

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Welcome Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 417 South Main Street Oberlin, OH 44074	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38091</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, staff interview, review of a self reported incident (SRI) and subsequent investigation, review of a transcribed interview, policy review, and review of corrective action documentation, the facility failed to ensure residents were free from misappropriation. This affected two (#1 and #2) of three residents reviewed for misappropriation. The facility census was 83.</p> <p>Findings Include:</p> <p>Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included type two diabetes, chronic kidney disease, and major depressive disorder.</p> <p>Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact and required extensive assistance of one person for completing her activities of daily living (ADLs).</p> <p>Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, congestive heart failure, and malnutrition.</p> <p>Review of the most recent comprehensive MDS 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact and required extensive assistance of one person for completing her ADLs.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an SRI and investigation documentation revealed on 10/24/24 at approximately 3:00 P.M. Resident #1 reported money missing from her cellular telephone (cell phone)/wallet. Resident #1 stated the money was removed at some point after 10:00 A.M. on 10/23/24. Resident #1 verbalized she was in possession of \$85.00. Resident #1 stated when she went to check on the money at 2:30 P.M. on 10/24/24 it was gone. An investigation into the missing personal funds began immediately which included identifying all staff that worked around the time of the incident, interviewing staff, interviewing other residents, and a in-depth interview with Resident #1 and Resident #1's son. A camera was authorized and placed in Resident #1's private room on 10/24/24 and \$25.00 was placed in Resident #1's cell phone/wallet. While staff were placing the camera in Resident #1's room, Resident #2 reported to the facility's receptionist he was also missing money. Resident #2 stated he was out of his room from approximately 1:15 P.M. to 3:10 P.M. on 10/24/24, and when he returned and checked his wallet all but \$2.00 were missing. Resident #2 stated he got money from a bank the previous day and sold a cell phone to a friend for \$100.00. Resident #2 stated he had a total of \$200.00 in his possession. A second camera was ordered after the information was obtained from Resident #2. On Monday 10/28/24, the camera was placed at 11:51 A.M. in Resident #2's room and active monitoring of the cameras in Resident #1 and Resident #2's rooms began by facility administrative staff. Soon after placement, the camera alerted to motion in Resident #2's room. The camera recorded State tested Nurse Aide (STNA) #100 rummaging through Resident #2's bedside stand where STNA #100 found a wallet. STNA #100 proceeded to open the wallet and when she found no money, STNA #100 continued to search through the drawer and other locations in the room. After watching the video, the facility administration removed STNA #100 from the floor and brought her to administrative offices for questioning. STNA #100 initially denied any involvement in any missing money, but after further questions STNA #100 confessed to taking money from Resident #1 and Resident #2. The local police department was notified of the situation. Resident #1 and Resident #2 were both interviewed and expressed a desire to pursue prosecution, and STNA #100 was terminated immediately upon confession on 10/28/24.</p> <p>Review of a transcribed interview document dated 10/28/24 revealed STNA #100 confessed to taking money from Resident #1 and Resident #2.</p> <p>Interview with Director of Quality Assurance (DQA) #1 on 11/08/24 at 10:30 A.M. verified the facility confirmed STNA #100 took money from Resident #1 and Resident #2.</p> <p>Review of the policy titled, Abuse Prevention and Compliance Policy, dated 11/01/16, revealed the facility has no tolerance for abuse, neglect, and misappropriation of residents.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by 10/29/24:</p> <p>On 10/28/24, the facility replaced Resident #1 and Resident #2's stolen money.</p> <p>On 10/28/24, STNA #100's employment at the facility was terminated.</p> <p>On 10/28/24, upon STNA #100's confession of stealing money from Resident #1 and Resident #2, the local police department was contacted, a report was taken, and the criminal investigation was on-going.</p> <p>On 10/28/24, The Ohio Department of Health was notified of the incident and an investigation into the incident and actions taken against STNA #100's healthcare license were on-going.</p> <p>(continued on next page)</p>		

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