STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fenton Healthcare	512 Beach St Fenton, MI 48430

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(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** 37668 This Citation Pertains to Intake Number MI00148563. Based on interview and record review, the facility failed to protect the resident's right to be free from misappropriation of property by facility staff for one resident (Resident #701) of three residents reviewed. Findings include: Review of Facility Reported Incident (FRI) intake documentation dated as initially received on [DATE] revealed the facility was notified on [DATE] at approximately 1:40 PM by Family Member Witness D of fraudulent charges on Resident #701's credit card. The facility submitted documentation detailing that the allegation was substantiated by the facility. An interview was completed with the facility Administrator on [DATE] at 9:30 AM. When asked if they had substantiated the allegations in the FRI involving Resident #701, the Administrator replied, Yes. The Administrator was asked what happened and verbalized that Resident #701's family member came to their office and informed them there was some unusual activity on Resident #701's card and that they had canceled the card. The Administrator stated, There was one staff member whose answers did not add up during their investigation. The Administrator was asked who the staff member was and stated, (Certified Nursing Assistant [CNA] B). When queried what did not add up in what CNA B said, the Administrator replied, There were discrepancies in their story. With further inquiry, the Administrator revealed CNA B no longer worked at the facility. The Administrator stated, (CNA B) would not come back in (to the facility) for a follow-up in person interview but told Human Resources (HR) they did it and resigned. When queried regarding CNA B's work history, the Administrator revealed CNA B had worked at the facility for six years and did not have any prior any performance issues. Record review revealed Resident #701 was admitted to the facility on [DATE] with diagnoses which included cerebral infarct (stroke) with resulting speech and language deficits, depression, diabetes mellitus, and Congestive Heart Failure (CHF). A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required set-up to moderate assistance to complete all Activities of Daily Living (ADL) with the exception of eating. A review of facility provided investigation documentation revealed the following: (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident, Family, Employee, and Visitor Assistance Form . (Family Member D) . What is your concern about? Identified 'fraudulent' transactions on credit card and credit card is missing . When did the problem or incident occur? [DATE] and [DATE] . Who else knows about the problem or incident? No one- the bank . How can we address your issues? 'Just thought you should know.' Facility Response: Concern form initiated; Investigation initiated per facility protocol; Family states all charges were covered by the bank. Action to be Taken: Police notified on [DATE]; Concern identified- Permanently resolved; Continue routine quality rounds/education and monitoring . The form was signed by the Administrator on [DATE] and Family Member D on [DATE]. - CNA B's Workforce Background Check and hire information from 2018. - Chase Bank Transaction Statement detailing the following: Card Purchase on ,d+[DATE] at Halo Burger in [NAME] MI for $14.49 Card Purchase on ,d+[DATE] at [NAME] Ecorse MI for $2.10 Card Purchase on ,d+[DATE] at Vg's Food Center in [NAME] MI for $31.14 Card Purchase on ,d+[DATE] at Speedway in [NAME] MI for $7.35 Card Purchase on ,d+[DATE] at Speedway in [NAME] MI for $52.89 Card Purchase on ,d+[DATE] at Tips & Toes Nails in [NAME] MI for $53.50 Card Purchase on ,d+[DATE] at Panda Express in [NAME] MI for $17.75 - Incident and Accident Investigation Form . Date: [DATE] . 1:40 PM . Location: Unknown . Employee Involved in Incident: (CNA B) . Brief Description: Resident's brother stated 'fraudulent' transactions occurred on cred card- credit card is missing . (Witness D) notified (Administrator) . Investigation . Was the guest/resident . involved in the alleged incident questioned? Yes . [DATE] 11:00 AM . (Resident #701) . Conclusion . Concern seems to be substantiated. Suspect identified and no longer employed. Completed review of others that may be at risk: Yes . - Quality Assurance Interview Summary . Guest/Resident: (Resident #701) . Date of Interview: [DATE] . Not aware of wallet, could not recall last used credit card. No concerns didn't see anyone removing it. Not are of unauthorized transactions confirmed (Witness D) handles all of finances/card handling Name of Staff Member Interviewed: (Licensed Practical Nurse [LPN] C) . Date of Interview: [DATE] . I remember when (Resident #701) was admitted . (Resident #701's family) had called a few times regarding their cell phone. I did go thru their bag to look for the phone, but I never seen a wallet. (Resident #701) never mentioned a wallet and I never seen them with one. (Resident #701) wasn't even aware they had a phone . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Name of Staff Member Interviewed: (LPN G) . Date of Interview: [DATE] . Was the admitting nurse for (Resident #701) on [DATE]. Was her on [DATE]. Never saw a wallet or credit card at the resident's bedside . Name of Staff Member Interviewed: (CNA J) . Date of Interview: [DATE] . Assigned CNA for (Resident #701) [DATE]. Didn't recall seeing a wallet when in resident's room. Never saw a credit card. Had they observed a credit card, the nurse would've been notified. Not aware of any concerns involving resident's possessions including credit cards . Name of Staff Member Interviewed: (CNA B) . Date of Interview: [DATE], [DATE] . [DATE]: Never observed a wallet or credit card. Not aware of the location. [DATE]: Declined to come in for a follow-up interview. - Investigation Summary/Actions Taken: (Resident #701) was originally admitted on [DATE] . transferred from the hospital via ambulance . The resident is cognitively impaired and uses a wheelchair for locomotion. On [DATE] at approximately 1:40 PM, (Witness B) notified the Administrator that they became aware of fraudulent transactions using (Resident #701's) credit card on Monday, [DATE]. (Witness D) stated that two of the transactions were in [NAME] which made them think that the card was possibly taken from [NAME] Healthcare and used in the area . (Witness D) stated immediately contacted Chase Bank who deactivated the card and has since applied credit for the charges. (Witness D) stated that the transactions appear to have occurred on Saturday, [DATE] and Sunday, [DATE]. All of the charges have been reversed by the bank, and (Resident #701) has recovered all of the funds . (Witness D) stated they came to the facility on Monday, [DATE] and observed that the resident's wallet was in a drawer next to their bed. According to (Witness D), the wallet did not have the credit card in it. According to (Witness D) the wallet had a $5.00 bill, Driver's License, Social Security Card and a Credit Union card. The last time that that (missing) credit card was physically used was on [DATE] for an ATM transaction. The resident was interviewed, (Resident #701) was unable to recall the last time the card was used and was not aware that it was missing. (Witness D) handles all of (the Resident's) finances. (Resident #701) was unaware any of the charges that (Witness D) was referring to . expressed no concerns regarding anyone's handling of belongings, and didn't seem aware. The resident's roommate is not interview-able. Facility staff interviews were initiated . (LPN G) was the assigned to the resident on the following shift from admission, and multiple times since . stated observed very little belongings, and never observed a wallet, however had no reason to go into (Resident #701's) bedside dresser. (CNA B) was scheduled to work Friday ,d+[DATE], Saturday ,d+[DATE], and Sunday ,d+[DATE], (CNA B) worked the afternoon shift and was not assigned to the resident. (CNA B) was initially interviewed on [DATE] and stated they never saw a wallet, was not aware of a wallet or a credit card. (CNA B) said they observed the family with a wallet sometime on Saturday and thought they took it home. According to the family and the nurse, the wallet was taken home on Monday. A follow-up interview was attempted to be scheduled on [DATE], due to discrepancies in the initial statement on [DATE], as well as a discussion that the employee had when they called Human Resources (HR), after the initial interview. (HR Coordinator E) stated that (CNA B) had called and inquired about what would happen if someone used a resident's debit card, and what should they do if they had taken one. Human resources thought the call was unusual and reported the conversation to the Administrator. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator contacted (CNA B) via phone on [DATE] after (CNA B) called in for their scheduled shift that day, the employee stated was unable to come in for a follow-up discussion, the employee was suspended pending investigation at that time. Immediately after the call was ended with the Administrator the (CNA B) called (HR Coordinator E) and stated they resigned immediately, that they messed up, that they did it and didn't know what they were thinking. The Administrator attempted to reach the (CNA B) after the call, but there was no answer. The Administrator attempted to reach the City of [NAME] Police on [DATE] and on [DATE] with the updated information. Current interview-able residents were queried regarding any concerns with missing items, no concerns were identified. In conclusion, the allegation was substantiated. The resident has recovered all of the money for the unauthorized transactions. (CNA B) is no longer employed . The investigation documentation was reviewed with the Administrator on [DATE] at 11:00 AM. When queried regarding the location of the purchases and the facility, the Administrator revealed Halo Burger and VG's grocery store are approximately two miles from the facility. Review of CNA B address during their employment at the facility revealed the purchases completed in [NAME] were near and/or within a reasonable distance between the facility and CNA B's address. CNA B's time clock punch documentation for [DATE] to termination of employment was requested at this time. On [DATE] at 11:10 AM, a phone interview was attempted to be completed with CNA B. The phone number provided was disconnected/out of service. An interview was completed with Family Member Witness D on [DATE] at 11:29 AM. When queried regarding Resident #701, Witness D disclosed they live in Florida and stated, Since (Resident #87) had a stroke, I do their financial's as numbers confuse (Resident #701) now. Witness D revealed the Resident has two bank accounts and stated, After I pay (Resident #701's) bills, I would put the extra money in the Chase account and (Resident #701) could go to the Chase bank and take money out. Witness D stated, (Resident #701) only took out a lump sum out of the ATM and there would be $50 or $60 bucks left in the account. Witness D revealed Resident #701 was hospitalized prior to going to the facility and stated, When (Resident #701) was in the hospital, I kept putting money in (Chase account) and there was $300 or $400 in there. When queried regarding the fraudulent charges on Resident #701's card, Witness D stated, (Resident #701) went to (the facility) after the hospital. I went to see (the Resident) Monday morning and as I pulled in the driveway, my phone was going off like crazy. All the charges from the weekend dropped then. Witness D was asked what they meant and revealed they were on the Chase account with Resident #701 and had text alerts set up so they would know when money was withdrawn from the account. Witness D explained that any charges or withdrawals made from the account over the weekend, or when the bank was closed, did not drop or show on the account until Monday or when the bank reopened. Witness D stated the alerts were all for Point of sale charges (use of a credit or debit card to pay for goods) and stated, (Resident #701) never did a point of sale charge. Witness D reiterated Resident #701 only used the card to withdrawal cash. Witness D then stated, The charges were all in [NAME] and [NAME] and revealed Resident #701 lived and was in the hospital in Garden City (approximately one hour from the facility). Witness D continued, I happened to be in the parking lot of the facility when they received the bank notifications of the changes. Witness D stated, I went in and asked (Resident #701) where their wallet was, and the Chase card was missing. When asked where the Resident's wallet was, Witness D replied, In the top drawer. Witness D stated, I took (Resident #701's) wallet right then and took it home. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked what happened, Witness D revealed they contacted the bank, canceled the card, and the bank reimbursed the account. Witness D stated, I told the Administrator on Monday or the following or next day. Witness D revealed they told the admin I think they have a problem because of the card being missing and where the charges were made. When asked what the Administrators response was, Witness D stated, The Administrator suggested I complete a police report. When asked, Witness D revealed they did file a police report. When queried what transpired following the police report, Witness D stated, Probably a week later the Administrator told me they found out who they thought it was, and they were no longer a concern. Witness D was asked the name of Police Officer who they spoke to and revealed they were unsure but that it was the City Police Department. When asked about the charges on Resident #701's card, Witness D emailed a copy of the bank account statement dated [DATE] through [DATE] with the fraud charges highlighted. When queried how Resident #701 responded to their card being stolen and the fraudulent charges, Witness D verbalized the Resident did not know until they were told. Witness D further stated the Resident was upset and becomes easily confused. Witness D verbalized they would prefer Resident #701 was not asked about the card because they focus on it. At 12:13 PM on [DATE], the City Police Department was contacted. When queried regarding the report involving Resident #701, the dispatcher revealed the Officer who responded to the incident was Officer I. A voicemail message with return phone was left at this time. Review of Resident #701's Electronic Medical Record (EMR) revealed the following: - [DATE] at 2:03 AM: Nursing Summary . Arrived via EMS . A&O x 3 (Alert and Orientated to person, place, and time) . BLE (Bilateral Lower Extremity) weakness x 1 person transfers. Incontinent B&B (Bowel and Bladder) . - [DATE] at 2:03 AM: Admission Nursing Comprehensive Evaluation . Most Recent Admission: [DATE] 22:36 (10:36 PM) . admitted From . hospital . Mode of Transport . EMS . Reason for Admission: Needs assistance with ADL's . The Assessment was completed by Licensed Practical Nurse (LPN) C. On [DATE] at 2:10 PM, Resident #701 was observed in a wheelchair. An interview was completed at this time. When asked how they were doing, Resident #701 become tearful with visible tears. Resident #701 was asked what was wrong but did not provide a response. After Resident #701 stopped crying, they were asked if any of their personal items were lost or missing while at the facility and responded, My clothes. When asked how long their clothes had been missing, Resident #701 replied, Awhile. Resident #701 was asked what clothes were missing and indicated they did not know. The Resident was confused and unable to provide meaningful responses to questions. An interview was completed with CNA F on [DATE] at 2:25 PM. When queried regarding Resident #701 becoming tearful and crying, CNA F revealed the Resident frequently cries for no obvious known reason. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) G on [DATE] at 2:35 PM. When queried regarding Resident #701 becoming tearful and crying when asked how they were doing, LPN G revealed it is normal for the Resident to be emotional. LPN G revealed the Resident was recently started on medication which had improved their emotional liability. When queried regarding the Resident's confusion, LPN G stated, (Resident #701) has been (confused) since they came to the the facility. When asked if they recalled and had worked with CNA B, LPN G verbalized they did and had. When asked if they had ever observed CNA B remove any personal items from a resident's room, LPN G replied they never seen (CNA B) take anything. When queried if Residents have a locked drawer and/or area in their room to secure personal items, LPN G replied, They do but have to ask about them. When asked what the process is when a resident arrives to the facility with money and/or debit/credit cards, LPN G replied, If we notice during admission then take and lock up for family to pick up. LPN G was then queried regarding the facility process/procedure pertaining to inventory of resident personal items upon admission to the facility and stated, We usually look through their stuff in front of them (resident) and another nurse and then we document everything on an inventory sheet. On [DATE] at 2:50 PM, an interview was completed with Unit Manager LPN H. When queried if they were aware of any concerns with missing resident items including Resident #701's debit/credit card, LPN H responded they were Not aware of any concerns. When asked what staff are supposed to do regarding inventory of resident personal items upon admission to the facility, LPN H stated, We have the CNA's go through their (resident) stuff and then they mark it (on inventory sheet). The CNA's let the nurse know if there is anything of value. When asked who signs the inventory form, LPN H revealed the resident's assigned nurse signs the form. When queried if the CNA signs the form, as they are completing the form, LPN H revealed they did not think the CNA signed. When queried why the nurse signs the form, if they are not actually completing the inventory, LPN H did not provide an explanation. Review of CNA B's Timecard for Terminated Employee Report for [DATE] to [DATE] revealed CNA B worked the following dates and times: - [DATE] from 3:10 PM to 11:02 PM - [DATE] from 3:15 PM to 11:01 PM - [DATE] from 11:13 AM to 11:01 PM - [DATE] from 2:56 PM to 6:04 AM - [DATE] from 3:16 PM to 11:01 PM - [DATE] from 2:59 PM to 10:08 PM - [DATE] from 2:51 PM to 9:05 PM - [DATE] from 3:19 PM to 9:09 PM The timecard specified CNA B was a Call Off 3 PM - 11 PM on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the facility Administrator on [DATE] at 3:00 PM. When queried if they interviewed all staff who worked from when Resident #701 was admitted to when the card was used, the Administrator verbalized they did not because they identified who had taken the card and did not feel it was necessary. When queried if they spoke to/interviewed housekeeping staff, the Administrator stated they did not. CNA B's timecard was reviewed with the Administrator at this time. When asked, the Administrator confirmed CNA B's last worked shift was on [DATE]. An interview was conducted with HR Coordinator E on [DATE] at 3:52 PM. When queried if they recalled CNA B, HR Coordinator E confirmed they did. When asked if they recalled speaking to CNA B regarding their employment suspension, HR Coordinator E confirmed they did. HR Coordinator E stated, (The Administrator) and I were in their office, and we talked to (CNA B) about their suspension then via phone. When queried how the conversation went, HR Coordinator E stated, It was odd. (CNA B) was like okay and matter of fact about it. For (CNA B) it was to calm and to quick. When asked, HR Coordinator E revealed it was abnormal for CNA B to not be more boisterous and verbal. HR Coordinator E then stated, After we just hung up from talking to (CNA B), I got a phone call from them. I didn't have my phone on me, but I felt it on my I-watch. HR Coordinator E revealed they called CNA B back when they got their phone. When asked what CNA B said when they called then back, HR Coordinator E stated, (CNA B) said I quit I did it I f-ed up. When asked if they asked CNA B anything after they said that HR Coordinator E replied, (CNA B) said something about they would pay it back and I told her someone would get back to them in the near future. HR Coordinator E stated, We really didn't speak on the phone that long. When asked if CNA B was admitting to taking Resident #701's credit/debit card and were saying they would pay the Resident back, HR Coordinator E replied, That was my understanding. When queried if CNA B had any prior similar issues during their employment, HR Coordinator E replied, No, not that I am aware of. When queried if CNA B had said anything else to them regarding Resident #701's debit/credit card, HR Coordinator E stated, The day before, at the end of day, (CNA B) had been in my office. (CNA B) was saying stuff about what if somebody did that (took a Resident's credit/debit card) and I told them that if somebody did that they should talk to (the Administrator). (CNA B) called later and said if I knew who that person was what should they do, and I said do you know who did it. (CNA B) said yeah and I said you should tell to talk to (the Administrator). An interview was completed with LPN C on [DATE] at 4:40 PM. When queried regarding Resident #701's admission, LPN C verbalized they recalled the admission. When asked what occurred, LPN C stated, The family called and said they were trying to reach (Resident #701) on their cell phone. We were looking for it in some bags (the Resident) had and couldn't find it. When queried what the Resident brought with them, LPN C replied, Had clothes and a blanket. When asked if the Resident had a wallet with them, LPN C responded they did not see a wallet. When asked if they looked in the Resident's bedside dresser drawers, LPN C stated, No. LPN C was asked about Resident #701's cognitive status and stated, Pretty confused. Still pretty confused at times. When queried if they recalled working with CNA B, LPN C indicated they did and stated, (CNA B) died today. LPN C then stated, I don't know nothing about no debit card. When asked why they said that LPN C revealed they heard rumors and did not want to answer questions related to CNA B. Further review of Resident #701's EMR revealed an Inventory of Personal Effects which specified the Resident had 1 Nightgowns/pajamas and 1 cell phone, purple case with charger. The form was signed under On Admission on [DATE] but the signature was illegible. The section for Resident/Resident Representative Signature section on admission was blank. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA N on [DATE] at 9:50 AM. When queried regarding Resident #701, CNA N confirmed they knew the Resident. When asked if they had completed and/or assisted with completing the Resident's inventory sheet when they were admitted in November, CNA N replied, Never done them on third shift. CNA N was asked to clarify and verbalized they worked third shift and had not assisted with and/or completed an inventory sheet. When asked if they recalled if Resident #701 had a wallet and/or purse when they were admitted , CNA N stated, I don't remember because I don't go in (Resident #701's) drawers for nothing. On [DATE] at 9:55 AM, an interview was completed with CNA L. When queried regarding procedure for completion of resident inventory upon admission, CNA L stated, I try not to do that, I don't like going through peoples stuff. When queried regarding if they recalled completing Resident #701's inventory when they worked the day shift on [DATE], CNA L replied, I didn't touch any of (Resident #701's) stuff. When asked if they recalled seeing a wallet or debit card in the Resident's room, CNA L stated, No, but I heard that (CNA B) took a resident's debit card and got their nails done. When asked, CNA L was unable to provide any additional information pertaining to the incident. An interview was completed with CNA M on [DATE] at 9:59 AM. When queried if they recalled completing Resident #701's inventory, CNA M revealed they did not recall. When asked if they remembered if the Resident had a wallet or a purse, CNA M stated, I don't know. CNA M was asked if Resident #701 was a two person assist and replied, I don't even remember. When queried if they worked with CNA B, CNA M confirmed they did. When queried if CNA B had taken any of Resident #701's personal belongings, CNA M revealed they heard CNA B took Resident #701's debit card. CNA M then stated, I don't know if (Resident #701) had a purse or wallet or anything. When asked why they said that CNA M stated, (Witness D) came in and said they were getting notifications. (Witness D) told us. When asked who they meant when they told us, CNA M revealed Witness D informed CNA B and themselves in the facility. A second interview was completed with Witness D on [DATE] at 10:11 AM. When asked where they last saw Resident #701's wallet/purse, Witness D stated, (Resident #701) had their wallet with them at the hospital and then the ambulance took them from the hospital to the facility. Witness D verbalized they drove to Michigan on the 14th and 15th. When queried regarding the location of Resident #701's wallet during the EMS transfer from the hospital to the facility, Witness D stated, (Resident #701) would have carried it with them. Witness D reiterated they started to get alerts on their phone related to the fraudulent charges on the card when they pulled into facility parking lot to visit the Resident. Witness D restated that they went to the Resident's room and located the wallet in the Resident's drawer. When asked what drawer, Witness D revealed it was the dresser near the bed with two drawers. Witness D stated, It (wallet) had their Medicaid and Medicare card in it. When queried if any other family members could have brought the wallet to the facility after the Resident was admitted or is another family member/friend could have visited, Witness D responded, No and revealed the Resident's other sibling was in Florida during the timeframe and no one else would have visited. Witness D indicated they considered the possibility of someone not from the facility taking the card, but it was illogical due to the location of the hospital, EMS service, and the card charges. Witness D stated, (Resident #701) had it with them and I took it with me. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fenton Healthcare	512 Beach St Fenton, MI 48430

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(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	When queried if they were aware that the Resident's wallet and cards were not included on the initial Inventory list form, Witness D replied, They were missing multiple things on the inventory. They were missing (Resident #701's) hearing aids too and they were there with (Resident #701) when they came. Witness D was asked what happened with the hearing aids and stated, They were [NAME] (Missing In Action) until my spouse found them. They were in a cloth bag that (Resident #701) brought with them from the hospital. When queried what kind of bag, Witness D stated, Like a carry-on (bag). The wallet could have been in there originally. The staff didn't have that (bag) on their inventory either. Review of Unit Manager LPN H timekeeping clock in/out report revealed LPN H worked from 7:48 AM to 5:23 PM on [DATE] and from 6:21 AM to 4:26 PM on [DATE]. An interview was completed with the Director of Nursing (DON) and Administrator on [DATE] at 11:26 AM. The DON was asked if they were involved in the investigation involving Resident #701's debit/credit card, the DON specified they were not involved in the investigation. When queried regarding the misappropriation of Resident #701's debit/credit card and fraudulent charges while at the facility, the Administrator stated, There is no harm as the bank refunded the Resident's money and the facility did everything they were supposed to. The Administrator was then asked if the misappropriation occurred and replied they were unable to confirm CNA B took Resident #701's card. When queried regarding CNA B telling HR Coordinator E they took the card and would pay it back, the Administrator stated they were unaware CNA B had told HR Coordinator E they would pay back the charges. The Administrator was asked why they substantiated their investigation but did not provide additional explanation. The Administrator [TRUNCATED]