

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Countryside Manor Health & Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Marine Dr Anderson, IN 46016	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42685</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of misappropriation of resident property for 1 of 3 residents reviewed for misappropriation. (Resident B)</p> <p>Finding includes:</p> <p>Review of a facility investigation, on 9/9/24 at 3:20 p.m., indicated a statement signed on 8/2/24 by the Regional Marketing Consultant of a conversation held with the resident B's Family Member 2. It indicated Family Member 2 reported money was stolen from a plastic envelope out of the resident's purse in her nightstand. The statement lacked information regarding when it was identified missing, to whom it was reported, and who reported it missing prior to 8/2/24. The statement was not signed by Family Member 2. Five staff Abuse Allegation Questionnaires were included, but were not completed by direct staff members who were on duty when the alleged theft was reported. The investigation lacked how much money was reported missing, names or statements from staff who received the initial alleged reports of the resident's missing money on 8/1/24, indication of a timeline of events, nor a summary of the investigation.</p> <p>During an interview on 9/9/24 at 4:02 p.m., the Administrator indicated he was uncertain of the date and times he was notified of the allegation regarding the resident's missing money. He then indicated LPN 3 notified him sometime in the evening of 8/1/24 via telephone that the resident's Family Member 2 reported they could not find a gold envelope containing \$300.00 that was missing from the resident's purse. The Administrator did not have a statement or interview from LPN 3 in the investigation file. He was the one responsible for completing a thorough investigation of the alleged misappropriation. The staff he questioned had never seen the resident with the envelope nor any money in her room. He did not have a statement/interview from Resident B because she was not interviewable. He did not have a statement/interview with the resident's representative because he felt the Regional Marketing Consultant had obtained all the information he would have asked during an interview. The resident's Family Member 2, who reported the misappropriation, was readily available in the building visiting her family member every day. He was unaware of any time frame of how long the money was missing. The Administrator notified the Police Department of the missing money on 8/2/24 and was provided an incident number but was uncertain if they ever came to the facility for a report.</p> <p>During an interview on 9/9/24 at 4:56 p.m., the DON indicated the provided copy of the facility's investigation of Resident B's alleged misappropriation included the entire investigation.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155258
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident B's clinical record was reviewed on 9/10/24 at 12:58 p.m The resident admitted to the facility on [DATE]. Diagnoses included dependence on renal dialysis, unspecified atrial fibrillation, and anxiety.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was cognitively intact. She required moderate assistance with transfers and utilized a motorized wheelchair for mobility.</p> <p>Review of an Inventory of Personal Items, completed on 7/29/24 (14 days after admission), indicated the resident had a purse. The section that indicated to describe all contents in the purse/wallet was left blank.</p> <p>The clinical record lacked indication of the allegation of misappropriation of the resident's money from admission to discharge from the facility.</p> <p>Review of the police report, dated 8/2/24 at 10:54 a.m., provided by the Police Department, indicated the Administrator reported a resident advised him of missing money and did not want a report taken at this time. The amount of money was not included.</p> <p>During an interview on 9/10/24 at 3:06 p.m., LPN 3 indicated she was working on the 300 Unit on days shift on an unknown date when Family Member 2 reported Resident B had missing money in a specified amount. She thought she had made a progress note in the clinical record. LPN 3 was unable to recall how much money Family Member 2 alleged was missing from the shiny envelope that was in the resident's purse in her bottom drawer. The resident had been out of her room a large portion of the day getting her shower, attending activities, and then left for an appointment. Family Member 2 came to the facility before the resident returned from her appointment, but she was uncertain where Family Member 2 had been prior. RN 7, who also worked on the 300 unit that shift, told her she had observed the resident's family member go into the resident's room prior to the resident returning to the facility and reported the missing money. LPN 3 called the Administrator immediately when Family Member 2 reported the missing money. LPN 3 reported the details about alleged misappropriation of money to include the above mentioned details and the amount of money reported missing at the time. The Administrator instructed her to look everywhere for the resident's missing money and leave him a statement so he could do further follow-up. The Administrator did not tell her to get statements from anyone else. She went into the resident's room with the resident and Family Member 2 and the resident told her she usually took her purse with her for appointments, but she left in the facility that day because she was in a rush. LPN 3 was in a conversation with Family Member 3 on the phone while with the resident and Family Member 2 to ask how much money the resident had when Family Member 3 brought the resident money on Monday of that week. Family Member 3 provided a detailed description to LPN 3 of the amount the resident had when he brought the resident additional money and how much total money the resident had when he left the facility. LPN 3 could not recall those specific amounts since it had been quite some time, but it did not align with the amount of money Family Member 2 reported missing. After Family Member 3 discussed the amount of money the resident should have had in her envelope, Family Member 2 changed the amount of money she previously stated was missing. LPN 3 was uncertain if she had provided a statement for the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/10/24 at 4:06 p.m., RN 7 indicated she was uncertain of the date, but she was working the day Resident B's \$300.00 was reported missing by Family Member 2 to another nurse at the nurse station on the 300 Unit. Family Member 2 described the money was in Resident B's purse in the bottom drawer in her room. She had observed Family Member 2 entering Resident B's room twice before the resident returned to her room from an appointment that day. Family Member 2 had also changed her story about the amount of money missing on different times she came to the nurse station. RN 7 had been in the resident's room a couple of times to pick up the resident's meal trays that day because everyone assisted with meal trays throughout the unit. She mentioned this information when the other nurse at the nurse station called and spoke with the Administrator. No one had asked her to provide a statement/interview for an investigation of the alleged misappropriation. She worked on the 300 unit on a regular basis and Resident B nor any of her family members had reported they brought any money to the resident nor asked her to add any money to the resident's Personal Inventory Sheet. The resident's Personal Inventory Sheet lacked any listed money. RN 7 had not seen the resident with any money nor had the resident mentioned having any money with her when she had provided her care. She described Resident B's relationship with her family members tumultuous when they visited.</p> <p>During a telephone interview on 9/10/24 at 4:33 p.m., the Regional Marketing Consultant indicated Resident B's Family Member 2 was very chatty, so she provided a statement of what she heard Family Member 2 mention. Family Member 2 reported Resident B had money that was missing and there had been a time in the past when Resident B accused Family Member 3 of taking something that showed up later. The Regional Marketing Consultant could not recall any details about how much money was reported missing.</p> <p>During an interview on 9/11/24 at 1:15 p.m., LPN 4 indicated Resident B never mentioned anything in her purse until one day (uncertain of the date) on days shift, while in the resident's room, the resident reported to LPN 4 a gold envelope that contained money was missing from her purse. The resident had not seen anyone take it nor named anyone she thought may have taken it. She did not provide an amount of money that was missing. LPN 4 indicated she called the Administrator and reported the above information the resident reported to her. The Administrator told her he would look into it. LPN 4 could not recall if she was asked to provide a statement, but she would definitely have provided one if Administration requested one. She was uncertain if she had made any documentation in the resident's clinical record of the reported missing money.</p> <p>During an interview on 9/11/24 at 3:40 p.m., the Administrator indicated typically the individual who reported alleged misappropriation and the individual in which they reported to should have been included in an alleged misappropriation facility investigation. He had not requested additional pertinent information from the individual who reported the missing money. An investigation regarding missing money should have included how much money was reported missing. He did not have a reason for omitting staff interviews/statements who were knowledgeable of the situation for a complete and thorough investigation of alleged misappropriation. He followed the facility policy regarding the investigation of alleged misappropriation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, revised 6/4/19, titled Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy, provided by the Administrator on 9/9/24 at 10:55 a.m., indicated the following: .POLICY STATEMENT . It is the policy . to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and misappropriation of their property . No person under employment . shall knowingly: .d. Withhold information from law enforcement or other investigative agencies . III. 1. Preventing resident abuse is a primary concerns for this Community. It is our goal to achieve and maintain an abuse free environment. 2. Our abuse prevention/intervention program includes, but is not limited to, the following: . s. Thoroughly investigating each allegation regardless of source or credibility of information . V. ABUSE INVESTIGATIONS .1. Should an incident or suspected incident of . misappropriation of resident property be reported, the Administrator or designee . will appoint a member of management to investigate the alleged incident while retaining ultimate responsibility for ensuring a timely and thorough investigation .3. The individual conducting the investigation will, at minimum: .c. Interview the person(s) reporting the incident; d. Interview any witnesses or potential witnesses to the incident including staff, residents and visitors; e. Interview the resident (as medically appropriate); .g. Interview staff (on all shifts) who have had contact with the resident before, during, and immediately after the period of the alleged incident; .i. Interview the resident's . family members, and visitors; .l. Review all events leading up to the alleged incident and create a timeline . 6. The following guidelines will be used when conducting interviews: . c. The interview will be documented and, as appropriate, followed up with a written statement from the individual interviewed . 9. The known facts of each situation will be considered objectively in making decisions that best protect the residents and ensure ongoing Community operations . 12. The results of the investigation will be recorded and kept in a file for review</p> <p>This citation relates to Complaints IN00440157.</p> <p>3.1-28(d)</p>		