STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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** 43193 Based on interview and record review, the facility failed to protect all residents from misappropriation of property when one resident's (Resident #1) laptop, that was listed on the resident's inventory of personal effects, could not be located. A sample of four residents was reviewed in the facility with a census of 28. Review of the facility's policy titled Abuse Prohibition Protocol Manual, undated, showed the following: -The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat-the-resident's-medical-symptoms; -Each resident has the right to be free from misappropriation of property and exploitation; -Misappropriation of resident property as defined at 483.5 means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent; -It is the policy of this facility that each resident will be free from abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment or involuntary seclusion. 1. Review of Resident #1's face sheet (a document that gives resident information at a quick glance) showed the following: -admitted [DATE]; -Resident was his/her own responsible party; -Diagnoses included vascular dementia (brain damage caused by multiple strokes), post traumatic stress disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.), and Alzheimer's disease (a progressive and irreversible brain disorder that causes memory loss, confusion, and other cognitive decline). (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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(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	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/01/24, showed the following: -Cognitively intact; -No behaviors; -Required no assistance from staff for activities of daily living (ADL - dressing, eating, bathing, etc.), mobility or transfers except for moderate assistance of one staff to bathe and for shower transfers. Review of the resident's current care plan showed the following: -The resident required minimal to moderate assistance with ADL performance. -Always knock on his/her door before entering and announce yourself. Review of the resident's Inventory of Personal Effects, dated 08/20/24, showed the resident had two laptops. During an interview on 12/20/24, at 9:12 A.M., the resident said the following: -His/her laptop was missing. The laptop and box for the laptop were on the floor of his/her closet with long dresses covering them and both were gone; -He/she did not see who took it; -He/she kept the laptop and box to the laptop on the floor of his/her closet with long dresses covering them. The mouse was on top of them, but they did not take the mouse; -He/she purchased the laptop within the last year and it was on his/her inventory sheet. Review of the facility's undated investigation showed the following: -The resident reported he/she was missing his/her laptop. He/she reported it to the housekeeping supervisor; -He/she reported his/her mouse was sitting on top of his/her laptop in his/her closet in his/her old room; -He/she reported to the Business Office Manager (BOM) that his/her laptop was in his/her new closet under his/her mouse; (continued on next page)

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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 the Administrator went to talk with the resident, the Administrator noted that the resident's laptop was in his/her new room in his/her closet under his/her mouse. The Administrator looked in the resident's closet and noted his/her mouse to be in his/her closet still. The resident had an older laptop next to the closet in a case. The resident noted that was not the laptop he/she was looking for. The resident noted that he/she did not know exactly when it went missing just noted that he/she noted it missing after he/she switched rooms from 200 hall to 300 hall. The resident noted that he/she did not think anyone took it he/she just did not know where it is; -The resident was independent and does not receive much assistance from staff. He/she goes in and out to smoke and mostly lays in his/her room; -Staff tried calling family to see if they had been in. One family member was not able to be reached and another family member lived in a different state; -Reported to state as a self-report; -Will continue to look for laptop. (Staff did not document a report made to law enforcement, staff interviews besides the housekeeping supervisor, resident interviews, or a conclusion.) Review of the Housekeeping Supervisor's written statement, undated, showed when moving the resident from 200 hall to 300 hall, the resident and the Housekeeping Supervisor discovered his/her computer was missing. The resident had no idea how long it had been gone. The Housekeeping Supervisor had his/her old computer in the office and took it to him/her. During an interview on 12/20/24, at 10:36 A.M., the Housekeeping Supervisor said the following: -He/she completed the resident Inventory of Personal Effects when the resident moved to the facility; -The resident had two laptops at that time and one was in a box; -The resident reported one laptop was missing when he/she assisted the resident to move to a new room; -He/she assisted the resident to look for the laptop, but the laptop was not found. During an interview on 12/20/24, at 11:22 A.M., the Business Office Manager (BOM) said the following: -On 12/04/24, the resident told him/her that housekeeping was looking for the resident's laptop; -The resident said he/she noticed the laptop missing after he/she was in his/her new room; -The resident said the laptop made it to the new room with the box it came in and his/her mouse and he/she kept it in the bottom of his/her closet; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The BOM looked in the resident's closet and only saw the mouse; -When the resident was moved to his/her new room on 11/20/24, all of his/her belongings were placed on a dolly in the housekeeping area near the employee lockers. The computer box was on the dolly, but the BOM did not know if the laptop was in the box; -The laptop was not found. During an interview on 12/20/24, at 11:57 A.M., the MDS Coordinator said the following: -The resident reported his/her laptop was gone when he/she moved to a new room on 11/20/24; -Housekeeping said the resident's old laptop was in storage, but the other one was not found. During an interview on 12/20/24, at 12:38 P.M., the Director of Nursing said the following: -The resident had two laptops listed on his/her Inventory of Personal Effects; -The resident's laptop was not found; -The facility planned to reimburse the resident financially or buy the resident a new laptop. During an interview on 12/20/24, at 12:13 P.M., the Administrator said the following: -The resident reported his/her laptop missing around the time of his/her room move on 11/20/24; -The resident's laptop was on his/her Inventory of Personal Effects; -He/she was working on reimbursing the resident for the laptop; -The laptop was not found. MO00246139

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to report an allegation of possible misappropriation to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required twenty-four hour timeframe after facility staff became aware of the allegation of misappropriation of property for one resident (Resident #1). The facility failed to notify local law enforcement of the allegation of misappropriation. A sample of four residents was reviewed in the facility with a census of 28. Review of the facility's undated policy titled Abuse Prohibition Protocol Manual showed the following: -Each resident has the right to be free from misappropriation of property and exploitation; -It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation; -An owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator; -The nursing home administrator or designee will report abuse to the state agency per State and Federal requirements; -All allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown sources and misappropriation of resident property by facility employees, contract employees, volunteers, contract services, consultants, physicians, visitors, family members, or other individuals will be reported immediately but no later than the following timeframes. If abuse is alleged or the allegation results in serious bodily injury, the allegation must be reported within two hours after the allegation was made. If the allegation does not allege abuse or result in serious bodily injury, the report must be made within 24 hours after the allegation was made; -The facility will ensure that all reports are made within two hours (abuse or serious bodily injury) or 24 hours (non-abuse). The two hour timeframe must be met even during the night shift or during the weekend. -The facility will ensure that any reasonable suspicion of crimes committed against a resident of this facility will be reported to the appropriate Law Enforcement Agency as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010. When there is reasonable suspicion that a crime has occurred, then in addition to reporting the allegation of abuse to the State Survey Agency, the incident must be reported to the local law enforcement; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility will adhere to reporting timeframes as outlined for reporting to the State Survey Agency for reporting to law enforcement. When there is reasonable suspicion that a crime has occurred, to include but not limited to: abuse or the crime results in serious bodily injury, the crime must be reported within two hours. If the crime is not abuse or result in serious bodily injury, the report must be made within 24 hours. 1. Review of Resident #1's face sheet (a document that gives resident information at a quick glance) showed the following: -admitted [DATE]; -Resident was his/her own responsible party; -Diagnoses included vascular dementia (brain damage caused by multiple strokes), post traumatic stress disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.), and Alzheimer's disease (a progressive and irreversible brain disorder that causes memory loss, confusion, and other cognitive decline). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/01/24, showed the following: -Cognitively intact; -No behaviors; -Required no assistance from staff for activities of daily living (ADL - dressing, eating, bathing, etc.), mobility or transfers except for moderate assistance of one staff to bathe and for shower transfers. Review of the resident's current care plan showed the following: -The resident required minimal to moderate assistance with ADL performance. -Always knock on his/her door before entering and announce yourself. Review of the resident's Inventory of Personal Effects, dated 08/20/24, showed the resident had two laptops. During an interview on 12/20/24, at 9:12 A.M., the resident said he/she reported his/her missing laptop to staff. During an interview on 12/20/24, at 10:36 A.M., the Housekeeping Supervisor said the following: -The resident reported the missing laptop to him/her when he/she moved the resident to a different room around the middle to end of November 2024; -He/she reported this to the Administrator the same day; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she considered theft of a laptop a crime and should be reported to law enforcement because it was no different than someone breaking into his/her home and stealing items. Review of DHSS records showed the facility reported the allegation of misappropriation on 12/05/24. During an interview on 12/20/24, at 11:22 A.M., the Business Office Manager (BOM) said the following: -On 12/04/24, the resident told him/her that housekeeping was looking for the resident's laptop; -He/she immediately reported this to the Administrator and a corporate staff member told the Administrator to report to DHSS within 24 hours; -He/she reported allegations of misappropriation to the Administrator immediately; -He/she considered misappropriation to be a crime but did not know if staff had to report this to law enforcement. During an interview on 12/20/24, at 11:57 A.M., the MDS Coordinator said the following: -The resident reported his/her laptop missing to the Housekeeping Supervisor when the resident moved to another room on 11/20/24; -The Housekeeping Supervisor said he/she reported it to the Administrator at that time; -He/she knew the Administrator knew about the missing laptop because around Black Friday he/she suggested to the Administrator that would be a good time to get the nurses a new laptop for the nurses' station and to replace the resident's laptop with the sales going on; -When the laptop was brought up again at a later date, he/she found out the Administrator had not reported to DHSS and told the Administrator this should have been reported; -The Administrator should have notified law enforcement, but he/she did not believe the Administrator reported it. During an interview on 12/20/24, at 10:54 A.M., Certified Nursing Assistant (CNA) A said the following: -If a resident reported a missing item, he/she reported to the charge nurse immediately; -The Administrator reported allegations of misappropriation to DHSS within two hours; -He/she considered misappropriation to be a crime and the Administrator should report to the police department. During an interview on 12/20/24, at 11:14 A.M., CNA B said the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she reported allegations of misappropriation to the charge nurse immediately; -The Administrator reported allegations of misappropriation to DHSS within two hours; -He/she considered misappropriation a crime and the Administrator notified law enforcement. During an interview on 12/20/24, at 10:59 A.M., Certified Medication Technician (CMT) C said the following: -If a resident reported a missing item, he/she reported to the charge nurse immediately; -The Administrator reported allegations of misappropriation to DHSS within two hours; -He/she considered misappropriation to be a crime, but did not know if it was reportable to law enforcement. During an interview on 12/20/24, at 11:07 A.M., Registered Nurse (RN) D said the following: -CNAs and CMTs reported allegations of misappropriation to the charge nurse immediately; -The charge nurse reported allegations of misappropriation to the Administrator immediately; -The Administrator reported allegations of misappropriation to DHSS within two hours; -He/she considered misappropriation to be a crime and the Administrator or Director of Nursing (DON) reported this to law enforcement. During an interview on 12/20/24, at 12:38 P.M., the DON said the following: -He/she was notified of the missing laptop on 12/20/24; -The Administrator reported he/she was notified on 12/04/24 and reported to DHSS on 12/05/24; -He/she was told the Housekeeping Supervisor reported to the Administrator on 11/20/24; -The Administrator had not notified law enforcement; -The Administrator should have reported the allegation within 24 hours. During an interview on 12/20/24, at 12:13 P.M., the Administrator said the following: -The resident reported his/her missing laptop around 11/20/24 to the Housekeeping Supervisor; -The Housekeeping Supervisor did not report this to him/her until 12/04/24 and he/she reported this to DHSS on 12/05/24; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did know staff were looking for something before this, but did not follow-up on it and did not ask any specifics. When he/she did not hear anything else, he/she assumed what staff were searching for was found; -He/she did not report the laptop to law enforcement because corporate staff said she did not need to since the resident only reported the laptop missing; -He/she reported the laptop to DHSS because it was on the resident's inventory sheet. -He/she expected staff to report allegations of misappropriation to him/her immediately; -He/she reported to DHSS within 24 hours; -He/she considered misappropriation to be a crime and notified law enforcement and the resident's responsible party within 24 hours. MO00246139

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43193 Based on interview and record review, the facility failed to document a timely and thorough investigation of all allegations of misappropriation when staff failed begin an immediate investigation into one resident's (Resident #1) allegation of misappropriation and failed to document interviews with multiple staff and residents as part of the investigation. A sample of four residents was reviewed in the facility with a census of 28. Review of the facility's policy titled Abuse Prohibition Protocol Manual, undated, showed the following: -It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated; -The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration; -Investigation regarding misappropriation: The facility staff will complete an active search for missing item (s) including documentation of investigation. The investigation will consist of at least the following: a review of the completed complaint report; an interview with the person or persons reporting the incident; interviews with any witnesses to the incident; a review of the resident medical record if indicated; a search of resident room (with resident permission); an interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident; and interview with the resident's roommate, family members, and visitors; -The Administrator will keep the resident or his/her resident representative informed of the progress of the investigation; -The results of the investigation will be recorded and attached to the report; -The Administrator or human resources designee will complete a copy of the investigation materials; -The Administrator or designee will inform the resident and/or his/her representative of the findings of the investigation and corrective action taken. 1. Review of Resident #1's face sheet (a document that gives resident information at a quick glance) showed the following: -admitted [DATE]; -Resident was his/her own responsible party; (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included vascular dementia (brain damage caused by multiple strokes), post traumatic stress disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.), and Alzheimer's disease (a progressive and irreversible brain disorder that causes memory loss, confusion, and other cognitive decline). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/01/24, showed the following: -Cognitively intact; -No behaviors; -Required no assistance from staff for activities of daily living (ADL - dressing, eating, bathing, etc.), mobility or transfers except for moderate assistance of one staff to bathe and for shower transfers. Review of the resident's current care plan showed the following: -The resident required minimal to moderate assistance with ADL performance. -Always knock on his/her door before entering and announce yourself. Review of the resident's Inventory of Personal Effects, dated 08/20/24, showed the resident had two laptops. Review of the facility's undated investigation showed the following: -The resident reported he/she was missing his/her laptop. He/she reported it to the housekeeping supervisor; -He/she reported his/her mouse was sitting on top of his/her laptop in his/her closet in his/her old room; -He/she reported to the Business Office Manager (BOM) that his/her laptop was in his/her new closet under his/her mouse; -When the Administrator went to talk with the resident, the Administrator noted that the resident's laptop was in his/her new room in his/her closet under his/her mouse. The Administrator looked in the resident's closet and noted his/her mouse to be in his/her closet still. The resident had an older laptop next to the closet in a case. The resident noted that was not the laptop he/she was looking for. The resident noted that he/she did not know exactly when it went missing just noted that he/she noted it missing after he/she switched rooms from 200 hall to 300 hall. The resident noted that he/she did not think anyone took it he/she just did not know where it is; -The resident was independent and does not receive much assistance from staff. He/she goes in and out to smoke and mostly lays in his/her room; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff tried calling family to see if they had been in. One family member was not able to be reached and another family member lived in a different state; -Reported to state as a self-report; -Will continue to look for laptop. (Staff did not document a report made to law enforcement, staff interviews besides the housekeeping supervisor, resident interviews, or a conclusion.) During an interview on 12/20/24, at 9:12 A.M., the resident said the following: -He/she had a laptop that was missing; -He/she did not see anyone take the laptop; -The laptop was on the floor of the closet with long dresses covering it; -The box for the laptop was in the closet too and both the box and laptop were gone. The laptop was brand new. He/she purchased the laptop within the last year and it was on his/her inventory sheet; -The staff searched for the laptop; -Staff did not assist him/her to file a police report; -The facility did not reimburse him/her for the expense of the laptop; -The staff had not let him/her know there was any effort to investigate; -The Administrator told him/her that resident's were not allowed to have anything that expensive at the facility. During interviews on 12/20/24, at 10:36 A.M. and 1:06 P.M., the Housekeeping Supervisor said the following: -The resident reported the missing laptop to him/her when he/she moved the resident to a different room around the middle to end of November 2024; -He/she reported this to the Administrator the same day; -He/she looked for the laptop and the laptop was not found; -The resident had two laptops when the resident moved in to the facility; -He/she completed the resident's inventory sheet when the resident moved into the facility; -He/she did not know what the facility planned to do about the laptop; (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The statement he/she wrote for the investigation was written on 12/20/24; -The housekeeping supervisor said the Administrator and Director of Nursing (DON) completed the investigations. During an interview on 12/20/24, at 11:22 A.M., the Business Office Manager (BOM) said the following: -He/she interviewed the resident to determine when the resident noticed the laptop was missing; -He/she searched the resident's room and did not see the laptop or laptop box, but did see the mouse in the bottom of the closet; -He/she attempted to contact the resident's family member but was unable to reach him/her; -The Administrator investigated allegations of misappropriation; -The investigation included interviews with the resident, other residents, and staff. During an interview on 12/20/24, at 10:54 A.M., Certified Nursing Assistant (CNA) A said the Administrator investigated allegations of misappropriation. During an interview on 12/20/24, at 11:14 A.M., CNA B said the following: -The Administrator completed investigations on allegations of misappropriation; -The Administrator should look at the cameras and interview residents and staff. During an interview on 12/20/24, at 10:59 A.M., Certified Medication Technician (CMT) C said the he/she did not know who completed the investigation on allegations of misappropriation but an investigation should be done. During an interview on 12/20/24, at 11:07 A.M., Registered Nurse (RN) D said the charge nurse, DON and Administrator completed investigations on allegations of misappropriation. During an interview on 12/20/24, at 11:57 A.M., the MDS Coordinator said the following: -The Administrator completed the investigations on allegations of misappropriation; -Investigations included the who, what, when and where of the allegation and interviews with residents and staff. During an interview on 12/20/24, at 12:38 P.M., the DON said the following: -Staff called the facility where the resident's old roommate moved to and the laptop was not at that facility; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Administrator started investigations on allegations of misappropriation and had five days to complete the investigation and turn it into DHSS; -Investigations included interviews with the affected resident, other residents and staff; -The completed investigation should include any interviews completed, staff statements, police report if completed, a synopsis of the investigation and the plan to rectify the situation. During an interview on 12/20/24, at 12:13 P.M., the Administrator said the following: -The investigation included the summary, inventory sheet, and statement from the Housekeeping Supervisor; -The BOM interviewed the resident, but he/she did not add that to the investigation; -He/she interviewed the staff, but forgot to add that to the investigation; -There were no cameras in the hallways where the resident resided to review; -Staff searched for the laptop, but did not find it; -He/she and the DON investigated allegations of misappropriation; -Investigations included interview with the resident and staff, review of the resident's inventory sheet and speaking with the resident's family. MO00246139