STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366240	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Reserve Masonic Comm	4931 Nettleton Road Medina, OH 44256

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** 32650 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, record review, review of two Self-Reported Incidents (SRI), and policy and procedure review, the facility failed to prevent misappropriation of resident property. This affected two residents (Residents #51 and #52) of three residents reviewed for misappropriation. This facility census was 36. Findings Include: 1. Resident #52 was admitted to the facility on [DATE] with diagnoses of dementia without behavioral disturbance, Alzheimer's disease, osteoporosis, and high cholesterol. The resident expired in the facility on [DATE]. Review of the physician's orders revealed Resident #52 was admitted to hospice services on [DATE]. Review of the comprehensive Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was severely cognitively impaired and required staff to provide all personal care. Review of the progress notes for Resident #52 revealed on [DATE] Resident #52's son informed Social Services Designee (SSD) #362 that his mother's wedding ring set was missing. The son described the ring as a gold band with a diamond solitaire and a gold band encircled in diamonds that she wore on her right ring finger. SSD #362 immediately notified the Administrator and an investigation was initiated. (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	Review of SRI #243500 dated [DATE] revealed the SRI was filed with the state agency for an allegation of misappropriation. The Administrator spoke with Resident #52's son after being notified of the missing rings, the son told the Administrator he had visited the resident on [DATE] and he had planned to take the resident's rings to the jeweler and have them cleaned but he was unable to remove them from his mother's finger. When he arrived today ([DATE]) she was not wearing the rings. Resident #52 would not have been able to remove the rings herself because of bilateral hand contractures. The resident's room was searched, and the rings were not found. A police report was filed and an investigation was initiated. STNA #316 was interviewed on [DATE] and revealed the last time she had seen Resident #52's ring was when she was training STNA #308 on how to wash the resident's hands during a bed bath on [DATE]. STNA #308 also confirmed she had seen the resident's ring on [DATE]. Review of the video footage revealed the last time Resident #52's ring was observed on her finger was on [DATE] at 1:20 P.M. Agency STNA #510 was assigned to care for Resident #52 the night of [DATE] from 11:00 P.M. to 7:00 A.M. At the end of STNA #510's shift, the aide was observed meeting agency Licensed Practical Nurse (LPN) #500 in the cafe area of the nursing home and the video showed STNA #510 passed something in her hand to LPN #500 who put the object into his pants pocket then returned to his assigned unit. LPN #500 was assigned to the Assisted Living while STNA #510 was assigned to the skilled nursing facility. The video showed LPN #500 and STNA #510 exited the facility at different times but left in the same car. All the video footage was provided to the local police department. STNA #510 was scheduled to work on [DATE] but called off. 2. Resident #51 was admitted to the facility on [DATE] with diagnoses including repeated falls, dementia without behaviors, severe protein calorie malnutrition, Alzheimer's disease, chronic kidney disease, and anxiety disorder. The resident expired in the facility on [DATE]. Review of the physician's orders revealed Resident #51 was admitted to hospice services on [DATE]. Review of the Significant Change comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed Resident #51 was severely cognitively impaired and required staff to perform all personal care. Review of SRI #243513, dated [DATE], revealed while investigating a separate incident of misappropriation of jewelry staff discovered Resident #51's tear shaped gold wedding ring was missing. The Administrator went to the resident's room and asked to see her hands but did not see her ring. Resident #51 did not know what happened to her ring. Resident #51's husband was in the room and the Administrator asked when he had last seen the resident's rings and he did not remember. Resident #51's room was searched and the ring was not found. The police were notified and a report was filed. The facility reviewed video footage to determine when Resident #51 was last seen wearing her ring. The last day the resident was observed on video wearing her ring was [DATE] at 5:56 P.M. On the night of [DATE] from 11:00 P.M. to 7:00 A.M. agency State tested Nursing Assistant (STNA) #510 was assigned to care for Resident #51. The video footage was the same as for Resident #52. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on [DATE] at 11:45 A.M. revealed he watched 10 hours of video footage from the night of [DATE] and the movements of STNA #510 did not make sense. He observed her in the cafe of the skilled nursing facility towards the end of her shift. The Administrator said STNA #510 kept looking around and then LPN #500 entered the cafe. STNA #510 handed something to LPN #500 and the two of them just looked at it. The Administrator said he was unable to see what it was. LPN #500 then returned to his assigned unit in the Assisted Living building and STNA #510 returned to the long term care unit. The facility was informed in March charges were filed against LPN #500 and STNA #510. In April the facility was informed Resident #51 and #52's rings were recovered and returned to the residents' families. Review of the facility's Freedom from Abuse, Neglect, and Exploitation policy, last revised [DATE], revealed misappropriation was the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The employee who was told about or first identified any type of abuse was to immediately report it to their immediate supervisor. The supervisor was to gather all the facts regarding the incident and inform the Administrator. The Administrator was to notify the department directors, appropriate officers of the organization, the legal guardian, spouse, and responsible party. The investigation was to consists of written statements from the person reporting the alleged violation, the suspected perpetrator, any witnesses, and the resident if possible. The Administrator would submit an SRI to the state agency and would continue a thorough investigation into the incident and file a final report with the state agency no later than five days working days of the incident. The deficient practice was corrected on [DATE] when the facility implemented the following corrective actions. On [DATE] at 4:01 P.M. an SRI was filed with Ohio Department of Health (ODH) regarding Resident #52's missing rings and the facility began their investigation. On [DATE] at approximately 6:00 P.M. the DON and the Administrator went from resident to resident and inventoried all jewelry for each resident and interviewed them to determine if there were any concerns. On [DATE] at 8:47 P.M. an SRI was filed with ODH regarding Resident #51's missing ring and the facility began their investigation. On [DATE] the facility notified the local police department and a report was filed regarding the missing rings. On [DATE] the facility notified the responsible parties of the missing rings and that an investigation was in progress. Between [DATE] and [DATE] the facility interviewed all staff. Between [DATE] and [DATE] the Administrator reviewed all video footage available. On [DATE] at 8:45 P.M. the facility notified the local police department of findings of the video footage. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Between [DATE] and [DATE] all facility staff were in-serviced on the facility's abuse, neglect, and misappropriation policies and procedures. On [DATE] at 4:00 P.M., the police came to the facility to discuss their findings. On [DATE] the facility contacted the agency which employed LPN #500 and STNA #510. LPN #500 was no longer employed by the agency and STNA #510 was placed on the do not return list. Review of misappropriation systems was ongoing via the Quality Assurance Performance Improvement committee. This deficiency represents non-compliance investigated under Complaint Number OH00155175.