STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING KK on 3/24/10 B. WING	C 02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS Correction date 3/8/10 Investigation of Complaint #27302-C, facility self reported incident #26766-M and 27309-I was substantiated with deficiencies. See Code of Federal Regulations (42 CFR) Par 483, Subpart B-C.	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

POC accepted 4/24/10 KK summary

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F 159	Continued From page 1 The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Relates to Complaint #26766-M: Based on review of accounting records, clinical records, and interviews with staff and family members, the facility failed to safeguard residents funds with management oversight and failed to maintain receipts for 7 of 7 residents accounts (Resident #1, #2, #3, #4, #5, #6, and #7).The facility reported a census of 102. Findings include: According to the facility Abuse Program & Prevention Protocol (undated) misappropriation of resident property means the deliberate misplacement, exploitation, wrongful, temporary or permanent use of resident' s belongings or	F 159		

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F 159	Continued From page 2 money without the resident' s consent. A review of the facility investigation labeled Possible Missing/Misappropriation of Funds (undated) identified Staff B had consent from the facility to purchase Christmas gifts using the residents' personal funds. The investigation documented " Each resident signed/gave finger print signature for funds from their trust accounts on 12/11/10. " The following amounts were removed by Staff D and given to Staff B as follows: Resident #1 $600.00 Resident #4 $150.00 Resident #2 $150.00 Resident #3 $100.00 Resident #7 $100.00 Resident #6 $75.00 Resident #5 $38.00 In an interview conducted on 1/14/10 at 2:08 p.m. Staff D revealed that on 12/10/09 Staff B obtained signed or finger-printed resident vouchers to remove funds from the residents' personal account. Staff D withdrew $1213.00 on 12/10/09 and gave the money to Staff B on 12/11/09 to go shopping for the residents over the weekend. According to the same investigation report, Staff B completed some of the shopping on 12/14/09, and made some purchase for residents, and then on 12/16/09 the remaining balance of $1213.00 came up missing. The investigation report documented the funds were not located and Staff B was allowed to use her own personal funds to replace the missing money.	F 159		

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F 159	Continued From page 3 According to the Admission Agreements under Section V Rights and Responsibilities of the Facility, documented the following: If the facility agrees to manage a resident ' s personal funds it shall be disbursed from a resident ' s account upon request of the resident or the residents legal representative, family member or responsible party. The Admission Agreements for all seven residents (Residents #1 - #7) were signed upon admission by either a responsible party/family member or legal representative. During an interview with Staff D on 1/14/10 at 2:08 p.m. she stated she told Staff B that 4 residents needed a spend down and to purchase items the residents wanted or needed. Staff D stated that she trained Staff B to have residents sign vouchers to get money out and to turn in receipts with change. Staff D stated Staff B took the resident vouchers around to the seven residents and had them sign or/and fingerprinted for money to be drawn out. Staff D stated [only] Staff B witnessed these residents agreeing to this transaction. Staff B brought these vouchers back to the office and had a separate list of gift ideas she was going to purchase. Staff D stated that she did not question if she [Staff B] had contacted the family members for permission for the residents who could not make their own decisions, because in her experience that was second nature. Staff D stated she then took the vouchers and added up the amount, wrote out a check for cash from trust fund and cashed the check. Staff D stated Staff B requested to pick up the money Friday12/11/09 after her shift because she did not want to lose it and was going to shop for the residents over the weekend. Staff D stated	F 159		

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F 159	Continued From page 4 on Wednesday 12/16/09, she was informed that Staff B lost the money and receipts. Staff D stated she gave Staff B $1528.00 over the weekend, and Staff B spent $251.42 and returned $63.58 leaving a total of $1213.00 missing. 1). A document labeled Resident Voucher dated 12/10/09 contained Resident #1' s name, withdrawal amount listed as $600.00, purpose listed as Christmas, Resident #1 signature and right thumb print and a witness signature line signed by Staff B. a). Resident #1 ' s clinical record identified the resident with a diagnosis of Alzheimer ' s. The Minimum Data Set (MDS) dated 11/22/09 for Resident #1 revealed additional diagnoses of diabetes mellitus, hypertension, arthritis, osteoporosis, anxiety, depression, and macular degeneration. The MDS documented Resident #1 had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident had the ability to make him/herself understood and to understand others. Resident #1 ' s Care Plan with a start date of 1/24/08 revealed that the resident had impaired cognition, poor safety awareness any impaired decision-making ability related to Alzheimer's dementia and indicated the resident resided on the Chronic Confusion and Dementing Illness unit (CCDI). b.) In an interview conducted on 1/27/10 at 10:53 a.m. with Resident #1's Power of Attorney (POA) revealed that he/she did not know that the facility could spend the resident' s money and indicated that he/she wanted notification prior to the facility	F 159		

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F 159	Continued From page 5 spending any more of the resident ' s money. c.) In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $600.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #1 over the weekend. On 12/14/09 Staff B had Staff L (RN) lock the residents ' envelopes [with the money and receipts] in the narcotic box in the medication cart on the CCDI unit until 2:30 p.m. when Staff B removed the envelopes and placed them in an unsecure green bag in an unsecure nurse ' s office. Staff B admitted to leaving the residents envelopes unsecured until she noticed the envelopes missing on 12/16/09 at 10:30 a.m. Staff B reported she alerted Staff J and Staff C (DON) that the residents ' money and receipts were missing and she thought the amount of money missing was $500.00. On 12/17/09, Staff B indicated that he/she repaid the facility $600.00 to return to Resident #1's account. Staff B then reported that he/she had requested to return the purchased items to recover his/her expense and he/she indicated the Administrator agreed. 2.) A document labeled Resident Voucher dated 12/10/09 contained Resident #2's name, withdrawal amount listed as $150.00, purpose listed as Christmas, Resident #2's signature, and a witness signature line signed by Staff B. a). Clinical record review of the Medication Administration Record (MAR) dated 12/23/09 for Resident #2 revealed diagnosis as Alzheimer's disease, hypertension, dementia, and benign prostatic hyperplasia (enlarged prostate). The MDS dated 11/08/09 documented the resident	F 159		

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F 159	Continued From page 6 had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented resident had the ability to make him/her(self) understood and to understand others. The Care Plan dated 12/14/08 directed staff to use simple step-by-step instructions and do not overload resident with too much information at once and indicated the resident resided on the CCDI unit for safety. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $150.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #2 over the weekend. Staff B reported that he/she did not turn in the receipts or the remaining cash when he/she returned to work on 12/14/09 and told Staff D that he/she would continue shopping throughout the week. On 12/16/09, Staff B reported to the facility the money and receipts were missing. On 12/17/09, Staff B indicated that he/she repaid the facility $150.00 to return to Resident #2's account. c). In an interview conducted on 1/27/10 at 11:11 a.m., Resident #2's POA indicated that he/she would expect the facility to notify him/her prior to purchasing anything over $50.00 for Resident #2. The POA indicated that Resident #2 is not financially responsible. 3. A document labeled Resident Voucher dated 12/10/09 contained Resident #3's name, withdrawal amount listed as $100.00, purpose listed as Christmas, Resident #3's left thumb print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated	F 159		

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F 159	Continued From page 7 12/06/09 for Resident #3 revealed diagnoses as dementia, hypertension, and depression. The MDS documented the resident had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented resident with the ability to make him/her (self) understood and to understand others. The Care Plan dated 1/31/08 indicated the resident resided on the CCDI unit and directed staff to use visual cueing, pictures, and gestures with communication. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $100.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #3 over the weekend. Staff B reported that he/she did not notify Resident #3's family prior to obtaining the resident's consent. Staff B reported Resident #3 missing money to the facility on 12/16/09. On 12/17/09, Staff B indicated that he/she repaid the facility $100.00 to return to Resident #3's account. 4). A document labeled Resident Voucher dated 12/10/09 contained Resident #4 ' s name, withdrawal amount listed as $150.00, purpose listed as Christmas, Resident #4's signature and left thumb print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 3/4/09 for Resident #4 revealed diagnosis as Alzheimer's. The MDS documented resident had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her(self) understood and to	F 159		

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F 159	Continued From page 8 understand others. b).The Care Plan dated 3/18/09 indicated the resident resided on the CCDI unit for decreased stimulation and smaller environment and directed staff to use cueing and supervision with activities of daily living and decision- making. c).In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $150.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #4 over the weekend. Staff B indicated that after reporting the money missing he/she repaid the facility $150.00 to return to the resident's account. 5.) A document labeled Resident Voucher dated 12/10/09 contained Resident #6's name, withdrawal amount listed as $75.00, purpose listed as Christmas, Resident #6's left thumb-print and a witness signature line signed by Staff B. a).Clinical record review of the MDS dated 8/23/09 for Resident #6 revealed diagnoses as dementia, depression, metastatic breast cancer, hypertension, and hypothyroidism. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her (self) understood and to understand others. The Care Plan dated 10/18/07 directed staff to redirect activities when resident exhibited disruptive/confused behaviors and offer simple choices. The resident resided on the CCDI unit and received services from Hospice.	F 159		

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F 159	Continued From page 9 b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $75.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #6 over the weekend. Staff B indicated that after reporting the money missing he/she repaid the facility $75.00 to return to the resident's account. On 1/27/10 at 8:18 a.m., the facility reported to this surveyor that Resident #6 passed away on 1/25/10. 6). A document labeled Resident Voucher dated 12/10/09 contained Resident #7's name, withdrawal amount listed as $100.00, purpose listed as Christmas, Resident #7's right thumb-print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 1/10/10 for Resident #7 revealed diagnoses as Alzheimer's disease, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, depression, stroke with left sided weakness and heart failure. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her(self) understood and usually understands others but may miss the intent of the message. The Care Plan dated 6/12/08 directed staff to use basic step directions and allow ample time for responses. The resident resided on the CCDI unit. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received	F 159		

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F 159	Continued From page 10 $100.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #7 over the weekend. Staff B indicated that after reporting the money missing he/she repaid the facility $100.00 to return to the resident's account c). In an interview conducted on 1/27/10 at 10:04 a.m. with a family member of Resident #7. The family member stated that he/she knows that the resident did not authorize the facility to spend his/her money because he/she is not mentally capable and did not understand financial matters. 7). A document labeled Resident Voucher dated 12/10/09 contained Resident #5's name, withdrawal amount listed as $38.00, purpose listed as Christmas, Resident #5's signature, and a witness signature line signed by Staff B. Clinical record review of the MDS dated 7/15/09 for Resident #5 revealed diagnoses that included dementia, renal failure history of skull fracture, seizure disorder, alcoholism and cardiac dysrhythmia. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her(self) understood and to understand others. The Care Plan dated 8/6/09 directed staff to allow the resident to make simple decisions and to intervene if there is a safety concern. Resident #5 resided on the CCDI unit. Staff B reported the missing money and repaid the facility $38.00 to return to the resident's account.	F 159		

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F 159	Continued From page 11 During an interview with Staff N on 1/14/10 at 10:28 a.m. she explained it was her duty to do resident shopping and it was taught to her as follows: She would speak to the resident, if cogitatively able to make their own decision about their need or want. Staff N stated she would get a form from the business office which would be filled out with the resident ' s name, the date, the reason for the withdrawal of cash, the resident ' s signature, and then the staff witness signature. Staff N stated she would turn the voucher into the business office and obtain the cash. Staff N stated she would purchase the item, brings it back to the resident, and turn the receipt and change into the Staff D. Staff N stated for example if the resident needed a new television, she would contact the family for consent. Staff N stated if the resident did not have family, the leadership team would discuss the need, if no other payee were in place, then she would obtain a voucher, fill it out and purchase the item and give the receipt to the office. Staff N said this process was explained at admission, along with the intent of the resident trust account that was set up in the business office. Staff N stated that upon admission she tells the family that if it is a small item, for example $60.00 or less of grocery, clothing, or other items will not require family consent but larger purchase would require consideration by family, resident, and staff. In an interview conducted on 1/28/10 at 11:38 a.m. the Administrator reported that the facility had policies and procedures in place to protect the resident's funds in interest bearing accounts. During additional interview on 2/22/10 at 1:30 p.m., the Administrator stated that when he went to get the policies for management of resident	F 159		

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F 159	Continued From page 12 funds, he found the facility did not have them in writing. He stated the facility did have practices in place and these are in written form now. The resident has the right to deposit funds with the facility per the regulations. The facility would track these funds and deposit any amount of $50 in an interest-bearing account. With withdrawals, the facility would use a witnessed voucher and either a signature or fingerprint validation from the resident. During further interview on 2/23/10 at 3:45 p.m., when asked, the administrator stated it would be a good idea to ask a family member or power of attorney for permission for withdrawals with residents who have cognitive impairment. However, at the time, the facility asked permission on a 'hit and miss' basis. The facility also learned later that family members were not aware of every purchase made on a resident's behalf.	F 159		
F 224 SS=H	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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: Relates to Complaint #26766-M: Based on review of accounting records, clinical records, facility abuse protocol, and interviews with staff and family members, the facility failed to	F 224		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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implement measures to prevent misappropriation of resident property and failed to obtain consent from residents ' legal representatives or family members before allowing one employee to make purchases for seven or seven residents. Concerns were identified for Resident #1, #2, #3, #4, #5, #6, and #7. The facility reported a census of 102.

Findings include:

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. (according to the State Operations Manual 42 CFR 488.301).

According to the facility Abuse Program & Prevention Protocol (undated) misappropriation of resident property means the deliberate misplacement, exploitation, wrongful, temporary or permanent use of resident ' s belongings or money without the resident ' s consent.

A review of the facility investigation labeled Possible Missing/Misappropriation of Funds (undated) identified Staff B had consent from the facility to purchase Christmas gifts using the residents' personal funds. The investigation documented " Each resident signed/gave finger print signature for funds from their trust accounts on 12/11/10. " The following amounts were removed by Staff D and given to Staff B as follows:

Resident #1 $600.00
Resident #4 $150.00
Resident #2 $150.00

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F 224	Continued From page 14 Resident #3 $100.00 Resident #7 $100.00 Resident #6 $75.00 Resident #5 $38.00 In an interview conducted on 1/14/10 at 2:08 p.m. Staff D revealed that on 12/10/09 Staff B obtained signed or finger-printed resident vouchers to remove funds from the residents' personal account. Staff D withdrew $1213.00 on 12/10/09 and gave the money to Staff B on 12/11/09 to go shopping for the residents over the weekend. According to the same investigation report, Staff B completed some of the shopping on 12/14/09, and made some purchase for residents, and then on 12/16/09 the remaining balance of $1213.00 came up missing. The investigation report documented the funds were not located and Staff B was allowed to use her own personal funds to replace the missing money. According to the Admission Agreements under Section V Rights and Responsibilities of the Facility, documented the following: If the facility agrees to manage a resident ' s personal funds it shall be disbursed from a resident ' s account upon request of the resident or the residents legal representative, family member or responsible party. The Admission Agreements for all seven residents (Residents #1 - #7) were signed upon admission by either a responsible party/family member or legal representative. During an interview with Staff D on 1/14/10 at 2:08 p.m. she stated she told Staff B that 4	F 224		

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F 224	Continued From page 15 residents needed a spend down and to purchase items the residents wanted or needed. Staff D stated Staff B took the resident vouchers around to the seven residents and had them sign or/and fingerprinted for money to be drawn out. Staff D stated [only] Staff B witnessed these residents agreeing to this transaction. Staff B brought these vouchers back to the office and had a separate list of gift ideas she was going to purchase. Staff D stated that she did not question if she [Staff B] had contacted the family members for permission for the residents who could not make their own decisions, because in her experience that was second nature. Staff D stated she then took the vouchers and added up the amount, wrote out a check for cash from trust fund and cashed the check. Staff D stated Staff B requested to pick up the money Friday12/11/09 after her shift because she did not want to lose it and was going to shop for the residents over the weekend. Staff D stated on Wednesday 12/16/09, she was informed that Staff B lost the money. Staff D stated she gave Staff B $1528.00 over the weekend, and Staff B spent $251.42 with receipts and returned $63.58 leaving a total of $1213.00 missing. 1). A document labeled Resident Voucher dated 12/10/09 contained Resident #1' s name, withdrawal amount listed as $600.00, purpose listed as Christmas, Resident #1 signature and right thumb print and a witness signature line signed by Staff B. a). Resident #1 ' s clinical record identified the resident with a diagnosis of Alzheimer ' s. The Minimum Data Set (MDS) dated 11/22/09 for Resident #1 revealed additional diagnoses of diabetes mellitus, hypertension, arthritis, osteoporosis, anxiety, depression, and macular	F 224		

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degeneration. The MDS documented Resident #1 had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident had the ability to make him/herself understood and to understand others.

Resident #1 ' s Care Plan with a start date of 1/24/08 revealed that the resident had impaired cognition, poor safety awareness any impaired decision-making ability related to Alzheimer's dementia and indicated the resident resided on the Chronic Confusion and Dementing Illness unit (CCDI).

b). In an interview conducted on 1/27/10 at 10:53 a.m. with Resident #1's Power of Attorney (POA) revealed that he/she did not know that the facility could spend the resident' s money and indicated that he/she wanted notification prior to the facility spending any more of the resident ' s money.

c). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $600.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #1 over the weekend. Staff B reported that he/she purchased 1 gift basket from Bath & Body Works for $37.45, a radio for $100.00 and 1 baby doll for $10.00 from Target, 1 purse and wallet for $30.00 and a bedding set for $40.00 from Sears. Staff B reported that he/she did not turn in the receipts or the remaining cash when he/she returned to work on 12/14/09 and told Staff D that she would continue shopping throughout the week. Staff B reported to Staff J and Staff C (DON) that the residents ' money was missing and she thought the amount of money missing was $500.00. Staff B said that while on the way home to search

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F 224	Continued From page 17 the apartment that she was so upset that she called her mother and told her what was going on and that she lost $1213.00. On 12/17/09, Staff B indicated that he/she repaid the facility $600.00 to return to Resident #1's account. Staff B then reported that he/she had requested to return the purchased items to recover his/her expense and he/she indicated the Administrator agreed. 2). A document labeled Resident Voucher dated 12/10/09 contained Resident #2's name, withdrawal amount listed as $150.00, purpose listed as Christmas, Resident #2's signature, and a witness signature line signed by Staff B. a). Clinical record review of the Medication Administration Record (MAR) dated 12/23/09 for Resident #2 revealed diagnosis as Alzheimer's disease, hypertension, dementia, and benign prostatic hyperplasia (enlarged prostate). The MDS dated 11/08/09 documented the resident had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented resident had the ability to make him/her(self) understood and to understand others. The Care Plan dated 12/14/08 directed staff to use simple step-by-step instructions and do not overload resident with too much information at once and indicated the resident resided on the CCDI unit for safety. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $150.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #2 over the weekend. Staff B reported that he/she purchased clothing items at Target totaling $30.00. Staff B	F 224		

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F 224	Continued From page 18 reported that he/she did not turn in the receipts or the remaining cash when he/she returned to work on 12/14/09 and told Staff D that he/she would continue shopping throughout the week. On 12/16/09, Staff B reported to the facility the money and receipts were missing. On 12/17/09, Staff B indicated that he/she repaid the facility $150.00 to return to Resident #2's account. Staff B indicated that Target would only give in-store credit. c). In an interview conducted on 1/27/10 at 11:11 a.m., Resident #2's POA indicated that he/she would expect the facility to notify him/her prior to purchasing anything over $50.00 for Resident #2. The POA indicated that Resident #2 is not financially responsible. 3. A document labeled Resident Voucher dated 12/10/09 contained Resident #3's name, withdrawal amount listed as $100.00, purpose listed as Christmas, Resident #3's left thumb print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 12/06/09 for Resident #3 revealed diagnoses as dementia, hypertension, and depression. The MDS documented the resident had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented resident with the ability to make him/her(self) understood and to understand others. The Care Plan dated 1/31/08 indicated the resident resided on the CCDI unit and directed staff to use visual cueing, pictures, and gestures with communication.	F 224		

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F 224	Continued From page 19 b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $100.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #3 over the weekend. Staff B reported that he/she did not notify Resident #3's family prior to obtaining the resident's consent. Staff B reported Resident #3 missing money to the facility on 12/16/09. On 12/17/09, Staff B indicated that he/she repaid the facility $100.00 to return to Resident #3's account. 4). A document labeled Resident Voucher dated 12/10/09 contained Resident #4 ' s name, withdrawal amount listed as $150.00, purpose listed as Christmas, Resident #4's signature and left thumb print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 3/4/09 for Resident #4 revealed diagnosis as Alzheimer's. The MDS documented resident had short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her (self) understood and to understand others. b).The Care Plan dated 3/18/09 indicated the resident resided on the CCDI unit for decreased stimulation and smaller environment and directed staff to use cueing and supervision with activities of daily living and decision- making. c). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $150.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #4 over the weekend. Staff B reported that he/she purchased a gift basket from Bath & Body Works for $37.45	F 224		

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F 224	Continued From page 20 for Resident #4. Staff B indicated that after reporting the money missing he/she repaid the facility $150.00 to return to the resident's account and kept the basket for his/her own personal use. 5). A document labeled Resident Voucher dated 12/10/09 contained Resident #6's name, withdrawal amount listed as $75.00, purpose listed as Christmas, Resident #6's left thumb-print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 8/23/09 for Resident #6 revealed diagnoses as dementia, depression, metastatic breast cancer, hypertension, and hypothyroidism. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her (self) understood and to understand others. The Care Plan dated 10/18/07 directed staff to redirect activities when resident exhibited disruptive/confused behaviors and offer simple choices. The resident resided on the CCDI unit and received services from Hospice. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $75.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #6 over the weekend. Staff B reported that he/she purchased a gift basket from Bath & Body Works for $37.45 for Resident #6. Staff B indicated that after reporting the money missing he/she repaid the facility $75.00 to return to the resident's account and sold the basket to a co-worker.	F 224		

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F 224	Continued From page 21 On 1/27/10 at 8:18 a.m., the facility reported to this surveyor that Resident #6 passed away on 1/25/10. 6). A document labeled Resident Voucher dated 12/10/09 contained Resident #7's name, withdrawal amount listed as $100.00, purpose listed as Christmas, Resident #7's right thumb-print and a witness signature line signed by Staff B. a). Clinical record review of the MDS dated 1/10/10 for Resident #7 revealed diagnoses as Alzheimer's disease, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, depression, stroke with left sided weakness and heart failure. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her(self) understood and usually understands others but may miss the intent of the message. The Care Plan dated 6/12/08 directed staff to use basic step directions and allow ample time for responses. The resident resided on the CCDI unit. b). In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $100.00 from Staff D on 12/11/09 to purchase Christmas gifts for Resident #7 over the weekend. Staff B reported that he/she purchased a gift basket from Bath & Body Works for $37.45 and a baby doll for $10.00 from Target for Resident #7. Staff B indicated that after reporting the money missing he/she repaid the facility $100.00 to return to the resident's account and	F 224		

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F 224	Continued From page 22 sold the basket to a co-worker and returned the doll to Target for in-store credit. c). In an interview conducted on 1/27/10 at 10:04 a.m. with a family member of Resident #7. The family member stated that he/she knows that the resident did not authorize the facility to spend his/her money because he/she is not mentally capable and did not understand financial matters. 7). A document labeled Resident Voucher dated 12/10/09 contained Resident #5's name, withdrawal amount listed as $38.00, purpose listed as Christmas, Resident #5's signature, and a witness signature line signed by Staff B. a).Clinical record review of the MDS dated 7/15/09 for Resident #5 revealed diagnoses that included dementia, renal failure history of skull fracture, seizure disorder, alcoholism and cardiac dysrhythmia. The MDS documented the resident with short and long-term memory loss and moderately impaired cognitive skills for daily decision-making. The MDS documented the resident with the ability to make him/her(self) understood and to understand others. The Care Plan dated 8/6/09 directed staff to allow the resident to make simple decisions and to intervene if there is a safety concern. Resident #5 resided on the CCDI unit. Staff B reported the missing money and repaid the facility $38.00 to return to the resident's account. During an interview with Staff N on 1/14/10 at 10:28 a.m. she explained it was her duty to do resident shopping and it was taught to her as	F 224		

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follows: She would speak to the resident, if cogitatively able to make their own decision about their need or want. Staff N stated she would get a form from the business office which would be filled out with the resident ' s name, the date, the reason for the withdrawal of cash, the resident ' s signature, and then the staff witness signature. Staff N stated she would turn the voucher into the business office and obtain the cash. Staff N stated she would purchase the item, brings it back to the resident, and turn the receipt and change into the Staff D. Staff N stated for example if the resident needed a new television, she would contact the family for consent. Staff N stated if the resident did not have family, the leadership team would discuss the need, if no other payee were in place, then she would obtain a voucher, fill it out and purchase the item and give the receipt to the office. Staff N said this process was explained at admission, along with the intent of the resident trust account that was set up in the business office. Staff N stated that upon admission she tells the family that if it is a small item, for example $60.00 or less of grocery, clothing, or other items will not require family consent but larger purchase would require consideration by family, resident, and staff.

In an interview conducted on 1/28/10 at 11:38 a.m. the Administrator reported that the facility had policies and procedures in place to protect the resident ' s funds in interest bearing accounts.

During additional interview on 2/22/10 at 1:30 p.m., the administrator stated that when he went to get the policies for management of resident funds, he found the facility did not have them in writing. He stated the facility did have practices in place and these are in written form now. The

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F 224	Continued From page 24 resident has the right to deposit funds with the facility per the regulations. The facility would track these funds and deposit any amount of $50 in an interest-bearing account. With withdrawals, the facility would use a witnessed voucher and either a signature or fingerprint validation from the resident. During further interview on 2/23/10 at 3:45 p.m., when asked, the administrator stated it would be a good idea to ask a family member or power of attorney for permission for withdrawals with residents who have cognitive impairment. However, at the time, the facility asked permission on a 'hit and miss' basis. The facility also learned later that family members were not aware of every purchase made on a resident's behalf. The facility failed to follow their own Admission Agreement to maintain the responsibility to obtain consent from the resident ' s family members, or legal representatives prior to removing funds. The facility had not written policy to address resident ' s legal representative or family members consent prior to removing resident(s) funds.	F 224		
F 281 SS=B	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Relates to # 27302-C and # 27309-I: Based on clinical record review, and staff interviews, the facility failed to follow Physician's	F 281		

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F 281	Continued From page 25 orders as written and to accurately transcribe physician's orders to the Medication Administration Record/Treatment Record for 1 of 16 residents reviewed (Residents #14). The facility reported a census of 102 residents. Findings include: 1. A review of the Minimum Data Set (MDS) assessment tool dated 10/02/09 for Resident #14 revealed diagnoses of hypothyroidism, cardiac dysrhythmias, hypertension, hip fracture, osteoporosis, Parkinson's disease and depression. The MDS of 12/27/09 identified the resident with short and long-term memory problems and with moderately impaired decision-making skills. The assessment documented the resident had abrasions, bruises and open lesions other than ulcers, rashes or cuts. The assessment also recorded the resident used an indwelling catheter. A. A review of the Care Plan updated on 1/19/10 indicated the resident at risk for skin breakdown and the areas to the right hip and right ear will show signs of healing. An update on 1/20/10 indicated that the Hospice Enterostomal Therapist (ET skin care nurse) directed staff to leave right hip and right ear wound areas open to air. A review of the Physician's order dated 1/18/10 revealed staff direction not to apply a dressing or creams to the right hip or ear, to leave them open to air and keep pressure off. A review of the Treatment record dated 1/18/10 revealed a directive to leave right hip and right ear open to air and keep pressure off. The nursing	F 281		

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F 281	Continued From page 26 staff failed to accurately transcribe the Physician's order by not including to apply no dressing or creams to right hip or ear as the order stated. During an observation conducted on 2/3/10 at 7:56 a.m. nursing staff applied Extra protective cream to Resident #14's right hip wound area after providing peri-care. In an interview conducted on 2/3/10 at 10:40 a.m. with Staff A, Resident Care Coordinator, stated the nursing staff were educated regarding proper wound care for Resident #14.	F 281		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of clinical records, facility Abuse Protocol review, and staff interviews, the facility failed to report misappropriation of resident property for seven residents to the Department within 24 hours, and failed to identify and separate the alleged perpetrator from the alleged victims for 7 of 7 resident sampled (Resident #1, #2, #3, #4, #5, #6, and #7). The facility reported a census of 102. Findings include: Misappropriation of resident property means the	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 02/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 27 deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. (according to the State Operations Manual 42 CFR 488.301). According to the facility Abuse Program & Prevention Protocol (undated) misappropriation of resident property means the deliberate misplacement, exploitation, wrongful, temporary or permanent use of resident ' s belongings or money without the resident ' s consent. According to the facility Abuse Program & Prevention Protocol (undated) misappropriation of resident property means the deliberate misplacement, exploitation, wrongful, temporary or permanent use of resident ' s belongings or money without the resident ' s consent Under the Responsibility section the form documented the following: the Administrator is responsible for the implementation and overall compliance of the abuse protocols. A review of the facility investigation labeled Possible Missing/Misappropriation of Funds (undated) identified Staff B had consent from the facility to purchase Christmas gifts using the residents' personal funds. The investigation documented " Each resident signed/gave finger print signature for funds from their trust accounts on 12/11/10. " The following amounts were removed by Staff D and given to Staff B as follows: Resident #1 $600.00 Resident #4 $150.00 Resident #2 $150.00 Resident #3 $100.00	F 492		

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F 492	Continued From page 28 Resident #7 $100.00 Resident #6 $75.00 Resident #5 $38.00 In an interview conducted on 1/14/10 at 2:08 p.m. Staff D revealed that on 12/10/09 Staff B obtained signed or finger-printed resident vouchers to remove funds from the residents' personal account. Staff D withdrew $1213.00 on 12/10/09 and gave the money to Staff B on 12/11/09 to go shopping for the residents over the weekend. According to the same investigation report, Staff B completed some of the shopping on 12/14/09, and made some purchase for residents, and then on 12/16/09 the remaining balance of $1213.00 came up missing. The investigation report documented the funds were not located and Staff B was allowed to use her own personal funds to replace the missing money. In an interview conducted on 1/22/10 at 3:12 p.m., Staff B reported that he/she had received $1528.00 600.00 from Staff D on 12/11/09 to purchase Christmas gifts for Residents #1, #2, #3,#4,#5,#6 and #7. On 12/14/09 Staff B had Staff L (RN) lock the residents ' envelopes [with the money and receipts] in the narcotic box in the medication cart on the CCDI unit until 2:30 p.m. when Staff B removed the envelopes and placed them in an unsecure green bag in an unsecure nurse ' s office. Staff B admitted to leaving the residents envelopes unsecured until she noticed the envelopes missing on 12/16/09 at 10:30 a.m. Staff B said that she alerted Staff J and Staff C (DON) that the residents ' money and receipts were missing. Staff B told both Staff J and Staff C (DON) that she thought the amount of money	F 492		

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F 492	Continued From page 29 missing was $500.00. On 12/17/09, Staff B indicated that he/she repaid the facility $1213.00 to return to the seven residents ' account. Staff B then reported that he/she had requested to return the purchased items to recover his/her expense and he/she indicated the Administrator agreed. During an interview with Staff D on 1/14/10 at 2:08 p.m. she stated she told Staff B that 4 residents needed a spend down and to purchase items the residents wanted or needed. Staff D stated that she trained Staff B to have residents sign vouchers to get money out and to turn in receipts with change. Staff D stated Staff B took the resident vouchers around to the seven residents and had them sign or/and fingerprinted for money to be drawn out. Staff D stated [only] Staff B witnessed these residents agreeing to this transaction. Staff B brought these vouchers back to the office and had a separate list of gift ideas she was going to purchase. Staff D stated that she did not question if she [Staff B] had contacted the family members for permission for the residents who could not make their own decisions, because in her experience that was second nature. Staff D stated she then took the vouchers and added up the amount, wrote out a check for cash from trust fund and cashed the check. Staff D stated Staff B requested to pick up the money Friday12/11/09 after her shift because she did not want to lose it and was going to shop for the residents over the weekend. Staff D stated on Wednesday 12/16/09, later that morning Staff B and Staff J (RCC) came to her office and Staff J stated that Staff B lost the money. Staff D stated throughout the day Staff B repeatedly called her or came in the office very anxious and stating that she would replace the	F 492		

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F 492	Continued From page 30	F 492		

money. Staff D stated that at 6:00 p.m. Staff B came back to the facility with Staff M and gave her $1213.00. Staff D stated she told Staff M and Staff B again that night that she would not take any money until she spoke with the Administrator. Staff D stated that Staff C(DON) had been in contact with him and she had contacted a staff at the home office of incident. Staff D stated on Thursday morning, 12/17/09 the Administrator told her he wanted to talk with Staff B before he spoke with her. Staff D stated later that morning she went to the Administrator ' s office while Staff B was still sitting there and the Administrator told Staff D to deposit the money that Staff B brought in to make the residents accounts even and on 12/18/09 she completed this. Staff D stated that as part of the investigation, the Administrator directed her to call all employees that have worked on C hall (CCDI unit) from Monday morning to Wednesday afternoon. Staff D stated she questioned the staff whether they saw an envelope or money and/or if they took or know of anyone who took the money. Staff D stated that Staff A (RCC) was directed to contact the families concerning this matter. Staff D stated that when Staff B gave her two-week noticed, she found this odd. Staff D stated she was a mandatory reporter. Staff D stated that she felt that if the money was even and no evidence of Staff B using the money and therefore nothing to report. Staff D said that she was also directed by the Administrator not to report the incident. Staff D stated she gave Staff B $1528.00 over the weekend, and Staff B spent $251.42 and returned $63.58 leaving a total of $1213.00.

In an interview conducted on 1/28/10 at 11:38 a.m. the Administrator indicated that initially the facility considered Staff B as a "victim" and did

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F 492	Continued From page 31 not make a report to the Department until 12/21/09, 5 days later. The Department contacted the facility on 12/22/09 and asked if the facility had separated Staff B from the residents. The facility had not. After notification from the Department, the facility immediately removed Staff B from the CCDI unit. During further interview on 2/23/10 at 3:45 p.m., the Administrator stated that he became aware of the loss on 12/16/09 via a test message, while away from the facility. He spoke to the Director of Nurses (DON) twice that day and he talked with Staff B at 9 a.m. on 12/17/09. Initially, he thought she lost the money; she was distraught and her version matched the DON's. At 9:30 a.m., Staff B handed him an envelope of cash and told him she know she was responsible for the loss. He re-stated that originally, he felt Staff B had made a mistake and lost the money and she initially seemed credible. He did not separate Staff B from residents during his investigation and did not think abuse occurred. He stated someone from the Department called on 12/22/09 and asked if he had separated Staff B from residents. Staff B did not work that day, so the facility called her at home and took her off the schedule.	F 492		

F000 Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such a submission an admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance. All deficiencies will be corrected by March 8, 2010.

F159

Correct deficiency to individual:

To ensure the safeguard of resident funds with management oversight all monies were returned to each resident's trust account as follows:

Resident #1: $600.00 was replaced on 12/18/09.
Resident #2: $150.00 was replaced on 12/18/09.
Resident #3: $150.00 was replaced on 12/18/09.
Resident #4: $100.00 was replaced on 12/18/09.
Resident #5: $100.00 was replaced on 12/18/09.
Resident #6: $75.00 was replaced on 12/18/09.
Resident #7: $38.00 was replaced on 12/18/09.

Protect residents in similar situations:

The facility does maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each residents personal funds entrusted to the facility on the resident's behalf when the resident or his/her legal representative deposits funds into such account. The facility's resident trust procedures and the delegation of responsibility for the management of personal funds was reviewed, revised, and written on February 3, 2010. Business Office Manager and facility authorized representatives have been educated.

Measure/system to prevent re-occurrence:

Upon admission or any other time during normal business office hours the residents have the right to deposit their money into a resident trust account. The resident will sign a Delegation of Responsibility for the Management of Personal Funds form authorizing the facility to hold monies in a secure account. This form will also identify whether or not the resident is able to manage his/her own personal funds and whether or not notification is needed. Any transactions over $50.00 will necessitate the Business Office or the authorized facility representative to notify the resident's designated representative to determine the best means for providing these monies. The facility will deposit any resident funds above $50.00 in an interest bearing account which is separate from the facilities own funds. Up to $50.00 of resident's funds may be held in a non-interest bearing account/resident trust cash fund in the facility. Anyone may deposit money into the resident's account, but only the resident or the designated resident representative may withdrawal money out. To withdrawal money from the account, the resident and/or the designated resident representative must sign and/or fingerprint a voucher. This voucher must be witnessed and signed by either the Business Office Manager or authorized facility representative.

Monitor permanent solution:

Facility Administrator will conduct random resident trust account audits monthly for the next six months. Results will be brought to the monthly QA&A meeting and discussed for resolution and compliance.

F224

Correct deficiency to individual:

All monies were replaced to each resident's trust account as follows:
Resident #1: $600.00 was replaced on 12/18/09.
Resident #2: $150.00 was replaced on 12/18/09.
Resident #3: $150.00 was replaced on 12/18/09.
Resident #4: $100.00 was replaced on 12/18/09.
Resident #5: $100.00 was replaced on 12/18/09.
Resident #6: $75.00 was replaced on 12/18/09.
Resident #7: $38.00 was replaced on 12/18/09.

Protect residents in similar situations:

The facility develops, implements, and follows written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Facility's Abuse Program Prevention Protocol was reviewed and revised on January 28, 2010. All team members were in-serviced on February 10, 2010 regarding resident rights, facility's Abuse Program Prevention Protocol, and reporting procedure of mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility will continue to in-service all team members regarding the facility's Abuse Program Prevention Protocol annually and as needed. Furthermore, the facility maintains a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each residents personal funds entrusted to the facility on the resident's behalf when the resident or his/her legal representative deposits funds into such account. The facility's resident trust procedures and the delegation of responsibility for the management of personal funds was reviewed, revised, and written on February 3, 2010. Business Office Manager and facility authorized representatives have been educated.

Measures/system to prevent re-occurrence:

To prohibit mistreatment, neglect, and abuse of residents, and misappropriation of resident property upon admission or any other time during normal business office hours the residents have the right to deposit their money into a resident trust account. The resident will sign a Delegation of Responsibility for the Management of Personal Funds form authorizing the facility to hold monies in a secure account. This form will also identify whether or not the resident is able to manage his/her own personal funds and whether or not notification is needed. Any transactions over $50.00 will necessitate the Business Office or the authorized facility representative to notify the resident's designated representative to determine the best means for providing these monies. The facility will deposit any resident funds above $50.00 in an interest bearing account which is separate from the facilities own funds. Up to $50.00 of resident's funds may be held in a non-interest bearing account/resident trust cash fund in the facility. Anyone may deposit money into the resident's account, but only the resident or the designated resident representative may withdrawal money out. To withdrawal money from the account, the resident and/or the designated resident representative must sign and/or fingerprint a voucher. This voucher must be witnessed and signed by either the Business Office Manager or authorized facility representative.

Monitor permanent solution:

Facility Administrator will conduct random resident trust account audits monthly for the next six months. Results will be brought to the monthly QA&A meeting and discussed for resolution and compliance.

F281

Correct deficiency to individual:

Resident #14's physician order from 1/18/10 was clarified with his/her primary physician on February 1, 2010 and transcribed to the Medication Administration Record/Treatment Administration Record.

Protect residents in similar situations:

Facility provided in-service to nursing team members on February 10, 2010 regarding nursing documentation, receiving, transcribing, and following physician orders.

Measure/system to prevent re-occurrence:

DON/designee will review the 24 hour day sheets for each neighborhood daily. The DON/designee will then compare the 24 hour day sheets to the new physician orders to ensure accuracy. The DON/designee will also compare the physician orders to the Medication Administration Record/Treatment Administration Record daily to ensure accurate transcription.

Monitor permanent solution:

The DON/designee will conduct audits of the 24 hour day sheets, physician orders, and the Medication Administration Records/Treatment Administration Records weekly for the next four weeks and quarterly thereafter to ensure accuracy. The results will be brought to the monthly QA&A meeting and discussed for resolution and compliance.

F492

Correct deficiency to individual:

Staff B was separated from Residents #1, #2, #3, #4, #5, #6, and #7 on 12/22/09.

Protect residents in similar situations:

The facility develops, implements, and follows written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Facility's Abuse Program Prevention Protocol was reviewed and revised on January 28, 2010. All team members were in-serviced on February 10, 2010 regarding resident rights, facility's Abuse Program Prevention Protocol, and reporting procedure of mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility will continue to in-service all team members regarding the facility's Abuse Program Prevention Protocol annually and as needed.

Measure/system to prevent re-occurrence:

The facility will investigate all incidents or allegations of mistreatment, neglect, and abuse of residents and misappropriation of resident property. Facility Administrator or designee will be notified when the facility becomes aware of an incident and/or allegation of abuse. Any or all alleged perpetrators will be immediately separated from alleged victims. The Administrator or designee will notify the residents physician and sponsor when there is an allegation of mistreatment, neglect, and abuse of residents and misappropriation of resident property. Facility Administrator or designee will notify local police department if necessary and report to the appropriate State agency within 24 hours of incident and submit investigation results within 5 working days.

Monitor permanent solution:

All investigations of mistreatment, neglect, and abuse of residents and misappropriation of resident property will be reviewed and discussed at monthly QA&A meeting for resolution and compliance.