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 FORM APPROVED  
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF SHELBYVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>711 FRANKFORT ROAD SHELBYVILLE, KY 40066</b>
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F 000	INITIAL COMMENTS  An Abbreviated Survey was initiated on 10/28/14 and concluded on 10/29/14 to investigate KY22384. The Division of Health Care substantiated the allegation with related deficiencies cited.	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F 225	1. Resident #1 was reimbursed for missing funds on 10/28/2014 in the form of a resident trust. Wrist band to maintain key to lockbox that was provided to resident #1 by Social Services Director (SSD) on 10/28/2014. Appropriate law enforcement agencies notified on 10/28/2014 by SSD. Resident physical assessment conducted on 10/19/2014 by Charge Nurse, no distress was noted.  2. To identify other residents that might have been affected, the SSD and Social Services Assistant (SSA), under recommendation of the Quality Assurance Committee (QAC), identified all other residents in possession of lock boxes on 10/28/2014. Wrist bands were provided to the residents identified by SSD and SSA on 10/29/2014. Any resident not in possession of a lock box was offered one on 10/29/2014 and installed by Maintenance on 10/29/2014. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below.  3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows:  •Abuse Reporting and Prevention Policy was reviewed by QAC on 10/31/2014 to ensure inclusion appropriate interviews, assessments, and notifications per regulatory compliance.	

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

*X Robert N. Cooper*

TITLE

*X Administrator*

(X6) DATE

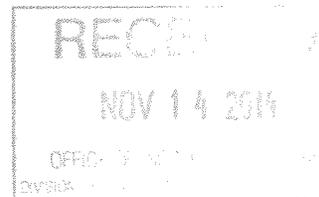
*X 11/14/2014*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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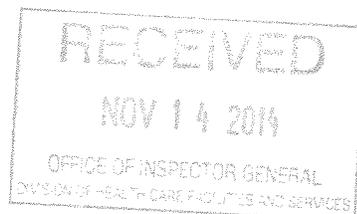
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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to conduct a thorough investigation into one (1) of ten (10) sampled residents. Resident #1 reported a missing wallet, containing \$85.00 dollars and driver's license. The facility failed to interview all staff on duty during the time frame identified. In addition, the facility failed to notify appropriate law enforcement agencies once determination was made there was a possibility a staff member had taken the wallet and its contents.  The findings include:  Review of the facility's Abuse Reporting and Prevention policy revealed any allegation from facility staff, residents, or other persons related to the facility, relating to actual or suspected abuse would be thoroughly investigated in-house by the Administrator and/or designated facility staff. If there was an allegation made of abuse, neglect or exploitation, the Administrator, or designee, would notify the Department for Community Based Services and Licensure & Regulation immediately. If there was a suspicion of a crime, the Administrator, or designee, would notify the Office of the Secretary and other law enforcement agencies as required by federal or state governing bodies within two hours. If any	F 225	<ul style="list-style-type: none"> <li>• New Hire Orientation was reviewed by QAC on 10/31/2014 to ensure inclusion of Abuse Reporting and Prevention Policy</li> <li>• Admission Packet was reviewed by QAC on 10/31/2014 to ensure Resident Fund and Security Acknowledgement.</li> <li>• Education was provided to all staff on 10/31/2014 and 11/14/2014 on Abuse Reporting and Prevention Policy by ADON, Administrator, and Respective Department Directors.</li> <li>• Resident Fund and Security Acknowledgement was presented at the Resident Council meeting on 11/12/14 by SSD.</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>• Social Service CQI Calendar was revised by the Administrator on 10/31/2014 to ensure SS-16 'Resident Lockbox Audit', are conducted monthly.</li> <li>• SS-16 'Resident Lockbox Audit' was revised by QAC on 10/31/2014 to include resident independent access to lockbox.</li> <li>• SSD will continue to use SS-16 to ensure performance is sustained.</li> <li>• QA committee reviewed and accepted the plan of correction that was presented by the Administrator on 11/14/2014.</li> </ul> <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	11/15/2014	



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F 225	<p>Continued From page 2</p> <p>employee was deemed responsible for the reported act(s) of abuse, that employee would be instructed to report directly to the Administrator and Department Head for appropriate disciplinary action, up to and including termination of employment.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) assessment, completed on 09/18/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a fourteen (14) out of fifteen (15) indicating cognitively intact.</p> <p>Interview with Resident #1, on 10/28/14 at 11:10 AM, revealed the last time Resident #1 had seen the wallet was on 10-17-14 when it was secured in the locked box. Resident #1 stated Sunday morning church services were about to begin and wanted to take money to put in the offering plate. Resident went to the locked box to retrieve the wallet and found it missing. Resident #1 immediately reported the missing wallet to staff.</p> <p>Continued interview with Resident #1 revealed the wallet was leather, brown in color and contained \$85.00 dollars: four (4) \$20.00 dollar bills; and one (1) \$5.00 dollar bill, along with a driver's license, social security card, and insurance card. Resident #1 stated the wallet was kept in a locked box in the second drawer and the key was kept hidden in the bottom drawer. Resident #1 requested police notification; however, the facility staff said they wanted to handle it in house. Resident #1 continued to state concerns about identity theft due to the types of cards in the wallet. Resident #1 stated a few days later facility staff informed him they had viewed the surveillance videos and thought they knew</p>	F 225			



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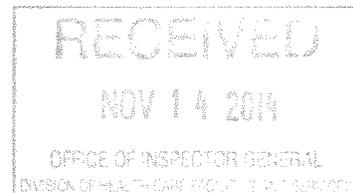
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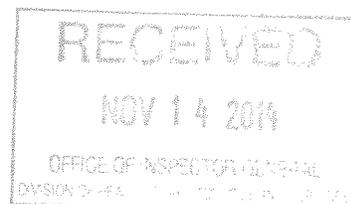
F 225	<p>Continued From page 3</p> <p>who might have taken wallet, but could not be certain.</p> <p>Telephone interview with CNA #1, on 10/29/14 at 1:55 PM, revealed Resident #1 reported a wallet missing from the locked box around 9:15 AM on 10/19/14. She stated the resident told her the wallet contained money, a driver's license, a social security card and insurance cards. The CNA notified LPN #1 regarding Resident #1's report of a missing wallet. CNA #1 stated while Resident #1 reported a missing wallet and contents to LPN, she search the resident's belongings and room; however, the search was unsuccessful in locating the wallet or its contents.</p> <p>Telephone interview with LPN #1, on 10/29/14 at 1:37 PM, revealed Resident #1 reported a wallet containing money, identification, insurance card and social security card as missing. A search was conducted, but was unsuccessful in locating the missing wallet or its contents. LPN #1 did not feel the need to do any further investigation due to the belief the wallet was just misplaced by the resident. LPN #1 stated Social Services conducted investigations regarding missing items, and since it was Sunday, she left a voice mail for the Social Services Director regarding the missing wallet.</p> <p>Telephone interview with Resident #1's immediate Family Member/Power of Attorney, on 10/28/14 at 8:04 AM, revealed they were in the facility on 10/19/14 at 09:45 AM to attend church with Resident #1. The Family Member stated Resident #1 informed them of the missing wallet. The Family Member stated they had removed the social security and insurance cards a couple of weeks ago, but left the \$85.00 dollars, driver's</p>	F 225		
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F 225	<p>Continued From page 4</p> <p>license and a Kroger card in the wallet. The Family Member stated they spoke with nursing staff and they were aware of the missing wallet and had notified Social Services. The Family Member stated Resident #1 wanted a police report to be made, but the facility told them they had regulations to follow and wanted to investigate before calling the police. Continued interview with the immediate Family Member revealed Social Services informed them the facility surveillance videos were reviewed, and a weekend employee was identified as the thief and the individual had self-terminated. The Family member stated it seemed like more should have been done.</p> <p>Interview with the DON, on 10/29/14 at 11:30 AM, revealed they did not call the police on 10/20/14 when they received notification of a missing wallet. She continued to state they should have contacted the police when they made their other required notifications. She stated notifying the police was on their checklist form as one of the tasks to complete, she was just not sure why they didn't.</p> <p>Interview with the Social Services Director (SSD), on 10/28/14 at 14:50 PM, revealed she had reviewed the surveillance video of the time CNA #1 provided care to Resident #1 and did not find any suspicious behavior. Continued interview revealed she did not notify the police department once a determination was made regarding the possibility that CNA #1 could have taken the resident's wallet until the Administrator directed her to do so on 10/28/14. She stated she called and gave a report to the Sheriff 's office at 12:20 PM on 10/28/14. She also stated they had not questioned all staff on duty during the identified</p>	F 225			



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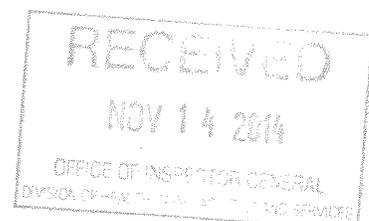
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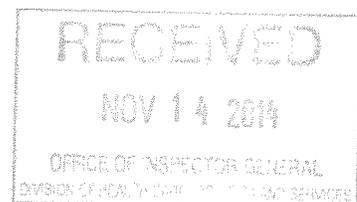
F 225	<p>Continued From page 5 time frame the wallet was missing, and was not aware of this until today.</p> <p>Continued interview with the DON, on 10/29/14, revealed she called CNA #1 twice on the evening of 10/20/14 and left messages with a male that answered the phone. The DON stated, CNA #1 did not return calls and she did not make any other attempts to contact CNA #1. The DON also stated she did not direct staff to contact her if CNA #1 called or came into the facility. The DON stated the determination that it was possible CNA#1 had taken the wallet was made because she: left early on Friday; did not come to work on Saturday or Sunday; was having financial difficulties; and self-terminated. She stated there were two different lists developed to account for statements and a correlation of the two was not completed to ensure everyone had been interviewed.</p> <p>Interviews, on 10/28/14 at 1:35 PM and 1:45 PM with the Staffing Coordinator and the Business Office Manager revealed they both had spoken with CNA #1 over the phone around 9:00 AM on 10/28/14. The Business Manager stated CNA #1 came to the facility on 10/20/14 to speak with her about her payroll check. The manager was not aware the Administrator needed to speak with CNA#1.</p> <p>Interview, on 10/28/14 at 1:00 PM, with CNA#2 revealed she worked the morning of 10/17/14 until about 10:00 AM. She said she spoke with the Unit Coordinator and requested to leave early and would not be coming back. CNA#1 stated her payroll check was short and she needed to leave to take care of business. She said she was in Resident #1's room several times assisting both</p>	F 225		
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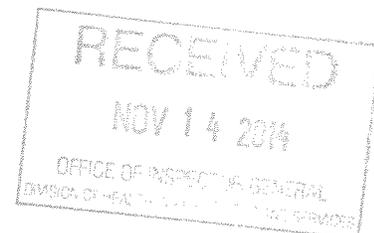
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F 225	<p>Continued From page 6</p> <p>Resident #1 and #2. She stated she did not see resident's wallet or money while in the room. She also stated she did not open the lock box or take \$85.00 dollars from Resident #1. CNA#1 stated the DON did try to contact her on Monday, but they had yet to have a conversation. CNA #2 stated she made the decision not to return because she believed the facility was not paying her correctly. She also stated that she was in the facility on 10/20/14 and she did call the facility on 10/28/14 around 8:45 AM to inquire about hours on next check and was not told she needed to be interviewed for an allegation of suspected misappropriations.</p> <p>Review of the surveillance video on 10/29/14 of footage for 10/17/14 from 6:11 AM to 11:33 AM (time frame CNA #2 worked and would have had access to Resident #1's wallet) revealed CNA #2 entered Resident #1's room at 7:04 AM, 7:12 AM, and 7:54 AM with no suspicious behavior noted. In addition, four (4) other staff members were viewed entering and exiting Resident #1's room during 6:11 AM and 11:33 AM timeframe with no suspicious behavior noted.</p> <p>Interview with the Administrator, on 10/28/14 at 11:50 AM, revealed he was out of town during the time Resident #1's missing wallet was being investigated. He also stated he was not aware appropriate law enforcement agencies had not been contacted. In addition, he was not aware the DON and Social Service Director (SSD) had not interviewed all potential staff identified during shifts the wallet was missing. He stated he had a telephone conversation with the DON and SSD to review the findings of the investigation, but he was not informed of the incomplete investigation and that all authorities were not contacted. He</p>	F 225			



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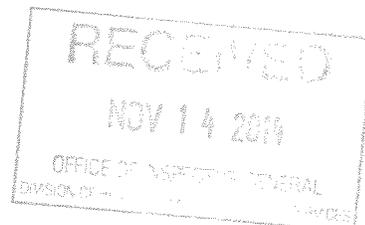
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F 225	Continued From page 7 stated he did not question the thoroughness of the investigation or provide any direction to call the police during their telephone conversation.	F 225			
F 226 SS=D	Continued interview, on 10/29/14 at 3:00 PM, with the Administrator revealed he believed the facility completed a thorough investigation even though, Nursing and Social Services did not: interview all potential staff on duty during the time frame of the event; document a patient assessment on the day of the allegation; or notify the police timely. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow their policy and procedures for investigating an allegation of misappropriation of a resident's property for one (1) of ten (10) sampled residents. (Resident #1)  The findings include:  Review of the facility's Abuse Reporting and Prevention policy revealed consistent monitoring/intervention would be carried out by all supervisory staff in an effort to teach and prevent escalation of an event; and, signs of stress/burnout. Any allegation from facility staff,	F 226	1. Resident #1 was reimbursed for missing funds on 10/28/2014 in the form of a resident trust. Wrist band to maintain key to lockbox that was provided to resident #1 by Social Services Director (SSD) on 10/28/2014. Appropriate law enforcement agencies notified on 10/28/2014 by SSD. Resident physical assessment conducted on 10/19/2014 by Charge Nurse, no distress was noted.  2. To identify other residents that might have been affected, the SSD and Social Services Assistant (SSA), under recommendation of the Quality Assurance Committee (QAC), identified all other residents in possession of lock boxes on 10/28/2014. Wrist bands were provided to the residents identified by SSD and SSA on 10/29/2014. Any resident not in possession of a lock box was offered one on 10/29/2014 and installed by Maintenance on 10/29/2014. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below.  3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows:  •Abuse Reporting and Prevention Policy was reviewed by QAC on 10/31/2014 to ensure inclusion appropriate interviews, assessments, and notifications per regulatory compliance.		



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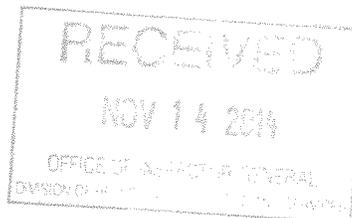
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F 226	Continued From page 8 residents, or other persons related to the facility, relating to actual or suspected abuse would be thoroughly investigated in-house by the Administrator and/or designated facility staff. The Administrator, or designee, would initiate an in-house investigation into any allegations and make appropriate determinations related to reporting of events to the Department of Social Services and Licensure & Regulation of the state of Kentucky. If there was an allegation made of abuse, neglect or exploitation, the Administrator, or designee, would notify the Department for Community Based Services and Licensure & Regulation immediately. If there was a suspicion of a crime, the Administrator, or designee, would notify the Office of the Secretary and other law enforcement agencies as required by federal or state governing bodies within two hours. Each supervisor, Department Head or designee would immediately inform the Administrator, or designee of the report and receive directions for further steps to be followed. As soon as possible, all information related to a report of abuse, would be obtained in writing from all persons with knowledge of the reported incident. Pertinent interviews would be conducted in a confidential, professional manner with a need to know priority of information. These interviews would include the resident, if possible, the individual reporting the event, all staff on duty at the time of the event with any probable first hand information, any other individual present in the area at the time of the reported incident. These interviews would be put in writing and discussed only by those with responsibility for determining substantiation of the report. If any employee was deemed responsible for the reported act(s) of abuse, that employee would be instructed to report directly to the Administrator and Department Head for	F 226	<ul style="list-style-type: none"> <li>• New Hire Orientation was reviewed by QAC on 10/31/2014 to ensure inclusion of Abuse Reporting and Prevention Policy</li> <li>• Admission Packet was reviewed by QAC on 10/31/2014 to ensure Resident Fund and Security Acknowledgement.</li> <li>• Education was provided to all staff on 10/31/2014 and 11/14/2014 on Abuse Reporting and Prevention Policy by ADON, Administrator, and Respective Department Directors.</li> <li>• Resident Fund and Security Acknowledgement was presented at the Resident Council meeting on 11/12/14 by SSD.</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>• Social Service CQI Calendar was revised by the Administrator on 10/31/2014 to ensure SS-16 'Resident Lockbox Audit', are conducted monthly.</li> <li>• SS-16 'Resident Lockbox Audit' was revised by QAC on 10/31/2014 to include resident independent access to lockbox.</li> <li>• SSD will continue to use SS-16 to ensure performance is sustained.</li> <li>• QA committee reviewed and accepted the plan of correction that was presented by the Administrator on 11/14/2014.</li> </ul> <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	11/15/2014	



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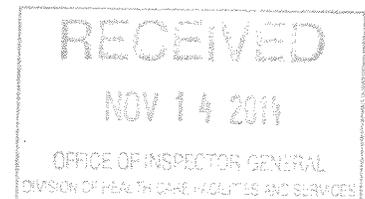
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185378</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MASONIC HOME OF SHELBYVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>711 FRANKFORT ROAD SHELBYVILLE, KY 40066</b>		
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F 226	<p>Continued From page 9</p> <p>appropriate disciplinary action, up to and including termination of employment. Continued review of policy revealed the charge nurse would complete an assessment of the Resident's condition.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) assessment, completed on 09/18/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a fourteen (14) out of fifteen (15) indicating cognitively intact.</p> <p>Interview with Resident #1, on 10/28/14 at 11:10 AM, revealed the last time Resident #1 had seen the wallet was on 10/17/14 when it was secured in the locked box. Resident #1 stated Sunday morning church services were about to begin and wanted to take money to put in the offering plate. Resident went to locked box to retrieve wallet and found it missing. Resident #1 immediately reported missing wallet to staff.</p> <p>Telephone interview with Resident #1's immediate Family Member/Power of Attorney, on 10/28/14 at 8:04 AM, revealed Social Services informed them the facility surveillance videos were reviewed, and a weekend employee was identified as the thief and the individual had self-terminated. The Family Member stated, it seems like more should have been done.</p> <p>Review of Resident #1's medical record revealed the nursing staff did not complete an assessment of Resident #1 for psychological effects from the missing wallet as per their policy.</p> <p>Telephone interview with LPN #1, on 10/29/14 at 1:37 PM, revealed she did not complete a nursing</p>	F 226			



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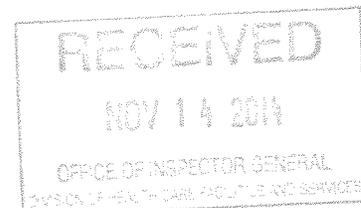
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F 226	<p>Continued From page 10 assessment because she believed the wallet was misplaced and not stolen.</p> <p>Interview with the DON, on 10/29/14 at 11:30 AM, revealed they did not call the police on 10/20/14 when they received notification of the missing wallet, because the report at first was treated as a misplaced wallet not one that was stolen. She continued to state they should have contacted the police when they made their determination and other required notifications. She stated notifying the police was on their checklist form as one of the tasks to complete, she was just not sure why they didn't, once there was a suspicion of a crime (as stated per policy).</p> <p>Interview with the Social Services Director, on 10/28/14 at 2:50 PM revealed when she began her investigation on 10/20/14 and she treated it as a misplaced wallet, a search was conducted and laundry was called. After the determination was made that CNA#2 could have taken the wallet, again a decision to call the police was not made. She stated she had not notified the police until the Administrator directed her to do so on 10/28/14. She stated she called and gave a report to the Sheriff 's office at 12:20 PM on 10/28/14. She also stated they had not questioned all staff on duty during the identified time frame the wallet was missing, and was not aware of this until today.</p> <p>Continued interview with DON, on 10/29/14 revealed she called CNA #1 twice on the evening of 10/20/14. The DON stated, CNA #1 did not return calls and she did not make any other attempts to contact the CNA. The DON also stated she did not direct staff to let her know if CNA #1 called or came into the facility. The DON</p>	F 226			



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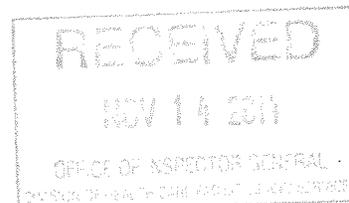
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F 226	<p>Continued From page 11</p> <p>stated the determination that it was possible CNA#1 had taken the wallet was made, because she: left early on Friday; did not come to work on Saturday or Sunday; was having financial difficulties; and, self-terminated. In addition, the DON was not aware all staff on duty during the identified time frame the wallet was missing had not been questioned. She stated there were two different lists developed to account for statements and a correlation of the two was not completed to ensure everyone had been interviewed. Further discussion with the DON revealed re-education of all staff on abuse and misappropriation of resident belongings, as an effort to teach and prevent escalation of an event of abuse (per policy), had not been provided as of 10/29/14, but was scheduled for 11/04/14.</p> <p>Interview, on 10/28/14 at 1:00 PM, with CNA #2 revealed she worked the morning of 10/17/14 until about 10:00 AM. CNA #1 stated the DON did try to contact her on Monday, but they had yet to have a conversation. CNA #2 stated she made the decision not to return because she believed the facility was not paying her correctly. She also stated she was in the facility on 10/20/14 and she did call the facility on 10/28/14 around 8:45 AM to inquire about hours on the next check and was not told she needed to be interviewed for an allegation of suspected misappropriations.</p> <p>Review of the surveillance video on 10/29/14 of footage for 10/17/14 from 6:11 AM to 11:33 AM (time frame CNA #2 worked and would have had access to Resident #1's wallet) revealed CNA #2 entered Resident #1's room at 7:04 AM, 7:12 AM, and 7:54 AM with no suspicious behavior noted. In addition, four (4) other staff members were viewed entering and exiting Resident #1's</p>	F 226			



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F 226	<p>Continued From page 12</p> <p>room during 6:11 AM and 11:33 AM timeframe with no suspicious behavior noted.</p> <p>Interviews, on 10/28/14 at 1:35 PM and 1:45 PM, with the Staffing Coordinator and the Business Office Manager revealed they both had spoken with CNA #1 over the phone around 9:00 AM on 10/28/14. The Business Manager stated CNA #1 came to the facility on 10/20/14 to speak with her about her payroll check. The manager was not aware the Administrator needed to speak with CNA #1.</p> <p>Interview with the Administrator, on 10/28/14 at 11:50 AM, revealed he was out of town during the time Resident #1's missing wallet was being investigated. The Administrator stated the faxed report to OIG was enough information for a thorough investigation. He further stated he would have to find out if the police were notified. He returned and stated the facility had not notified law enforcement. In addition, he was not aware the DON and Social Service Director (SSD) had not interviewed all potential staff identified during shifts the wallet was missing. He stated he had a telephone conversation with the DON and SSD to review the findings of the investigation, but he was not informed of the incomplete investigation and that all authorities were not contacted. He stated he did not question the thoroughness of investigation or provide any direction to call police during their telephone conversation.</p> <p>Continued interview, on 10/29/14 at 3:00 PM, with the Administrator revealed he believed the facility followed their policy and procedure and completed a thorough investigation even though, Nursing and Social Services did not interview all potential staff on duty during the time frame of the</p>	F 226			



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F 226	Continued From page 13 event; document a patient assessment on the day of the allegation; or notify the police timely.	F 226			

