STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365072	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna Maria of Aurora	889 North Aurora Road Aurora, OH 44202

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** 39969 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on staff interviews, resident interview, review of the facility self-reported incident (SRI), review of the facility investigation, and facility policy and procedure review, the facility failed to ensure misappropriation did not occur for Resident #50. This affected one resident (#50) of four residents reviewed for misappropriation. The facility census was 92. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included major depressive disorder, chronic congestive heart failure, and age-related osteoporosis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had intact cognition, required partial/moderate assistance from staff for transfers, and used a walker for ambulation. Review of the self-reported incident (SRI) tracking number 248730 dated 06/17/24 revealed Resident #50's wallet was found by a housekeeper in the staff restroom on the rehab unit the morning of 06/17/24. The wallet was returned, and the resident reported that a debit card was missing from the wallet. Resident #50 along with the Director of Nursing (DON), called the resident's bank to identify any questionable transactions. The resident identified two transactions, a withdrawal at 6:05 P.M. on 06/16/24 from an ATM at a gas station down the street and another ATM withdrawal at a nearby ATM at 11:18 PM on 06/16/27. The resident then closed the account while on the phone with the bank. Review of the facility's investigation revealed an undated handwritten statement from Housekeeper (HSK) #601 revealed on 06/17/24 she was cleaning the bathroom by the nurse's station in the rehab unit. While bending down to restock the shelf, she noticed it was very dusty. When she took her rag to wipe, her nail caught on something. When she looked to see what it was, she found a wallet. She then took said wallet to the front desk and was not sure who it belonged to. (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	Further review of the facility's investigation revealed a typed statement by the DON dated 06/17/24 revealed a nurse approached her at approximately 8:00 A.M. to let her know that a resident's wallet was found in the staff bathroom on the rehab unit. The DON spoke with Resident #50, who stated that her debit card was missing and that she believed the wallet was last in her purse yesterday, the morning of 06/16/24. In the typed statement, Resident #50 stated the pin code to her debit card was written on a piece of paper in her purse. Resident #50 gave the DON permission to call the bank where they noted transactions on 06/16/24 at 6:05 P.M. for $403.50 at a non-bank ATM. There was also a cash transaction at a bank ATM on 06/16/24 at 11:18 P.M. for $117.00. Resident #50 did not make the transactions as she was in the facility and presumed the fraudulent transactions were from the theft of her debit card. The DON assisted the resident with cancelling her debit card and reporting that her credit card was stolen. The statement also indicated the resident and daughter stated the purse was last seen either on 06/11/24 or 06/13/24. The investigation included a typed timeline based on the review of camera footage throughout the facility showing State tested Nurse Aide (STNA) #507 entered Resident #50's room from 5:33 P.M. to 5:34 P.M. STNA #507 went to the restroom on the rehab unit from 5:46 P.M. to 5:48 P.M. STNA #507 then went into Resident #50's room at 5:48 P.M. to 5:51 P.M. STNA #507 left the facility at 5:57 P.M. STNA #507 pulled out of the parking lot at 5:59 P.M. STNA #507 returned to parking lot at 6:19 P.M. STNA #507 returned to the facility at 6:24 P.M. STNA #507 left facility at 10:56 P.M. to the parking lot. STNA #507 left the parking lot at 11:13 P.M. turning right out of the parking lot. Review of Resident #507's punch detail revealed he last worked on 06/16/24 from 3:23 P.M. to 10:55 P.M. Review of the typed statement for STNA #507 dated 06/18/24 at 12:25 P.M. via phone revealed he worked on 06/16/24 from 3:00 P.M. to 11:00 P.M. on the rehab unit (Resident #50's unit). STNA #507 denied being aware Resident #50 having a purse/wallet in her room or of it going missing. Interview on 07/12/24 at 9:14 A.M. with the Administrator revealed STNA #507 was permanently suspended until final evidence was subpoenaed from the ATM videos. The Administrator stated the police were involved and there was currently an ongoing investigation. The Administrator stated they can't say STNA #507 did it, and he never admitted anything. The Administrator stated they substantiated their investigation because Resident #50's wallet was taken. The Administrator stated they suspect STNA #507 but had no hard evidence. The Administrator stated on the facility's camera footage they were able to see STNA #507 leaving around the time of the withdrawals. Interview on 07/12/24 at 10:17 A.M. with Resident #50 revealed she hated that it happened. Resident #50 stated she had a small wallet that contained her identification card, medical cards, $20 bill, check book, and bank card. Resident #50 stated her purse was in bag wrapped tight, in the drawer, close to her bed. Resident #50 stated she wasn't aware it was missing until one morning a nurse came in with her wallet and stated someone put in the lost and found. Resident #50 stated someone took money from her, but she had talked to a detective who came out. Resident #50 stated as far as she knows they were looking into everything but don't know if they came up with anything. Resident #50 stated she had to cancel the card right away. Resident #50 stated she did not know who could have done it but didn't believe it was someone working at the facility because she felt the staff were excellent. Resident #50 stated she wasn't always in her room and at times she was in therapy or outside with her sister. Resident #50 stated it was kind of scary, and her daughter was upset about the incident. Resident #50 stated she got everything back except her bankcard. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Abuse, Neglect, Misappropriation of Resident Property, Exploitation, and Mistreatment Policy, revised 01/28/17, revealed the facility will not tolerate, abuse, neglect, exploitation, or mistreatment of its residents, or misappropriation of resident property by anyone. It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, exploitation, mistreatment, the misappropriation of resident property and injury of unknown source and report the results of any such investigation as required by law. The deficient practice was corrected on 07/09/24 when the facility implemented the following corrective actions: All staff were educated on Abuse/Neglect/Misappropriation on 06/17/24. Care conference forms with residents and their representatives list under question number three: security measure or intervention to reduce risk of loss currently in place now include a statement for family to monitor, advise to alert staff immediately if personal belongings are missing. Care conferences are conducted within seven days of admission to the rehab unit and weekly throughout facility. Resident/Family Handbook on page 13 revised to include loss/missing items: the facility encourages residents to not keep valuables, jewelry and/or significant amounts of money (cash, credit cards, etc.) on their person or in their room. However, if the resident finds that something is missing (property, money, etc.) please let the nurse, nurse manager, or administrator know immediately. Residents and family can also voice their concerns by calling the facility confidential concern/grievance line. (The number was listed). Weekly Resident Property Monitoring of four resident interviews weekly dated 06/21/24, 06/26/24, 06/28/24, 07/05/24, and 07/12/24 with no negative findings completed by Assistant Director of Nursing (ADON) #467 and Nurse Unit Manager (UM) #441. Weekly camera monitoring of staff on various shift once weekly dated 06/25/24 of third shift on 06/18/24, 07/01/24 of second shift on 06/30/24, and 07/09/25 of first and second shifts on 07/06/24 with no negative findings completed by Human Resources (HR) #602. Audits and monitors to continue for six weeks. Review in QAA/QAPI committee in the upcoming meeting next week. This deficiency represents non-compliance investigated under Master Complaint Number OH00155122.