STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST WALDRON, IN 46182

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00418875, IN00419976, IN00419986, IN00420158, and IN00417033 . Complaint IN00418875 - Federal/state deficiencies related to the allegations are cited at F0684. Complaint IN00419976 - Federal/state deficiencies related to the allegations are cited at F0602, F0609, F0610, and F0684. Complaint IN00419986 - Federal/state deficiencies related to the allegations are cited at F0602, F0609, and F0610. Complaint IN00420158 - No deficiencies related to the allegations are cited.. Complaint IN00417033 - No deficiencies related to the allegations are cited. Survey dates: October 23 and 24, 2023 Facility number: 00432 Provider number: 155704 AIM number: 100290450 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 9 Medicaid: 35 Other: 9 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2023	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Clapp	ED	11/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident's money was secure and accounted for while it was being stored by a staff person for 1 of 3 residents reviewed for misappropriation of a resident's property. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/23/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, Parkinson's Disease. The 7/29/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident C was cognitively intact. A reportable incident to the Indiana Department of Health on 10/20/23 indicated an incident had occurred on 10/16/23 of an allegation of misappropriation of funds. The immediate action that was taken was the MDS Coordinator was suspended, police were notified and an investigation was started. A follow up of the investigation dated 10/20/23 indicated "The facility DON [Director of Nursing] received an email from [Resident C's Power of Attorney] alleging that [MDS Coordinator] took [Resident C]	F 0602	F602 D Free from Misappropriation/Exploitation The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1 Immediate actions taken for those residents identified: Resident C allegation of 10/16/23 was investigated and reported to IDOH and local law enforcement agency. Resident C was kept abridged of ongoing investigation as well as their responsible party and primary care physician. Employee identified as responsible for the facility misappropriation was investigated by facility and local law	11/07/2023

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	out on LOA (leave of absence) August 18, 2023. [Resident C's POA] indicated [MDS Coordinator] took [Resident C] to the bank withdraw $ 9,975.00 dollars. DON provided a copy of the email immediately to ED (Executive Director) office and informed [MDS Coordinator] there was an allegation of misappropriation of funds and that the facility would be placing her on administrative leave. [MDS Coordinator] agreed that she had taken the resident out on 8/18/23 and had assisted the resident to make a withdraw of $9,975.00 dollars from the bank. [MDS Coordinator] advised the ED that she had the resident's money in her office and was asked by [Resident C] to hold the money for safe keeping. [MDS Coordinator] stated that [Resident C's POA] was also aware that she had taken him out on a pass and was keeping the money in her office. [Resident C]'s money was retrieved from [MDS Coordinator]'s office and counted. There was only $6,404.00. ED inquired what happened to the remainder of the money and [MDS Coordinator] said she purchased cigarettes and liquor for [Resident C]. and [Resident C] had given $100.00 dollars to a friend. [Police Officer 4] arrived at the facility and talked with us briefly before [MDS Coordinator] was asked to leave the facility. The officer and I went back to [Resident C]'s room. [Resident C] was upset and wanted [MDS Coordinator] in the room and then he would agree to talk to us. ED explained from the start what was going on and why it was important that he needed to talk to the officer and why [MDS Coordinator] was not permitted in his room/facility. [Resident C] confirmed the amount of withdraw, and that he had asked [MDS Coordinator] to keep his money. ED asked how much and/or what [MDS Coordinator] bought with his money. [Resident C] stated the following: liquor, cigs (cigarettes), and gave a $100 [$100.00] to a friend. [Resident C]		enforcement agency. Employee was released from employment with facility and local law enforcement continues to investigate allegation. 2 How the facility identified other residents: No other resident identified to have been affected related to facility misappropriation. Audit was conducted of facility residents to determine if any further allegations were outstanding. If any allegations are noted, facility will report and investigate per regulation. 3 Measures put into place/System changes: Facility staff educated on components of F602 Misappropriation/Exploitation. Education provided to staff to notify ED immediately of any allegation of abuse. Education provided to staff that staff may not accept any form of a gift from a resident. Education provided to facility staff on completion of investigation for any allegation and documentation requirements. 4 How the corrective actions will be monitored: The responsible party for this plan of correction is the Executive Director and the Director of Nursing who will interview three residents and three staff weekly related to abuse. Identified areas of concern will be immediately reported and investigated per guidelines and additional education provided as	

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	advised ED and officer that he believed he spent approximately $400.00 of the $9,975.00 and that [MDS Coordinator] was in possession of the resident's money. When [Resident C] was advised that more than $400.00 was missing, he inquired about receipts and at that time the officer advised [Resident C] that [MDS Coordinator] stated she did not keep any receipts. [Resident C] was asked what he would like to do with the remaining money and offered an account at the facility to which he declined. [Resident C] also did not wish to deposit the remaining amount of money back into the bank and expressed he did not wish to send the money to his [POA]. [Resident C] asked that his money be kept in a lock box and placed in a safe which was done..." The investigation involving Resident C and the MDS Coordinator regarding the allegation of misappropriation of funds was provided by the ED on 10/23/23 at 12:00 p.m. The file included the following: Copies of text messages exchanged between the MDS Coordinator and Resident C's POA dated 8/19/23 provided by the MDS Coordinator on her cell phone to the ED. A text message was sent by the MDS Coordinator notifying Resident C's POA; the resident and herself were out of the facility and running errands. The resident had requested the MDS Coordinator notify his POA of a withdraw of $ 9,975.00. The resident's POA inquired via phone text, the safety of the money being stored in the facility. The MDS Coordinator offered to lock the money in her desk drawer and/or provide a safe. The messages continued with the POA wanting the funds returned back to the resident's bank account on Monday. She thanked the MDS Coordinator for agreeing to return the resident back to the bank on Monday		required. All staff will be educated on abuse upon hire, annually and as needed. Abuse audits and investigation process will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. Audits will continue for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of Correction: 11/7/2023	

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	to deposit the funds back into his bank account. An email sent by Resident C's POA to the DON dated 10/16/23 indicated, the MDS Coordinator had taken Resident C on an outing. She had taken the resident to his bank and removed $ 9,975.00 in cash from his banking account. The MDS Coordinator had stated to her she would store the money in a desk drawer or get him a safe. Resident C's POA had requested the MDS Coordinator take him back to the bank and deposit his money back in his account on Monday. She did not feel comfortable with the money being placed in a safe or locked in a desk drawer. The money as of that day had not been returned to his banking account nor a safe purchased. She was asking for copies of ledgers and/or receipts to be provided for her review. A statement by the DON indicated on 10/16/23, she had received an email from Resident C's POA that the MDS Coordinator had taken Resident C to the bank and had withdrew $9,975.00 from his bank account. She had forwarded the email to the ED. During an interview, MDS Coordinator had stated she did assist Resident C to the bank in August, and he did withdrew money from his banking account. The resident's POA was aware. The MDS Coordinator then forwarded text messages exchanges from her cell phone between her and Resident C's POA about the withdraw. The text messages did indicated the resident's POA did want the money to be returned to his banking account. The MDS Coordinator had stated the resident refused to return the money back to his banking account, but she did have his money locked in her office. The MDS Coordinator then provided the resident's money that was stored in a box, and then she left the facility. At that time, the ED counted the resident's money			

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	that was in the box. There was a total amount of $6,404.00. The resident's POA was notified at that time. A statement by the ED indicated she had informed the MDS Coordinator she had an allegation of misappropriation of funds, and she would have to leave the facility. The MDS Coordinator did indicate at that time she did have Resident C's money, and the resident's POA was aware. She then provided the money and text messages exchanged between herself and the resident's POA. The money that was provided was counted, and the total amount was $6,404.00. The resident was interviewed and informed of the amount remaining. During the interview with Resident C; he confirmed the amount withdrew from his banking account, and the MDS Coordinator did have his money. He indicated the MDS Coordinator had bought him using his money liquor and cigarettes. He also had given a $100.00 to a friend. He had spent "at the most $ 400.00" from the $9,975.00. At that time, the resident requested the ED to provide receipts the MDS Coordinator would have had from the purchases that she made with his money. Police Officer 4 was present during the interview, informed Resident C that the MDS Coordinator had indicated she did not have any receipts for purchases that were made with his money. The resident had asked about where the remaining amount of money was located at that time. The ED indicated to the resident it was stored in a lock box in the facility's safe. The resident indicated he did not want the money returned back in the bank nor given to his POA. After, The MDS Coordinator's office was observed with a bottle of Jim Beam and cigarettes with Resident C's name on it in her office. A second statement by the ED indicated that she			

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	had attempted to obtain a statement by the MDS Coordinator. The MDS Coordinator did indicate the resident's money was stored in her car when she moved offices. She had already told the police officer what she had purchased for the resident using his money. The resident did not want receipts for the purchases. At that time, the MDS Coordinator indicated she would not answer anymore questions. A statement by Human Resources dated 10/16/23 indicated she was asked to sit in with the ED, DON and a police officer while they called MDS Coordinator into the office to question her about an email received by Resident C's POA alleging a withdraw that had been made by Resident C with the assistance of the MDS Coordinator from Resident C's bank account of $ 9,975.00 on August 18th. During the interview, the MDS Coordinator had confirmed she had taken the resident to the bank and withdrew that amount. She also confirmed she was asked by the resident to hold onto the money. The MDS Coordinator then retrieved the money from her office. She stated at that time, the resident had requested for a couple hundred dollars from the funds, and there was approximately $ 6,000.00 left. The money was counted, and the total amount was $6,404.00. An interview was conducted with Resident C's Power of Attorney (POA) on 10/23/23 at 3:06 p.m. She indicated she had been notified via phone text by the MDS Coordinator in August, she had taken Resident C to run some errands that day. During the outing, they went to his bank, and the resident withdrew from his banking account $9,975.00. The MDS Coordinator had indicated via text she could store the money in a locked desk drawer or go buy a safe to ensure the money was safe. During the phone texting exchange, the			

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	resident and the MDS Coordinator was at a restaurant. Resident C's POA had indicated at that time, she had called them and had continued the conversation verbally about the money. She was uncertain the money would be safe stored in the facility. She had requested at that time with the agreement by the MDS Coordinator the money would be returned back to the bank and deposited back in Resident C's banking account on Monday. Resident C's POA was grateful the MDS Coordinator had taken Resident C out on an outing at the time, but was not comfortable with the money he withdrew from his bank account being kept in the facility. She was unaware until that day the resident had planned to remove money from his banking account. The money was never returned on that Monday as requested nor given a reason why. She had spoken to the resident on several occasions via phone questioning why the money had not been placed back in his banking account. In October, she had then reached out via email to the DON requesting his money to be returned back to his account. She then was notified that day the resident did not have the entire amount that had been withdrawn. The facility was unable to provide a ledger or receipts to account for $ 3,571.00 that was missing from the funds. An interview was conducted with Resident C and his POA on 10/23/23 at 4:28 p.m. He indicated he had asked the MDS Coordinator if she would take him the bank. He wanted the money to be removed from the account. The resident and the MDS Coordinator agreed upon a day she was available to do so. The resident and the MDS Coordinator did go to the bank and withdrew $ 9,975.00 from his account. During the outing that day, he purchased liquor at a liquor store, a carton of cigarettes at a tobacco shop and then went to a			

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	bar grill restaurant. He was thankful for the MDS Coordinator for taking the time out of her day to take him. He paid for her meal and drinks they had at the restaurant. That was the only time he had left the facility with the MDS Coordinator. He considered the MDS Coordinator as a friend, and he trusted her. He can recall taking from the funds $ 50.00 that day of the outing and 103.00 a couple of weeks after the outing. The MDS Coordinator had indicated she had a drawer in her office that locked to store his money. He was unaware of the amount of his funds until the police officer, and the ED came to speak with him about it. The facility staff were not available to take him back to the bank to return the money in his account. During the interview, the resident indicated he would like for his money to be returned back to his bank account at the bank, and the money wired to his POA. The MDS Coordinator was unable to be reached for a statement. An interview was conducted with the ED and DON on 10/24/23 at 10:19 a.m. The ED and the DON indicated they were not aware of Resident C's withdraw of $ 9,975.00 from his bank account with the MDS Coordinator in August until the DON received the email from Resident C's POA on 10/16/23. They were not aware the MDS had stored the money for the resident. That was not appropriate. She should not have taken the resident to the bank. The MDS Coordinator should have notified the ED of the bank visit, and she had the resident's funds in her possession. The facility does not manage a resident's funds unless the resident has chosen to open a personal funds account with the facility. The staff are not to store resident's money. During the investigation, the money was counted after it was			

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	provided by the MDS Coordinator. The remaining amount of the $ 9,975.00 was $ 6,404.00. The MDS Coordinator confirmed she had taken the resident and did store his money. She had stated the resident refused to return the money to the bank on that Monday as requested by the POA. Resident C would not reveal the friend he had given the $100.00 to, but he ensured the ED it was not a staff person. During the investigation, the resident had indicated he did not want to open a personal funds account with the facility, return the money to his bank account or give the money to his POA. Currently, the money was stored in the facility's safe. An interview was conducted with Police Officer 4 on 10/24/23 at 11:48 a.m. He indicated during an interview with the MDS Coordinator she indicated she was the owner of the bar grill restaurant in which Resident C and herself had visited on their outing in August. The resident paid for only his drinks not her meal. She indicated she did not keep ledgers or receipts to track the money. A residents funds policy was provided by the ED on 10/24/23 at 1:21 p.m. The policy indicated "...Each one of the facility's residents has the right to manage his or her financial affairs. This includes the right to know, in advance, what charges the facility may impose against a resident's personal funds. The facility does not require residents to deposit their personal funds with the facility. If the resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility shall act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility...8. Inquiries concerning the facility's management of resident funds are referred to the			

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	administrator or to the business office..." An abuse policy was provided by the ED on 10/23/23 at 11:58 a.m. It indicated "...Policy: It is the policy of this facility to report and submit abuse and incidents to the Indiana State Department of Health in compliance with federal regulations and/or state rules and this policy as applicable...Misappropriation of resident property: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent..." This citation relates to Complaints IN00419976 and IN00419986. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey			

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	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to timely report an allegation of misappropriation to the IDOH (Indiana Department of Health) per policy for 1 of 4 residents reviewed for misappropriation. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/24/23 at 10:02 a.m. His diagnoses included, but were not limited to, end stage renal disease, heart failure, and serous retinal detachment. The 7/26/23 Quarterly MDS (Minimum Data Set) assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact. An interview was conducted with Resident E on 10/24/23 at 10:40 a.m. He indicated prior to going to the hospital on 10/13/23, about $500, probably more, went missing from his wallet. He could tell it was $500 by the thickness of his wallet, as he couldn't see well, due to having degenerative eye disease. CNA 9 took it, and he knew it was her. He went outside to smoke, and when he came back to	F 0609	F609 D Reporting of Alleged Violations The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1 Immediate actions taken for the resident identified: a Resident E identified continues to reside at the facility b Identified areas of concern related to 10/11/23 event was reported. c Facility education provided on reporting requirements. 2 How the facility identified other residents:	11/07/2023

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	155704	A. BUILDING 00 B. WING	10/24/2023

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	his room, his door wasn't shut all the way. He sat down on his bed and saw CNA 9 come "out the other side of the bathroom." He informed the Medical Records/Scheduler that same day. The Medical Records/Scheduler took him into the DON's (Director of Nursing's) office and "I told her too." No one came to talk to him about this until last week. "The sheriff came and all that." He briefly told the sheriff and "that was it." CNA 9 was currently off work. The facility brought him a lock box a few days later, that he was going to start using. He and CNA 9 were supposed to go out to eat that same week and he was going to buy her dinner for taking him to the restaurant, because he wanted a steak dinner. They didn't end up going until the following day, but he was thinking about how CNA 9 stole his money the whole time. He stated, "I didn't think she'd do this to me, kind of caught me off guard....It was a pretty miserable dinner to tell you the truth." An interview was conducted with the Medical Records/Scheduler on 10/24/23 at 10:57 a.m. She indicated on 10/12/23, Resident E told her he had about $500 missing, so she and Receptionist 5 told the DON about it. Both she and Receptionist 5 got permission from the DON to go into Resident E's room to look around for the money. They saw his wallet and there was $241 inside, mostly $10, $5, and $1 bills, with a $20 bill being the highest bill inside the wallet. Receptionist 5 tried clarifying with Resident E how much money he had, but Resident E didn't know, and just informed he knew he had a lot missing. She thinks the money went missing on 10/11/23, but Resident E didn't realize it until 10/12/23. An interview was conducted with Receptionist 5 on 10/24/23 at 11:25 a.m. She indicated Resident E recognized her by voice. He was down the hall a		a An audit was conducted of interview able residents and grievances were reviewed over the past 60 days along with 24-hour clinical reviews to identify any other areas of concern that may have met reporting requirements. No other resident was affected. 3 Measures put into place/System changes: a Education was provided on Policy and Procedure related to reporting requirements. b The Executive Director and Director of Nursing will be notified of any reportable event, assistance with reporting will be provided as required. c Events will be reported per reporting guidelines. d Review of the 24-hour report during scheduled IDT meetings to identify reportable events. e Issues identified will be immediately addressed with additional education and or disciplinary action. 4 How the corrective actions will be monitored: a The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee. b Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review 24-hour report to determine if anything had occurred that may meet the reporting requirements.	

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	bit and called her by name and said, "Someone came in his room and stole money." He was excited and said it was there the previous day, but it was gone now. Receptionist 5 suggested he go with her to the DON's office to inform her. Resident E informed the DON that he had $500 missing. Receptionist 5 suggested they look for the money in his room. On their way to his room, they ran into the Medical Records/Scheduler, so they both went to look for the money in his room. The looked in a cabinet and a drawer in his nightstand. They found his wallet under his pillow, but he was still missing some money from it. They also searched through his linens. At the time, Resident E didn't accuse anyone specifically, "but was adamant someone took it." The 10/18/23 incident report, reported by the ED (Executive Director,) for Resident E indicated Resident E was missing funds which he believed were taken from him. A preventive measure was that he was offered an account with the business office, but declined. He was also offered a lock box and stated he would like one. The facility was going to work on obtaining one for him. An interview was conducted with the DON on 10/24/23 at 11:30 a.m. She indicated Receptionist 5 brought Resident E into her office on 10/12/23, when he informed he was missing $500 that he'd had for 6 months. He last saw it in his billfold the day before. He couldn't say what specific bills he had, because he went by the feel of the money. Resident E, Receptionist 5, and the Medical Records/Scheduler all went back to his room to look for it. The ED (Executive Director) was on vacation at the time. The DON indicated she was responsible for reporting the allegation/incident to the IDOH, but it was not reported timely.		c Facility staff will immediately notify Executive Director should an event occur that requires reporting. d Identified areas of concern will be reported per guidelines and additional education provided as required. e Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. f Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. 5 Date of Correction: 11/7/2023	

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	An interview was conducted with the ED on 10/24/23 at 11:49 a.m. She indicated she was on vacation the week Resident E first reported his money missing. She ended up reporting the allegation on 10/18/23, because his story changed. It was her understanding Resident E reported the money missing while she was on vacation, but didn't accuse anyone of taking it. The Abuse and Incident Reporting to IDOH policy was provided by the SSD (Social Services Director) on 10/23/23 at 11:58 a.m. It read, "It is the policy of this facility to report and submit abuse and incidents to the Indiana State Department of Health in compliance with federal regulations and/or state rules and this policy as applicable. Time frames for reporting: IMMEDIATELY, but not later than 2 hours-suspicion of a crime with serious bodily injury OR allegation of abuse. WITHIN 24 HOURS: does not involve abuse and does not result in serious bodily injury. Procedure: The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with state and federal regulations....Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." This citation relates to Complaint IN00419986 and IN00419976. 3.1-28(c)			
F 0610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation			

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a thorough investigation was conducted for 1 of 3 residents reviewed for misappropriation of a resident's property. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/23/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, Parkinson's Disease. The 7/29/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident C was cognitively intact. A reportable incident to the Indiana Department of Health on 10/20/23 indicated an incident had occurred on 10/16/23 of an allegation of misappropriation of funds. The immediate action	F 0610	F-610 D Investigate/Prevent/Correct Alleged Violation The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1 Immediate actions taken for those residents identified: Resident C allegation was investigated and reported to IDOH	11/07/2023

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	that was taken was the MDS Coordinator was suspended, police were notified and an investigation was started. A follow up of the investigation dated 10/20/23 indicated "The facility DON [Director of Nursing] received an email from [Resident C's Power of Attorney] alleging that [MDS Coordinator] took [Resident C] out on LOA (leave of absence) August 18, 2023. [Resident C's POA] indicated [MDS Coordinator] took [Resident C] to the bank withdraw $ 9,975.00 dollars. DON provided a copy of the email immediately to ED (Executive Director) office and informed [MDS Coordinator] there was an allegation of misappropriation of funds and that the facility would be placing her on administrative leave. [MDS Coordinator] agreed that she had taken the resident out on 8/18/23 and had assisted the resident to make a withdraw of $9,975.00 dollars from the bank. [MDS Coordinator] advised the ED that she had the resident's money in her office and was asked by [Resident C] to hold the money for safe keeping. [MDS Coordinator] stated that [Resident C's POA] was also aware that she had taken him out on a pass and was keeping the money in her office. [Resident C]'s money was retrieved from [MDS Coordinator]'s office and counted. There was only $6,404.00. ED inquired what happened to the remainder of the money and [MDS Coordinator] said she purchased cigarettes and liquor for [Resident C]. and [Resident C] had given $100.00 dollars to a friend. [Police Officer 4] arrived at the facility and talked with us briefly before [MDS Coordinator] was asked to leave the facility. The officer and I went back to [Resident C]'s room. [Resident C] was upset and wanted [MDS Coordinator] in the room and then he would agree to talk to us. ED explained from the start what was going on and why it was important that he needed to talk to the officer and why [MDS Coordinator] was not		related to 10/16/2023 event. Resident C was interviewed per ED, DON, SSD, and local law enforcement officer. Resident C was seen by Psych NP and has no ongoing psychosocial issues noted. Care plan reviewed and updated as required. Allegations will be investigated and reported immediately to IDOH per requirements. 2 How the facility identified other residents: No other resident identified to have been affected. A facility audit was conducted of interview able residents to determine if any further allegations were outstanding. If any allegations are noted, facility will report and investigate per regulation. 3 Measures put into place/System changes: Facility staff educated on components for F610 Investigate/Prevent/Correct Alleged Violation. Investigation forms reviewed with Executive Director and Director of Nursing. Staff educated on completion of grievance forms. Education provided to facility staff on completion of investigation for any allegation and documentation requirements. 4 How the corrective actions will be monitored: The responsible party for this plan of correction is the Executive Director and the Director of Nursing who will interview three residents and three	

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	permitted in his room/facility. [Resident C] confirmed the amount of withdraw, and that he had asked [MDS Coordinator] to keep his money. ED asked how much and/or what [MDS Coordinator] bought with his money. [Resident C] stated the following: liquor, cigs (cigarettes), and gave a $100 [$100.00] to a friend. [Resident C] advised ED and officer that he believed he spent approximately $400.00 of the $9,975.00 and that [MDS Coordinator] was in possession of the resident's money. When [Resident C] was advised that more than $400.00 was missing, he inquired about receipts and at that time the officer advised [Resident C] that [MDS Coordinator] stated she did not keep any receipts. [Resident C] was asked what he would like to do with the remaining money and offered an account at the facility to which he declined. [Resident C] also did not wish to deposit the remaining amount of money back into the bank and expressed he did not wish to send the money to his [POA]. [Resident C] asked that his money be kept in a lock box and placed in a safe which was done..." The investigation involving Resident C and the MDS Coordinator regarding the allegation of misappropriation of funds was provided by the ED on 10/23/23 at 12:00 p.m. The file included the following: Copies of text messages exchanged between the MDS Coordinator and Resident C's POA dated 8/19/23 provided by the MDS Coordinator on her cell phone to the ED. A text message was sent by the MDS Coordinator notifying Resident C's POA; the resident and herself were out of the facility and running errands. The resident had requested the MDS Coordinator notify his POA of a withdraw of $ 9,975.00. The resident's POA inquired via phone text, the safety of the money		staff weekly related to abuse. Identified areas of concern will be immediately reported and investigated per guidelines and additional education provided as required. All staff will be educated on abuse upon hire, annually and as needed. Abuse audits and investigation process will be reviewed during scheduled morning IDT meetings or until 100% compliance is achieved for three consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of Correction: 11/7/2023	

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	being stored in the facility. The MDS Coordinator offered to lock the money in her desk drawer and/or provide a safe. The messages continued with the POA wanting the funds returned back to the resident's bank account on Monday. She thanked the MDS Coordinator for agreeing to return the resident back to the bank on Monday to deposit the funds back into his bank account. An email sent by Resident C's POA to the DON dated 10/16/23 indicated, the MDS Coordinator had taken Resident C on an outing. She had taken the resident to his bank and removed $ 9,975.00 in cash from his banking account. The MDS Coordinator had stated to her she would store the money in a desk drawer or get him a safe. Resident C's POA had requested the MDS Coordinator take him back to the bank and deposit his money back in his account on Monday. She did not feel comfortable with the money being placed in a safe or locked in a desk drawer. The money as of that day had not been returned to his banking account nor a safe purchased. She was asking for copies of ledgers and/or receipts to be provided for her review. A statement by the DON indicated on 10/16/23, she had received an email from Resident C's POA that the MDS Coordinator had taken Resident C to the bank and had withdrew $9,975.00 from his bank account. She had forwarded the email to the ED. During an interview, MDS Coordinator had stated she did assist Resident C to the bank in August, and he did withdrew money from his banking account. The resident's POA was aware. The MDS Coordinator then forwarded text messages exchanges from her cell phone between her and Resident C's POA about the withdraw. The text messages did indicated the resident's POA did want the money to be returned to his			

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	banking account. The MDS Coordinator had stated the resident refused to return the money back to his banking account, but she did have his money locked in her office. The MDS Coordinator then provided the resident's money that was stored in a box, and then she left the facility. At that time, the ED counted the resident's money that was in the box. There was a total amount of $6,404.00. The resident's POA was notified at that time. A statement by the ED indicated she had informed the MDS Coordinator she had an allegation of misappropriation of funds, and she would have to leave the facility. The MDS Coordinator did indicate at that time she did have Resident C's money, and the resident's POA was aware. She then provided the money and text messages exchanged between herself and the resident's POA. The money that was provided was counted, and the total amount was $6,404.00. The resident was interviewed and informed of the amount remaining. During the interview with Resident C; he confirmed the amount withdrew from his banking account, and the MDS Coordinator did have his money. He indicated the MDS Coordinator had bought him using his money liquor and cigarettes. He also had given a $100.00 to a friend. He had spent "at the most $ 400.00" from the $9,975.00. At that time, the resident requested the ED to provide receipts the MDS Coordinator would have had from the purchases that she made with his money. Police Officer 4 was present during the interview, informed Resident C that the MDS Coordinator had indicated she did not have any receipts for purchases that were made with his money. The resident had asked about where the remaining amount of money was located at that time. The ED indicated to the resident it was stored in a lock box in the facility's			

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	safe. The resident indicated he did not want the money returned back in the bank nor given to his POA. After, The MDS Coordinator's office was observed with a bottle of Jim Beam and cigarettes with Resident C's name on it in her office. A second statement by the ED indicated that she had attempted to obtain a statement by the MDS Coordinator. The MDS Coordinator did indicate the resident's money was stored in her car when she moved offices. She had already told the police officer what she had purchased for the resident using his money. The resident did not want receipts for the purchases. At that time, the MDS Coordinator indicated she would not answer anymore questions. A statement by Human Resources dated 10/16/23 indicated she was asked to sit in with the ED, DON and a police officer while they called MDS Coordinator into the office to question her about an email received by Resident C's POA alleging a withdraw that had been made by Resident C with the assistance of the MDS Coordinator from Resident C's bank account of $ 9,975.00 on August 18th. During the interview, the MDS Coordinator had confirm she had taken the resident to the bank and withdrew that amount. She also confirmed she was asked by the resident to hold onto the money. The MDS Coordinator then retrieved the money from her office. She stated at that time, the resident had requested for a couple hundred dollars from the funds, and there was approximately $ 6,000.00 left. The money was counted, and the total amount was $6,404.00. A bank statement from Resident C's bank account that included the amount withdraw of $9,975.00. Interviewable residents' statements that included			

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	the following questions that were asked to those residents during the investigation: "1. Do you have any cash in your room?, 2. Do you have any concerns with it in your room?, and 3. Would you like a lockbox?" The investigation did not include the interviewable residents were asked if they had been assisted by staff to the bank nor if a staff person held their funds. An interview was conducted with Resident C's Power of Attorney (POA) on 10/23/23 at 3:06 p.m. She indicated she had been notified via phone text by the MDS Coordinator in August, she had taken Resident C to run some errands that day. During the outing, they went to his bank, and the resident withdrew from his banking account $9,975.00. The MDS Coordinator had indicated via text she could store the money in a locked desk drawer or go buy a safe to ensure the money was safe. During the phone texting exchange, the resident and the MDS Coordinator was at a restaurant. Resident C's POA had indicated at that time, she had called them and had continued the conversation verbally about the money. She was uncertain the money would be safe stored in the facility. She had requested at that time with the agreement by the MDS Coordinator the money would be returned back to the bank and deposited back in Resident C's banking account on Monday. Resident C's POA was grateful the MDS Coordinator had taken Resident C out on an outing at the time, but was not comfortable with the money he withdrew from his bank account being kept in the facility. She was unaware until that day the resident had planned to remove money from his banking account. The money was never returned on that Monday as requested nor given a reason why. She had spoken to the			

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	resident on several occasions via phone questioning why the money had not been placed back in his banking account. In October, she had then reached out via email to the DON requesting his money to be returned back to his account. She then was notified that day the resident did not have the entire amount that had been withdrawn. The facility was unable to provide a ledger or receipts to account for $ 3,571.00 that was missing from the funds. An interview was conducted with Resident C and his POA on 10/23/23 at 4:28 p.m. He indicated he had asked the MDS Coordinator if she would take him the bank. He wanted the money to be removed from the account. The resident and the MDS Coordinator agreed upon a day she was available to do so. The resident and the MDS Coordinator did go to the bank and withdrew $ 9,975.00 from his account. During the outing that day, he purchased liquor at a liquor store, a carton of cigarettes at a tobacco shop and then went to a bar grill restaurant. He was thankful for the MDS Coordinator for taking the time out of her day to take him. He paid for her meal and drinks they had at the restaurant. That was the only time he had left the facility with the MDS Coordinator. He considered the MDS Coordinator as a friend, and he trusted her. He can recall taking from the funds $ 50.00 that day of the outing and 103.00 a couple of weeks after the outing. The MDS Coordinator had indicated she had a drawer in her office that locked to store his money. He was unaware of the amount of his funds until the police officer, and the ED came to speak with him about it. The facility staff were not available to take him back to the bank to return the money in his account. During the interview, the resident indicated he would like for his money to be returned back to his bank account at the bank, and the money			

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	155704	A. BUILDING 00 B. WING	10/24/2023

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	wired to his POA. During an interview with the ED and the DON on 10/24/23 at 10:19 a.m., they indicated other interviewable residents in the facility were interviewed during the investigations, but they did not ask the residents any additional questions that included if staff had taken them on bank visits nor if any staff were holding any of their funds. An abuse policy was provided by the ED on 10/23/23 at 11:58 a.m. It indicated "...Policy: It is the policy of this facility to report and submit abuse and incidents to the Indiana State Department of Health in compliance with federal regulations and/or state rules and this policy as applicable...Procedure: The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with state and federal regulations...A full investigation will be conducted to accurately determine the root cause(s) of the incident. The facility will prevent further potential abuse while the investigation is in progress..." This citation relates to Complaints IN00419976 and IN00419986. 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to timely obtain a urinalysis as ordered and to ensure post fall occurrence follow-up assessments were completed at least once per shift for 72 hours following a fall for 2 of 3 residents reviewed for falls. (Resident C and F) Findings include: 1. The clinical record for Resident C was reviewed on 10/23/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, Parkinson's Disease. The 7/29/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident C was cognitively intact. A care plan for the resident's refusals of care dated 6/8/23 indicated the staff was to reapproach the resident at a later time if he refuses. A physician order for Resident C dated 10/18/23 indicated the staff was to obtain a urine culture. A nursing progress note dated 10/19/23 indicated the resident refused to obtain a urine culture. He indicated the urine culture should have been collected at night. The resident's medical chart did not include documentation the staff reattempt later in the day as per the resident requested.	F 0684	F684 Quality of Care The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1 Immediate actions taken for those residents identified: a Resident C assessed, orders reviewed, resident C re-approached to obtain UA, resident C chose to refuse. Resident C assessed and showing no signs or symptoms of a urinary infection. NP notified and new received to DC UA request order. Care plan reviewed. b Resident F assessed, orders reviewed, care plan reviewed. Resident F has no signs or symptoms of any negative outcomes. 2 How the facility identified other residents: a Any residents residing in the	11/07/2023

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	An interview was conducted with Resident C's Power of Attorney (POA) on 10/23/23 at 3:06 p.m. She indicated she had discussed with the Director of Nursing (DON) about Resident C's falls. She had request a urinalysis to be conducted to rule out a urinary tract infection. The urine culture still had not been obtained. During an interview with the DON on 10/24/23 at 10:19 a.m., She indicated the urine culture had been attempted to be collected, but the resident refused. The resident likes to sleep late, so she believes he would allow to collect his urine if it was attempted later in the afternoon when he was up. The DON indicated staff should have reattempted to obtain the urine culture. She had planned to reattempt that day. 2. The clinical record for Resident F was reviewed on 10/24/23 at 9:09 a.m. Resident F's diagnoses included, but not limited to, congestive heart failure, type II diabetes, and cerebral infarctions (strokes affecting both right and left sides). An Initial Occurrence Note dated 9/29/23 at 2 p.m. indicated, Resident F had a witnessed fall in her bathroom. The 72 hour occurrence follow-up assessments for the 9/29/23 fall were completed on 10/1/23 at 8:14 a.m. and 10/2/23 at 8:21 a.m. An Initial Occurrence Note dated 10/19/23 at 8:55 a.m. indicated Resident F had an unwitnessed fall. She was found on the floor next to her bed. The 72 hour occurrence follow-up assessments for the 9/29/23 fall were completed on: 10/20/23 at 4:20 a.m. 10/20/23 at 11:26 p.m. 10/23/23 at 4:04 p.m.		facility had the potential to be affected. b Audit completed of any residents who had a fall in the past 30 days to ensure 72 hour follow up charting was completed. Any identified issues were immediately addressed. c Audit was completed for any resident that may have refused a lab order, any resident identified was re-approached. NP and resident representatives made aware of any refusals. Care plan reviewed. Any identified issues were immediately addressed. 3 Measures put into place/System changes: a Nursing staff will be educated on the components of F684 Quality of Care, Fall Risk policy, ensuring residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. b Any resident requiring laboratory testing or ongoing assessment will be reviewed by the Director of Nursing c DON/ADON, Unit Managers will review physician/NP notes to ensure orders are identified. d Review of the 24-hour summary daily during scheduled clinical meeting per the DON/designee to identify residents that may have refused a laboratory test or residents who	

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	10/24/23 at 4:33 a.m. An interview with DON (Director of Nursing) conducted on 10/24/23 at 10:01 a.m. indicated, in the event a resident has had a fall, the expectations were to: if the fall was unwitnessed, neurological checks were to be initiated; completion of the initial post fall assessment and a fall risk assessment; and completion of post fall assessments once per shift for the following 72 hours (or 3 days). A Falls Management and Fall Risk policy received on 10/23/23 at 12:12 p.m. from DON indicated, the 72 hour occurrence follow-up charting is used to assess post fall for further injury or intervention..." This citation relates to Complaints IN00419976 and IN00418875. 3.1-37(a)		are in need of 72-hour follow up assessments. e DON/designee will audit 5 resident records weekly for resident testing and documentation. 4 How the corrective actions will be monitored: a The responsible party for this plan of correction is the Director of Nursing with the Executive Director oversight. b The results of audits will reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. c The QA committee will identify any trends and patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance: 11/7/2023	