicated on 7/31/2022

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between 5:30 P.M. and 7:00 P.M., they were sleeping in their chair in the living room and heard a strange noise in the bedroom. The resident indicated they always kept the bedroom door closed. The resident got up to check the bedroom and found CNA 1 in the bedroom, on his hand and knees looking at their stuff stored under the bed. When the resident questioned CNA 1, he said he was "looking for a leak." The resident indicated nothing was missing.

The investigation indicated CNA 1's work schedule was as followed: July 25, 3:00 P.M. to 11:00 P.M., July 26, 3:00 P.M. to 11:00 P.M., July 28, 3:00 P.M. to 11:00 P.M., July 30, 3:00 P.M. to 11:00 P.M. and July 31, 3:00 P.M. to 11:00 P.M.

On 9/27/2022 at 11:00 A.M., an interview with the Administrator indicated the facility had not had any further reports of missing items and no reportable incidents since prior reportable in June 2022, which was cited for misappropriation of property. All hiring procedures were followed and the criminal background checks were completed. Staff and Residents have been educated to watch out for unusual activity and report it to her or staff.

Review of CNA 1's employee records, began on 9/27/2022 at

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11:11 A.M. The employee's criminal background check was completed on 6/28/2022 and indicated the search was complete and clear. References were provided by CNA 1 of prior employers and were checked by the facility on 6/28/2022.

Review of the current facility policy, dated 8/10/18, titled, Abuse Prevention Policy, was provided by the Administrator on 9/27/2022 at 11:16 AM indicated, "...To establish guidelines and procedures for preventing, investigating, reporting and resolving allegations of resident abuse, neglect, involuntary seclusion, corporal punishment and misappropriation of property and to ensure staff are properly trained in effective methods of preventions and observation... Misappropriation of Property-the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent..."

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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
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