STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview and record review, the facility failed to ensure the right to be free from Misappropriation of Resident Property for 6 of 18 residents (Resident #'s 1,2,3,4,5, and 6). 1.The facility failed to prevent the misappropriation of bottle of megace (Resident #1) and (Resident #4), card of Zofran (Resident #5) and (Resident #3), card of Pantoprazole (Resident #6), card of montelukast (no legible name), Nystatin, Xyzal (no legible name), card of Flexeril (no legible name), (CMA H) removed the medication from the nurses' cart, without authorization, for personal gain. 2. The facility failed to ensure that Resident #2 was not subject to financial misappropriation or exploitation from Housekeeper A from the time period 2/11/2025 to 2/17/2025. Housekeeper A accepted cash in the amount of $60 from Resident #2. The noncompliance was identified as PNC. The past noncompliance began on 2/11/25 and ended on 4/4/25. The facility had corrected the noncompliance before the investigation began. This failure had the potential to affect the residents in the facility by placing them at risk for misappropriation of resident funds and drug diversion. Findings Included: 1. Record review of Resident #1's Face Sheet dated 3-21-25 revealed a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Alzheimer's (progressive disease that destroys memory and other important mental functions), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), type 2 diabetes mellitus with diabetic polyneuropathy (complication of diabetes mellitus (insulin resistance, with or without insulin deficiency that induces organ dysfunction) progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers) and essential hypertension (high blood pressure). Record review of Resident # 1's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 0 indicating Resident #1 cognition was severe. The Pain Assessment Section of the MDS indicated Resident #1 was unable to voice any pain concerns. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Record review of Resident #1's Care Plan dated 10-24-24 indicated Resident #1 had potential for pain and was at risk for injury from decrease in ADLs. The care plan interventions included, assess characteristics of pain: Location, Severity, on a scale of 1-10, type and frequency; discuss with resident factors that precipitate pain and what may reduce it; administer pain medications as ordered; discuss with resident the need to request pain medications before pain becomes severe; discuss with physician that for maximum pain relief pain medication are best given around the clock, with prns for breakthrough pain and monitor for potential side effects of pain medication. Record Review orders dated 11/23/2024 indicated Resident #1 was prescribed Megace for weight loss. Record review of Resident #3's Face Sheet dated 3-21-25 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis dementia without behavioral disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), cognitive communication deficit (the inability to think of the correct word), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), hypothyroidism (thyroid gland doesn't make enough thyroid hormone), GERD (gastro-esophageal reflux disease) (stomach acid or bile irritates the food pipe lining) and essential hypertension (high blood pressure). Record review of Resident # 3's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 9 indicating Resident #3's cognition was moderately impaired. The pain assessment frequency indicated resident was occasionally in pain. Record review of Resident #3's Care Plan dated 10-24-24 indicated Resident #1 had potential for pain and was at risk for Injury from Decrease in ADLs. The care plan interventions included discuss with resident factors that precipitate pain and what may reduce it; Administer pain medications as ordered; Discuss with physician that for maximum pain relief pain medication are best given around the clock, with prns for breakthrough pain; Monitor for potential side effects of pain medication and discuss with resident the need to request pain medications before pain becomes severe. Record Review orders dated 11/22/24 indicated Resident #3 was prescribed Zofran for nausea and vomiting. Record review of Resident #4's Face Sheet dated 3-21-25 revealed a 81-yer-old male who admitted to the facility on [DATE] with a primary diagnosis of hypotension (low blood pressure), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow) and cognitive communication deficit (the inability to think of the correct word). Record review of Resident # 4's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 5 indicating Resident #1 cognition was severe. The Pain Assessment Section of the MDS indicated Resident #4 did not have any pain concerns. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Care Plan dated 3-12-25 indicated Resident #4 had potential for pain and was at risk for injury from decrease in ADLs. The care plan interventions included, assess characteristics of pain; Discuss with resident factors that precipitate pain and what may reduce it; Administer pain medications as ordered; Discuss with resident the need to request pain medications before pain becomes severe; Discuss with physician that for maximum pain relief pain medication are best given around the clock, with prns for breakthrough pain and monitor for potential side effects of pain medication. Record Review orders dated 2/19/25 indicated Resident #4 was prescribed Megace for weight loss. Record Review orders dated 7/18/24 indicated was Resident #6 prescribed Pantoprazole for morning indigestion. Record review of Resident #5's Face Sheet dated 3-21-25 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to cognitive communication deficit (the inability to think of the correct word), GERD (gastro-esophageal reflux disease) (stomach acid or bile irritates the food pipe lining) and essential hypertension (high blood pressure). Record review of Resident # 5's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 5 indicating Resident #5 cognition was severe. The Pain Assessment Section of the MDS indicated Resident #5 was did not indicate any pain concerns. Record review of Resident #5's Care Plan dated 6-21-24 indicated Resident #5 had potential for pain and was at risk for injury from decrease in ADLs. The care plan interventions included, assess characteristics of pain: Location, Severity, on a scale of 1-10, type and frequency; discuss with resident factors that precipitate pain and what may reduce it; administer pain medications as ordered; discuss with resident the need to request pain medications before pain becomes severe; discuss with physician that for maximum pain relief pain medication are best given. around the clock, with prns for breakthrough pain and monitor for potential side effects of pain medication. Record Review orders dated 8/1/24 indicated Resident #5 was prescribed Zofran for nausea and vomiting. Record review of Resident #6's Face Sheet dated 3-21-25 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of dementia without behavioral disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar and essential hypertension (high blood pressure). Record review of Resident # 6's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 0 indicating Resident #6 cognition was severe. The Pain Assessment Section of the MDS indicated Resident #6 was having pain frequently. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's Care Plan dated 9-9-24 indicated Resident #6 had potential for pain and was at risk for injury from decrease in ADLs. The care plan interventions included, assess characteristics of pain; discuss with resident factors that precipitate pain and what may reduce it; administer pain medications as ordered; discuss with resident the need to request pain medications before pain becomes severe; discuss with physician that for maximum pain relief pain medication are best given around the clock, with prns for breakthrough pain and monitor for potential side effects of pain medication. Record review of facility's in-service training dated 3/28/25 revealed 35 employees (12 LVN's, 20 CNA's, 8 RN's, 4 CMA's, 1 Administrator) were trained by the abuse coordinator on drug storage: all discontinued medication or medications to be destroyed. Record Review of intake investigation worksheet dated 3/28/25 at 10:00 a.m., Narrative of The Incident: Received phone call from investigator for confidential District Attorney's office. He said he was at CMA H's house and wanted to know if we were missing any meds because he had multiple drugs they had found there while searching the home. He named off multiple prescription drugs that were found. He named off the identified names that were former residents here with what drug their name was on. (He also had names that were not residents here). Actions and Notifications: CMA H's was suspended pending investigation. Dr was notified. Police Officer said he would get a police report number for us. All residents listed were deceased and no meds were narcotics that are counted. Resident #1-megace; Resident#4-Megace; Resident #5-Zofran; Resident#6-pantoprazole; Resident #3-Zofran. -Ombudsman notified. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of typed note located inside the Provider investigation packet dated 3/28/25 at unknown time indicated, on 3/28/25 the Administrator received a phone call from investigator with confidential District Attorneys' office. He told me that he was at CMA H's house and wanted to know If she worked for us. I told him that she did work for us as a medication aide, and he asked if we had any medications missing. I told him that I was not aware of any medications that were missing. He said that he had found numerous cards and bottles of medications and wondered if she was getting them here. He told me that he had the following: 1. Bottle of megace with Resident #1's name, 2. Bottle of megace with Resident #4's name, 3. Card of Zofran with Resident #5's name, 4.Card of Zofran with Resident #3's name, 5. Card of Pantoprazole with Resident #6's name, 6. Card of montelukast with no legible name, 7. Nystatin with no legible name, 8. Xyzal with no name, 9. Card of Flexeril with no legible name, 10. Multiple OTCs, 11. One med with patient name someone else outside of the facility, 12. One med with patient name someone else's name. The Administrator wrote, I informed him that Resident #1, Resident #4, Resident #5, Resident #3 and Resident #6 were all previous patients here and all had passed away here. I told him that the medications would not be meds that we would count shift to shift as they were not narcotics, but that I could not recall any of these meds being an issue with not having with these patients and that I suspected that the meds were probably taken after they passed away. CMA H was arrested on 3/28/25 and therefore, suspended, pending outcome of this investigation. Medical Director was notified by DON. The pharmacist was notified by the DON. Results of the investigation indicated CMA H's was terminated for theft of medications. Ombudsman was notified by myself; Human Resources was notified of the allegation and previous disciplinary actions for attendance. The med carts were checked to ensure all current residents had their medications and there were no concerns found with meds being missing. A Narcotic count was done to ensure that all narcotic counts were correct and there were no concerns found. A list of current residents on the above meds was made and reviewed for any indications that they are not receiving their meds as ordered. There were no concerns noted by the DON. An in-service was conducted on clear bag policy and not having any personal bags in the med room. An additional in service was conducted on process to follow when drugs are discontinued or a resident pass away. Further investigation will be completed by DON in my absence. On 4/4/25 the investigation was completed, and CMA H was terminated. Record Review of the police incident report dated 3/28/25 at 11:11 am indicated, CMA H was facing multiple charges including 1. Possession of Controlled Substance, 2. Possession of Controlled Substance, 3. Forgery Financial Instrument, 4. Possession of Dangerous Drug and 5. Possession of Marijuana Record Review of in-services was reviewed on 5/20/25 at 10:22 a.m.; Ex Employee CMA H's was last in-service on abuse and neglect on 9/20/24. Record Review of the grievance log was reviewed on 5/20/25 at 10:35 a.m. and found no issues from December 2024 to May 2025. Record Review of the Drug and medication carts audits conducted by the Administrator and DON on 3/28/25 at 3:15 p.m., revealed all medications were accounted for. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/25 at 12:16 p.m., CMA B stated she had been employed since 2023. CMA B stated she had been in-service on misappropriation recently but did not know when her last in-service on misappropriation was last completed. CMA B stated it had not been too long ago since her last most recent in-service on misappropriation. CMA B stated she had never taken money from a resident. CMA B stated the abuse coordinator was the Administrator. CMA B stated if the medication was narcotics that she would let the DON take the medication off the cart. CMA B stated if the medication was not a narcotic then it's in a locked cabinet in the med room that the medication would be discarded in. CMA B stated the DON would discard the medication in the lock box. CMA B stated she had never logged or documented medication disposal. CMA B stated she was not sure if the DON documented medication disposal. CMA B stated the DON was responsible for removing and securing mediations that were no longer in use. CMA B stated the facility did not return medication to the pharmacy instead the medications would be disposed of at the facility. CMA B stated the designated area for disposing of medication would be the medication room. During an interview on 5/20/25 at 12:26 p.m., LVN C stated when a resident passed away or was discharged that medication was pulled from the cart. LVN C stated the nurses would pull the mediation from the carts. LVN C stated if the medication was a narcotic that she would get the DON who would be the one to remove the mediation off the carts. LVN C stated she would look at the count sheet, the nurses would make sure the count sheet was corrected and the DON would take the medication along with the count sheet and locked her office in her closet that was triple locked. LVN C stated if she found medication that were not labeled or appeared to be expired that she would put the medication in a destruction box located in the medication room. LVN C stated the designated area for medication disposal was the medication room. During an interview on 5/20/25 at 12:44 p.m., CNA E stated she had been employed at the facility for 5 or 6 years. CNA E stated she did not quite remember when her last in-service on abuse and neglect, but it might had been last month. CNA E stated she had so many in-services each month. CNA E stated she did not handle drug destruction or administering medication. During an interview on 5/20/25 at 12:48 p.m., CNA F stated she had been employed at the facility for 2 years. CNA F stated she was in serviced on misappropriation this month (May 2025). CNA F stated the Administrator was the abuse coordinator. CNA F stated the process for handling the medication that was not a narcotic was first she would put the medication inside a lock box in the medication room and let the DON know the medication was discarded in the locked cabinet. CNA F stated if the medication was a narcotic medication that she would count down the medication and write the number of pills left on the count sheet and let the DON know and the DON would remove the narcotic from off the carts. CNA F stated she did not return anything to the pharmacy instead the DON would dispose of the mediation at the facility. CNA F stated if she found medication that was not labeled or expired that she would let the DON know and have the DON to take the medication off the cart. CNA F stated the designated area for drug destruction was the medication room. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/25 at 1:03 p.m., LVN G stated she had been employed at the facility for 8 years. LVN G stated in-services on misappropriation was completed recently about a month ago. LVN G stated the abuse coordinator was the Administrator. LVN G stated she normal did not handle drug destruction. LVN G stated if a mediation had not been opened and needed to be returned to the pharmacy, then the pharmacy may pick up the medication. LVN G stated if the medication had been opened and was no longer needed by the resident that the medication would be destroyed by the DON. LVN G stated the DON destroyed medication at the facility. LVN G stated if she found mediation that were not labeled or expired that she gave medications to the DON. LVN G stated the medication room was the dedicated room for mediation disposal. LVN G stated the DON would be responsible for securing medication especially if it was a narcotic medication. During an observation and interview in the medication room on 5/21/25 at 11:30 a.m., with RN K the following were observed: Narcotics were locked in lock box located in the refrigerator; there was no observation of personal bags; there was a locked cabinet with a small hole at the top for placing non-narcotic medications inside for destruction. During an interview with RN K, RN K stated all expired or discontinued medication were to be given to the DON. RN K stated the med aide were to let the DON know that they had expired/discontinued medication and place the expired or discontinued medication inside the locked cabinet to be discarded by the DON. RN K stated the DON was the only person with the keys to the lock box for the narcotics. RN K stated there had never been a time when non-narcotic medication was placed on the countertop and not inside the locked cabinet. RN K stated in-services was last completed a few months ago on drug diversion. RN K stated the DON, and the charge nurses were the only one with the keys to non-narcotic locked cabinet locked in the medication room. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 12:00 p.m., the DON stated if the medication was not a narcotic then medication would go inside the lock cabinet under the counter. The DON stated once the medication was there then she would send the medication back for a possible refund and or to destroy the medication. The DON stated if the medication was a narcotic then she would get the medication off the cart. The DON stated when she received the medication, she verified the medication on the count sheet and lock up the medication in her file closet located in her room. The DON stated her file closet was triple locked. The DON stated herself and the charge nurses were responsible for removing and securing medications that are no longer in use. The DON stated she secured the drugs for resident that passed away or have been sent to the hospital by taking the medication out of the cart and putting the medication in the lock cabinet in the medication room. The DON stated she monitored the non-narcotic drug by conducting cart audit weekly. The DON stated during morning meeting if someone had passed away or was discharge, that she would go to the carts and pull the medications off the cart. The DON stated this process was the same for discontinued medications as well. The DON stated she kept a logbook for pharmacy for medication that were able to be returned to the pharmacy. The DON stated if there was medication that was not labeled or expired then the medication would go into the disposal lockbox. The DON stated she had not ever witnessed staff bringing bags into the medication room. The DON stated prior to this incident staff had been putting expired drugs on to the countertop and not inside the locked cabinet. The DON stated the process now was any drug that was not narcotic were to go inside the locked cabinet. The DON stated her and the ADON would follow up to make sure the medication was removed from the cart and placed in the locked cabinet. The DON stated the med aide, ADON, nurses and herself had a key to the medication room. The DON stated she had no clue regarding the medication found in CMA H's home was missing from the facility. The DON stated she check the medication room in the morning before the meeting and after the meeting she checked the carts to make sure everything was off and once a week she conducted audits. The DON stated it was important to ensure the medication was properly disposed of because the medication belonged to that resident, and it was important for safety. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #2's face sheet dated 05/20/2025 revealed the resident was a [AGE] year-old female admitted on [DATE]. The resident's diagnoses included: Parkinson's disease (brain disorder that causes unintended or uncontrollable movements), cognitive communication deficit (the inability to think of the correct word), dementia without behavioral disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and GERD (gastro-esophageal reflux disease) (stomach acid or bile irritates the food pipe lining).) and essential hypertension (high blood pressure). Record review of Resident #2s admission MDS dated [DATE] revealed a BIMS score of 11, indicating the resident was moderately cognitively impaired. Record review of Resident #2's comprehensive care plan, accessed on 11/07/2024, revealed the Resident has impaired cognitive function or impaired thought processes; Res has cognitive loss (loss of memory, time sense and requires assistance with decision making) Impaired decision-making abilities, is not always understood or able to understand verbal and non-verbal expression Dementia. Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness; Cue, reorient and supervise as needed; Discuss concerns about confusion, disease process, NH placement with resident/family/caregivers) and Review medications and record possible causes of cognitive deficit: new medications or dosage increases; anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. Record Review of intake investigation worksheet dated 2/11/25 at 3: 45 p.m., indicated, Narrative of The Incident: Met with, RP of Resident #2, who said that Resident #2 said she had given a staff member some money to get her a vape to keep in her room but did not get the vape. I followed up & met with Resident #2 who said that she had given Housekeeper A in housekeeping some money to get her a vape and some other things, but that Housekeeper A is no longer here because of car trouble and I just chalk that one up to being stupid for giving her money. She could not recall how much money; however, the of Resident#2 report she told her $60; Actions and Notifications: Housekeeper A no longer works here. Self-terminated 1/14/25. Family and MD have been notified. $60 replaced. Pending report to confidential Police Department (waiting for them to come out and take report). Ombudsman notified. Record Review of the Provider investigation Report dated 2/11/25 at 4:36 p.m., indicated, of resident #2, met with admin on 2/11/25 and said that Resident #2 told her (Administrator) that she (Resident #2) gave some money to a staff member who is no longer here to get her some items but that she no longer works here and never got the items. Resident #2 said that she thought it was $60 but could not recall exactly or when it happened. Met with Resident #2 who told me (Administrator) that she had given money to Housekeeping A in housekeeping but said that something was wrong with her car and changed Jobs and has not been back. She (Resident #2) could not recall how much money she had given her (Housekeeper A). I (Administrator) told her that I (Administrator) was going to replace the money and she (Resident #2) said that she did not need it replaced but instead chalked it up as not trusting anyone to give money to for things. I (Administrator) told her that she (Resident #2) could give money to myself or to the activity director, but that I (Administrator) really preferred she not give it to anyone else to get items. She (Resident #2) agreed. Had her (Resident #2) sign that she (Resident #2) received $60, and it was given to her to keep. Life Satisfaction rounds were conducted with no further issues noted. Housekeeper A self-terminated on 1/14/25. She (Housekeeper A) had started work on 11/21/24. Have been unsuccessful in attempts to reach Housekeeper A for her statement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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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 - Some	Record Review of written note by the Administrator dated from the Provider investigation report dated on 4/15/25 at unknown time indicated the Administrator received call from Housekeeper A, Saying that the police contacted Housekeeper A and she could be spending 2 years in jail. Housekeeper A said that she took the money-which she said was $40 and bought Resident #2 socks and laundry detergent and that she did bring them to her. Housekeeper A asked if she could bring $60 to us and it be taken care of that way. I told her that was between her and the police. Housekeeper A said she would contact them and then if okay, she would have her r bring us the money because she was now out of state. Record Review of in-services was reviewed on 5/20/25 at 10:22 a.m.; Ex Employee Housekeeping A was last in-service on abuse and neglect on 11/21/24. Record Review of the abuse and neglect policy was reviewed on 5/20/25 at 10:30 a.m. Record Review of the grievance log was reviewed on 5/20/25 at 10:35 a.m. and found no issues from December 2024 to May 2025. Record Review of personnel file for Ex-employee Housekeeper A reviewed on 5/20/25 at 10:44 a.m., revealed Housekeeper A self-terminated on 1/14/25. Record Review of the police Report dated, 2/14/25 at 2:00 p.m., the police report indicated on February 14, 2025, the Administrator came to the Police Department to make a report of a theft. This theft occurred the Nursing Facility, The Administrator informed the offer that Housekeeping A, a former employee at the nursing home received $60 from Resident #2, a resident. Housekeeping A was asked to pick up certain items for Resident #2 with the money she was given. Housekeeping A then left the employ of the nursing home and neither returned the money given nor brought Resident #2 the items requested. During an attempted phone interview with Resident #2 RP on 5/20/25 at 10:53 a.m., of resident #2 RP was unavailable to be reached by phone; voice message left for a return phone call. During an interview on 5/20/25 at 11:00 am Resident #2 stated she did not remember the employee's name who worked here, but [TRUNCATED]