STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255290	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Nursing Center	1500 Broad Avenue Gulfport, MS 39501

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. 42807 Based on interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from misappropriation when facility staff used a resident's credit card to purchase goods or services without the consent or authorization of the resident for one (1) of five (5) sampled residents, Resident #1. Based on the facility's implementation of corrective actions, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) as of 6/29/24, prior to the SA's entrance on 8/19/24. Findings Include: A review of the facility's policy, Abuse Neglect and Exploitation, dated 10/01/22, revealed that .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent .exploitation of resident property . Definitions .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 . Prevention of Abuse Neglect and Exploitation .The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves . addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors . A record review of the Facility Investigation Summary revealed that Registered Nurse (RN) #1 and the Administrator received a report from the RR for Resident #1 on 6/24/24 that there were suspicious charges on the resident's credit card statements. The Administrator obtained the credit card from the resident and locked it up securely. The Administrator reviewed the resident's credit card statements with the Resident and her RR and determined that there were $330.10 in suspicious charges to a local spa, nail salon, and restaurants. Detective #1 with the local police department responded on 7/25/24 and notified the Administrator that Certified Nursing Assistant (CNA) #1 had been arrested and that subpoenaed information on the CNA's personal cell phone revealed that she had a photograph of the resident's credit card saved on the phone. The Summary included reimbursement of all monies fraudulently charged on Resident #1's credit card. A record review of the Admission Record for Resident #1 revealed that the facility admitted the resident on 2/28/24, and she had current diagnoses including Diabetes and Atrial Fibrillation. (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Quarterly Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 7/22/24 revealed a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated no cognitive impairment. A record review of the personnel file for CNA #1 revealed the CNA was hired at the facility on 4/22/24, and her employment at the facility was terminated on 6/21/24, three (3) days prior to the discovery of suspicious charges on Resident #1's credit card. CNA #1's personnel file included no disciplinary actions prior to the termination of employment effective on 6/21/24, documentation of a background record found no violations that prevented her from working with residents served by a nursing home, and an Orientation Checklist dated 4/22/24 signed by the CNA, indicating that she had received information that included Resident Rights and Abuse, Neglect, and Exploitation Prevention and Protection and acknowledged complete understanding and agreement to comply accordingly. A record review of Historical Employee Clocking and Schedules from 4/17/24 to 8/19/24 for CNA #1 revealed that 6/05/24 was the last day the CNA clocked in for duty at the facility. On 8/19/24 at 10:00 AM, during an interview, Resident #1 revealed that her son (and RR) was her power of attorney and received and paid her bills. She said that she was shocked to find that her credit card had charges at a local spa, nail salon, and restaurants in May 2024. She said, It never dawned on me that anyone would do such a thing. She said that she never gave her card to anyone and always kept it in her purse in her room. She reported that she watched a home shopping channel on television and used the card for purchases from the program. She said that she had not been to a spa, nail salon, or out to any restaurants in May 2024. She said she had not given her card to anyone to use for any purpose. She said she remembered CNA #1 and had thought that she was a sweet girl. She reported that she never had any suspicion that her credit card had been compromised, photographed, or used without her authorization. Regarding the response of the facility, Resident #1 stated, I feel like they took care of it correctly. She stated that she had received reimbursement for all unauthorized charges. She denied feeling unsafe at the facility or fear of future misappropriation of property. She said she felt safe at the facility and that her belongings were secure and that everything had been taken care of. On 8/19/24 at 11:42 AM, during a telephone interview, the Resident Representative (RR) for Resident #1 stated that he had notified RN #1 and the Administrator on 6/24/24 after a review of Resident #1's credit card statements for May and June of 2024 revealed suspicious charges. He said he provided copies of the resident's credit card statements, which included charges at a local spa, nail salon, and restaurants during the resident's residence at the facility. He said that the Administrator contacted him on 7/25/24 and reported that CNA #1 had been identified as the person who had used Resident #1's credit card without authorization. He stated that Resident #1 had received restitution for all fraudulent charges. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 12:20 PM, during a telephone interview, Detective #1 confirmed that he had spoken with the Administrator and confirmed that Resident #1 was a vulnerable adult who resided at the facility and that CNA #1 had been employed at the facility in direct care from 4/22/24 through 6/05/24. He confirmed that the Administrator had reported an allegation of misappropriation of resident property on 6/24/24. He explained that the investigation led to the discovery that CNA #1 had pictures of Resident #1's credit card on her personal cell phone. Detective #1 said that CNA #1 had a prior arrest for similar charges involving a vulnerable adult, not a resident at the facility, days before being arrested for making unauthorized charges using Resident #1's credit card. The detective said that no police report was available until the investigation was concluded and that he was still investigating information discovered on CNA #1's cell phone regarding individuals who did not reside at the facility. He said he did not have the arrest date, and no court date had been set at the time of the interview. On 8/20/24 at 3:10 PM, during an interview, the Director of Nurses (DON) stated that the facility had provided in-service training regarding Resident Rights and Abuse, Neglect, and Misappropriation of Property after the event and usually completes this type of in-service at least monthly. The in-service included instructions that residents' belongings be respected and protected and that any allegations or signs/symptoms of abuse, neglect, or misappropriation of resident property be reported immediately to a supervisor, DON, or Administrator. A record review of the Quality Assurance and Improvement (QAPI) Committee Meeting Minutes dated 6/28/24 with attached sign-in sheets revealed that during the meeting attended by the facility Medical Director, Administrator, DON, and Infection Preventionist, the committee reviewed the incident and related policies and procedures and made no recommendations for changes. On 8/20/24 at 3:25 PM, during an interview, the Administrator stated that a mandatory in-service titled Abuse, Neglect and Misappropriation Prevention and Protection was provided by the facility to all facility staff on 6/25/24 and 6/26/24 and was completed on 6/26/24. The notifications were made to the SA, Attorney Generals Office (AGO), and local law enforcement. The Administrator also stated other residents were interviewed to make there were no other victims of misappropriation by CNA #1. On 8/2024, the SA validated through record reviews and interviews that the facility investigated the allegation of misappropriation when it was made by the RR, CNA #1 had voluntarily terminated her employment at the facility prior to the allegation being made, the appropriate agencies were notified timely, in-services were conducted for all staff, and a QAPI was held on 6/28/24 to review the incident. The SA determined that corrective actions were completed on 6/28/24 and the facility was in compliance effective 6/29/24, prior to the SA entrance on 8/19/24.