STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366387	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Darby Glenn Nursing and Rehabilitation Center	4787 Tremont Club Drive Hilliard, OH 43026

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** 43064 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview, medical record review, review of facility investigation, and review of facility self-reported incidents (SRI's) revealed the facility failed to ensure Resident #59's money was not misappropriated by facility staff. This affected one resident (#59) of three residents reviewed for misappropriation. The facility census was 94. Findings include: Review of the medical record for Resident #59 revealed an admitted [DATE] with diagnoses including Parkinson's disease, type two diabetes mellitus, bipolar disease, anxiety disorder, dementia, and major depressive disorder. Review of Resident #59's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. (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 the SRI created 12/18/24 and completed 12/26/24 revealed an incident of misappropriation had been substantiated. Resident #59's wallet had been missing. Review of the narrative revealed on 12/18/24 Resident #59 notified the assistant director of nursing (ADON) he could not find his wallet. The ADON notified social services and together they searched the resident's room and wheelchair for his wallet and were unable to locate it. Resident #59 stated he was going to go out to lunch with his power of attorney (POA) and would continue to look when he returned. When he returned, he stated he and his POA had gone to the bank and learned there had been a charge on his card at an automated teller machine (ATM) and he felt his card had been stolen. Social services notified the Administrator and an investigation was started. The residents' bank card was canceled, and it was confirmed the ATM withdrawal occurred at a gas station near the facility. The police were notified, and images were obtained from the gas station placing three facility housekeepers (#107, #113, and #117) at the gas station at the time of the withdrawal, the images revealed Housekeeper #113 was at the ATM located in the gas station. All three housekeepers were suspended immediately. Housekeeper #113 had been assigned to Resident #59's room on that day, and all three had been clocked out for lunch at the time of the withdrawal. When the Administrator interviewed the staff, they all declined being at the gas station at all. When informed they were observed on security footage, they denied using Resident #59's bank card. Housekeeper #107 indicated Housekeepers #113 and #117 were responsible and she had nothing to do with it. Hilliard Police arrived on 12/18/24 at 6:14 P.M. to file a report and are investigating the incident. All three housekeepers were no longer employed at the facility. Review of Resident #59's personal bank statement revealed on 12/18/24 there was a withdrawal of $400.00 from a ATM that was not at his bank location. There was a pending reversal of the ATM withdrawal. Written on this document was a statement that said a phone call with the back confirmed the withdrawal occurred at 12:26 P.M. at a gas station near the facility. Review of the police case report printed 12/23/24 revealed an incident was reported on 12/18/24 at 6:07 P. M. and had occurred that day from 12:10 P.M. to 12:30 P.M. The offense was stolen property and theft. The three suspects were redacted but Resident #59 was identified as the victim and the Administrator as an involved party. The offer reported he was dispatched to the facility on [DATE] at 6:14 P.M. and met with Resident #59 and the Administrator. Resident #59 had reported to the administrator that his wallet was lost or stolen, and he called the bank to report his debit card missing. The bank asked if he had made a $400.00 ATM withdrawal at a gas station, and he denied it. The withdrawal was considered fraudulent and done on another bank's ATM. The administrator had gone to the gas station and was provided with security camera photos. The photos were time stamped and showed three females inside the store, one of the females was at the ATM. The Administrator called all three employees, one staff member said she used her own debit card at the ATM, one staff member admitted that the other was using Resident #59's card, and the third denied knowing anything or being at the gas station at all. The Administrator provided the staff's time sheets and confirmed one of the housekeepers had been assigned to clean Resident #59's room that day. She verified all three staff were suspended while the incident was investigated and Resident #59 wished to pursue criminal charges. There were two additional redacted sheets attached to the police report as well as the security footage screenshots. There were six total screenshots, time stamped from 12:27 P.M. to 12:30 P. M. and someone had written the housekeeper's name on them. Housekeeper #113 was observed at the ATM, Housekeepers #113 and #107 were observed together in several pictures, and Housekeeper #117 was observed checking out with Housekeeper #107 standing behind her. (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 SRI documents related to Housekeeper #117 revealed a disciplinary action form dated 12/19/24 indicating she was suspended beginning on 12/18/24 as she had been found on camera using an ATM with a resident's missing card. An additional disciplinary action form dated 12/26/24 revealed she was terminated related to an incident on 12/18/24 where she was found on camera with an employee who was using a resident's debit card at an ATM machine and did not report the incident. Review of Housekeeper #117's time stamps revealed on 12/18/24 she had a lunch break from 12:14 P.M. to 12:54 P.M. Her statement indicated on 12/18/24 she went to work and worked a normal day. Later in the day she got a call from the Administrator about a missing wallet, and she did not know anything about it. Review of the SRI documents related to Housekeeper #107 revealed a disciplinary form dated 12/19/24 indicating she was suspended beginning 12/18/24 due to being found on camera using an ATM with a residents missing credit card. An additional disciplinary action form dated 12/26/24 revealed she was terminated related to an incident on 12/18/24 where she was found on camera with an employee who was using a resident's debit card at an ATM machine and did not report the incident. Review of Housekeeper #107's time stamps revealed on 12/18/24 she had a lunch break from 12:15 P.M. to 12:56 P.M. Review of Housekeeper #107's statement revealed she went to the gas station to get lunch, she saw Housekeeper #113 at the ATM and saw her give Housekeeper #117 money. She denied any involvement. Review of the SRI documents related to Housekeeper #113 revealed a disciplinary form dated 12/19/24 indicating she was suspended beginning 12/18/24 due to being found on camera using an ATM with a residents missing credit card. An additional disciplinary action form dated 12/26/24 revealed she was terminated related to an incident on 12/18/24 where she was found on camera using an ATM with residents missing debit card. Review of Housekeeper #113's time stamps on 12/18/24 revealed she went to lunch from 12:16 P.M. to 12:52 P.M. Her statement revealed she denied any wrongdoing and had nothing to do with a wallet or card. Interview on 01/14/25 at 9:30 A.M. with the Administrator revealed Resident #59 had been out on 12/18/24 so she had gone to the gas station to ensure he had not taken any money out and forgotten. She had spoken to the cashier who helpfully looked at the camera and reported there had not been an old man at the ATM but there had been three females, and she provided screenshots. They then called the police and the housekeepers. Housekeepers #113 and #117 had always denied involvement, at one point Housekeeper #107 reported that she had nothing to do with it and it had been Housekeeper #113. She reported they had sufficient evidence that the staff were responsible for the theft or had knowledge of the theft and had not reported it, so they were all terminated. Interview on 01/14/25 at 11:52 A.M. with Resident #59 revealed 'those three girls' had stolen his money. He reported his money had since been returned to him. Interview on 01/14/25 at 12:08 P.M. with Social Worker #150 revealed her and the ADON had just searched for his wallet at first because he has dropped things like his wallet before. She reported once it became clear it was gone and money had been taken, she helped him call the bank, cancel his card, and start the refund process. The deficient practice was corrected on 12/20/24 when the facility implemented the following corrective actions: Housekeepers #107, #113, and #117 were suspended on 12/18/24 and did not work again through their termination on 12/26/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 an audit of all residents was completed to ensure there were no further concerns related to misappropriation with no negative findings. From 12/19/24 to 12/20/24 all staff were educated on the abuse and misappropriation policy On 12/27/24 the Administrator or designee began weekly audits to ensure there were no concerns related to misappropriation. On 01/14/25, the review of resident council, grievances, and SRI's, and interview with residents and staff revealed no further misappropriation concerns from 12/20/24 to 01/14/25. This deficiency represents non-compliance investigated under OH00161059.