STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenawee Medical Care Facility	200 Sand Creek Hwy Adrian, MI 49221

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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 This citation pertains to Intake # MI00143838 Based on observation, interview, and record review, the facility failed to protect resident property in 1 of 3 residents reviewed for misappropriation of property (Resident #2), resulting in feelings of sadness and potential mistrust. Findings include: Resident #2 (R2) Review of the Face Sheet revealed that Resident #2 (R2) was admitted to the facility on [DATE] with diagnoses including Parkinson's, atrial fibrillation, and anxiety. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/24 showed that R2 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitive intactness. On 7/31/24 at 11:29 AM, R2 was observed in her room speaking with a family member (FM) R. R2 was well-groomed, seated in a recliner, and was easily conversant. Numerous photographs and colored pictures were observed on R2's wall. R2 explained that she had a favorite aide (certified nursing assistant) who colored pictures for her. However, another aide had entered R2's room one day, removed the colored pictures from her wall, and discarded them without R2's permission. R2 stated that this incident upset her, as she did not understand why it had happened. The colored pictures were replaced with new ones shortly afterward, and the aide responsible for removing and discarding the originals was terminated. During the same interview, FM R mentioned that R2 had an aide identified as CNA F whom she greatly valued. CNA F had colored pictures for R2 and displayed them on R2's wall at her request. FM R noted that there appeared to be competition between two CNAs working on the hall, which may have been a reason why CNA G removed the colored pictures from R2's wall when R2 was not present and without her permission. A review of the Facility Reported Incident investigation revealed that on 4/3/24, CNA F asked Social Worker (SW) K if she had seen the colored pictures on R2's wall. CNA F stated that the pictures had been removed from R2's room. The facility reviewed camera footage and discovered that CNA G had entered R2's room when she was absent and discarded the pictures in the community trash room. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation summary indicated that R2 noticed the colored pictures were missing upon returning to her room from an activity. R2 was upset and tearful at the discovery. A family member followed up with SW K about the concern, reporting that three pictures/drawings were removed from [R2's] room today . when [R2] returned, she noticed right away that the pictures/drawings were missing. Video footage revealed that CNA G exited R2's room with a crumpled piece of paper in her hand, entered the community trash room, and exited with no contents in her hand. During an interview, CNA G admitted to removing and discarding the pictures from R2's room. In a telephone interview on 8/1/23 at 10:32 AM, CNA F reported that she would sit and color with R2. CNA F displayed the pictures on R2's wall at R2's request. CNA F noted that other staff members reported that R2 would often look at the pictures, read CNA F's name written at the bottom of the pictures, and then call out for CNA F at all hours. In a telephone interview on 8/1/24 at 2:38 PM, CNA G reported that she removed and discarded the colored pictures from R2's wall because she believed the pictures caused R2 distress. CNA G claimed that R2 would read the name at the bottom of the pictures and call out for CNA F, which CNA G felt was disruptive. In an interview on 8/1/24 at 12:36 PM, Social Worker K stated that she was informed about the pictures being removed from R2's room and reported the incident to Nursing Home Administrator (NHA) A. SW K discussed the matter with R2's family, the facility reviewed the video footage, and confirmed the concern. SW K expressed that the removal of the pictures upset R2. In an interview on 8/1/24 at 3:58 PM, NHA A reported that the facility investigated the concern and confirmed that CNA G had removed and discarded the colored pictures from R2's room. The facility substantiated the misappropriation and CNA G was terminated.