STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675863	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frank M. Tejeda Texas State Veterans Home	200 Veterans Dr Floresville, TX 78114

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported immediately but not later than 2 hours (for an injury of unknown origin involving serious bodily injury) or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 2 of 10 Residents (Resident #1 and Resident #2) reviewed for abuse. 1.The facility Administrator failed to identify the unauthorized use of Resident #1's credit card by a staff member for a personal purchase as an alleged violation of misappropriation of funds following a grievance submission on 03/06/2026. 2.The Social Worker failed to report an alleged violation of theft or misappropriation of resident property for Resident #2 on 03/13/2026 to the Administrator of the facility and the Administrator failed to report the violation of theft or misappropriation of resident property not later than 24 hours to other officials (including to the State Survey Agency) in accordance with State law through established procedure. These deficient practices could place residents at risk of harm by not having theft or misappropriation of resident property investigated.Findings included: 1. Record review of Resident #1's admission record, dated 04/02/2026, reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included type 2 diabetes mellitus (a metabolic disorder that occurs when the body becomes resistant to insulin), unspecified dementia (associated with a decline in cognitive function severe enough to interfere with daily life), and cognitive communication deficit (refers to difficulties in communication that arise from impaired cognitive functions, such as attention, memory, reasoning, and problem-solving). Record review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE] and signed 03/02/2026 as completed, reflected a BIMS score of 14, indicating intact cognition, organized thinking and did not reveal concerns of short-term or long-term memory. Resident #1 was documented as dependent on staff for toileting hygiene and independent for eating, showering, and mobility functions. Record review of Resident #1's care plan, initiated 03/17/2026, indicated Resident #1 had impaired cognitive function/dementia or impaired thought process related to dementia. Record review of Resident #1's progress note, dated 02/28/2026 documented by LVN A During morning rounds resident states she doesn't feel good. Cough, congestion and wheezing noted. Provider informed and ordered to send resident to ER [emergency room] to be evaluated and treated. Record review of Resident #1's progress note, dated 02/28/2026 documented by LVN A Received call from [hospital] and was informed that resident will be admitted with Flu A. Record review of Resident #1's progress note, dated 03/02/2026 documented by LVN B, Resident Arrived Via [by way of] transport wheelchair. received discharge papers from driver. Resident #1 was unavailable for observation or interview. Record review of Resident #1's Grievance/Concern Report - Residents and Families, dated 03/06/2026 revealed the date of occurrence of her submitted grievance was on 03/02/2026. Concern/Details: [Resident #1] stated her daughter called her and stated that her credit card was charged for $152.00 at [grocery store's] curbside. She stated she did not make a purchase that day (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
	675863	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frank M. Tejeda Texas State Veterans Home	200 Veterans Dr Floresville, TX 78114

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3/2/26) from [grocery store] . The grievance was received by the Social Services Director. Action Taken: [Resident #1] stated she has the credit card in her wallet and it is not missing. Her daughter is canceling this credit card and will get a new one. Record review of Resident #1's Money Order, dated 03/09/2026, revealed Serial Number: 5509421227 in the amount of $155.00, pay to Resident #1, From: Responsible Party with Memo: Trust fund of Resident #1. Record review of Resident #1's Email Correspondence, dated 03/10/2026, revealed an email correspondence from Resident #1's Responsible Party addressed to the Business Office Manager, I just wanted to give you an update on my mom debit card. The issue has been resolved by the bank and [grocery store] she should be receiving or received a refund soon. I will keep her card off so there are no further issues or concerns. Record review of Resident #1's Statement, dated 03/10/2026 reflected the Health Information Manager's account of the incident, On February 28th, 2026 I made a curbside order and resident [Resident #1] credit card was used in error. Reason credit card was used in error I had previously ordered subway for resident [Resident #1] x2 [twice] using cc [credit card] which saved into my [phone] wallet account. I failed to change the cc [credit card] and pick MY own cc [credit card] and that is when a charge of $152.42 was charged to resident [Resident #1] . I reached out to RP [Responsible Party] and advised her [grocery store] had contacted me. I explained to her in detail what happened and she understood and I offered to fix this immediately. I purchased money order for RP [Responsible Party] and we agreed to post it to resident account. Once I confirmed money was posted to report to administrator situation. However, she beat me to this pulled me in office, and we discussed the entire situation. RP [Responsible Party] is not going to press charges, is not upset, she fully understood this was an innocent mistake. We agreed that she would tell resident that she has taken care of issue.Reason for this is because we agreed resident to be at peace knowing nobody took advantage of her and no details given to her so that she would not be given information that was not full story, added to or changed in any way. [sic] Record review of Resident #1's Resident Statement Landscape, dated 03/12/2026, reflected a money order in the amount of $155 was received and credited to Resident #1's resident account. Record review of facility document titled, In-Service Education, dated 03/11/2026 reflected Subject: Code of Conduct.Instructor: ADM. the Health Information Manager was the only staff in attendance and educated on the Confidentiality and HIPAA Compliance, as well as [facility] Code of Conduct for team members. Specifically, as it relates to assisting residents with purchasing personal items and/or food items. 2. Record review of Resident #2's admission record, dated 04/02/2026, reflected a [AGE] year-old male admitted [DATE]. His diagnoses included atherosclerotic heart disease (condition where the coronary arteries become narrowed or blocked due to buildup, which reduces blood flow to the heart muscle), personal history of transient ischemic attack (temporary blockage of blood flow to the brain), and seizures (a sudden burst of electrical activity in the brain). Record review of Resident #2's quarterly Minimum Data Set (MDS), dated [DATE] and signed 01/28/2026 as completed, reflected a BIMS score of 13, indicating intact cognition, organized thinking and did not reveal concerns of short-term or long-term memory. Resident #2's functional abilities were documented as being independent for self-care and mobility. Record review of Resident #2's care plan, created on 12/29/2023 and revised on 01/15/2024, indicated Resident #2 was able to participate in activities of my choice with my physical cognitive ability. Record review of Resident #2's Grievance/Concern - Residents and Families, dated 03/13/2026 revealed the date occurrence of his submitted grievance was on 03/09/2026 - 03/11/2026. Concern/Details: Missing 57 dollars from locked drawer, with resident remembering it was locked, with the key being in another drawer, that was not locked, with resident's socks, in the corner, where it is visible. Social Worker was the team member receiving report from Resident #2 and actions taken on 03/13/2026, Social worker examined drawer, not broken, and can not be opened without a key. Key visible where it was kept in other drawer, despite resident covering it w/ socks. No money found. Resident #2 notified in person of the facility response to his grievance, Response: educated resident on proper key use for locking drawer, that he has right to keep key on person, have (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frank M. Tejeda Texas State Veterans Home	200 Veterans Dr Floresville, TX 78114

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a log for spending, and that no one else has access to his drawer when locked, and that he has the right to file a police report. He stated he understood and did not want to file a police report at this time. The Administrator was made aware of the grievance and on 03/16/2026 signed off on the actions and response taken by the Social Worker followed by a secondary review on 03/18/2026 by the On Site Representative, the veteran's advocate on 03/18/2026. Resident #2 was unavailable for observation or interview. During an interview on 04/02/2026 at 3:00 p.m. the DON said all staff were expected to report allegations of ANE immediately to the Abuse Coordinator, the Administrator. She said she recalled Resident #1's grievance reported on 03/06/2026. She said she was notified immediately of the grievance. She said she recalled the Health Information Manager made a personal curbside purchase using Resident #1's credit card. She said Resident #1's credit card information had been stored in Health Information Manager personal cell phone after a food order she had made for her previously. She said the Health Information Manager notified her that she did not pay attention when making her personal curbside order with the grocery store and she used the wrong credit card and charged Resident #1's credit card. She said the funds were returned to Resident #1's resident account, the Health Information Manager was in-serviced on concern, the incident was not reported to the State, but perhaps it should have been. She said she was unsure if the Health Information Manager was counseled, but that she was present for the in-service conducted on 03/11/2026 that addressed confidentiality and HIPAA compliance, the facility's code of conduct for team members, specifically as it related to assisting residents with purchasing personal items and/or food items. The DON said she was unable to recall the date the credit card was used by the Health Information Manager and did not recall that Resident #1 was transferred to the hospital on 2/28/2026, which was the date of the unauthorized use of credit card reported. She said she was not notified of the grievance filed by Resident #2 on 03/13/2026 and would need to follow up with the Social Worker for additional details. She said Resident #2 did not have a history of filing grievances of alleged theft or misappropriation of property and his cognition was intact. During a phone interview on 04/02/2026 at 8:54 p.m. the Administrator said she educated the staff to report suspected or witnessed ANE immediately. She said she was responsible for following the State provider letter and required to report any incidents that were inappropriate. The Administrator said reporting timeframe for ANE was within 2 hours of being notified and other incidents within 24 hours of being notified. She said she refers to the State provider letter for specifics on misappropriation, exploitation, and unusual circumstances. The Administrator said she was made aware of Resident #1's grievance submitted to the Social Services Director on 3/06/2026, which she reviewed thoroughly on 03/10/2026 followed by On Site Representative review on 03/17/2026. She said she was notified the Health Information Manager used Resident 1's credit card without her authorization for a personal purchase by accident and it was not intentional. She said the Health Information Manager helped Resident #1 with making online orders often and her credit card was stored on Health Information Manager's personal cell phone. She said she spoke with the Responsible Party regarding the unintentional incident, and it was worked out. Administrator first said she was not aware, followed by stating she did not recall that Resident #1 was transferred to the hospital on [DATE], the day the Health Information Manager made the personal grocery store purchase with her credit card. She said Resident #1's account was credited on 03/12/2026 and the grievance was resolved. The Administrator said staff should not be using their personal phones or using any resident credit card information. She said the Health Information Manager has been employed with the facility for a while and did not feel the incident was intentional and it was a true accident. She said the Health Information Manager was disciplined and educated in the Code of Conduct and not using a resident's personal credit card or using their personal cell phone to make online orders for any resident. She said the Health Information Manager was the ambassador for Resident #1 and the expectation was for residents to be helped with anything in their power, she believed the incident was an honest mistake, she did not try to hide it, and her understanding was the team member made the report to her. The Administrator said she did not (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consider the tenure of a staff member when deciding if their actions were intentional or unintentional she was just making a statement of the confidence she has in the Health Information Manager to emphasize there have been no issues with staff exploiting residents at the facility. She said the incident was not reported to the State as it was not intentional and did not rise to the level of an alleged violation. The Administrator said she was aware of the grievance Resident #2 submitted on 03/16/2026 of his concern of missing money. She said Resident #2 brought the concern to the Social Worker's attention. She said a lot of guys [male residents] loan their money out. The Administrator said she was not sure if the missing money grievance was confirmed. She said the grievance of missing money was not brought to her attention as an allegation of theft. She said Resident #2 was alert and oriented, he wasforgetful at times, and he did not have a history of making allegations of missing money or property. She said she was not afraid to report incidents and if there was a specific allegation and not just a mention or grievance of missing money, then she would not report it to the State Agency. The Administrator said the Social Worker was responsible for monitoring the grievance log, ensuring the grievances were responded to in a timely manner, but at the end of the day she and the On Site Representative were responsible for reviewing and signing off on them. An Employee Coaching record review for the Health Information Manager regarding the unauthorized use of Resident #1's credit card was requested from the DON and the Administrator on 04/02/2026 and as of 04/13/2026 an employee coaching record was not provided prior to exit. Record review of document titled, Code of Conduct, undated, reflected the following: I will respect resident rights. I will not mistreat, neglect or abuse residents, and I will not take any resident property. I will immediately report any resident mistreatment, abuse, neglect, or theft of resident property, to my supervisor. I will report any actual or suspected violations of applicable laws, or this Code of Conduct, to my supervisor, community administrator. Record review of document titled, Grievances, dated 01/2023 reflected the following: The investigation of complaints and grievances is a vital function to protect the health, safety, and welfare of residents. Each resident has the right to receive prompt resolution of grievances, including those regarding the behavior of other residents. Record review of document titled, Statement of Resident Rights, dated January 2023 reflected the following: Resident/Patient Rights include: 3. To be free from abuse and exploitation; 14. To keep and use personal property, secure from theft or loss. Record review of document titled, Abuse Guidance: Preventing, Identifying and Reporting dated January 2024 reflected the following: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, community team members. It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to Community management.Reporting/Response- All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individuals as may be required by law and per the current state/federal reporting requirements. Types of abuse Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful (whether temporary or permanent) use of a resident's belongings or money without the resident's consent. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Record review of QAPI Collaboration: The facility will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI Committee.Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about.Tracking patterns of similar occurrences.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that alleged violations of abuse, neglect, and exploitation were thoroughly investigated, and the results of the investigation were reported to the State Survey Agency within five working days for 2 of 10 residents (Resident #1 and Resident #2) reviewed for abuse, neglect, and exploitation. 1.The facility failed to have evidence of an investigation of alleged misappropriation of funds of Resident #1.2.The facility failed to have evidence of an investigation of alleged theft of property of Resident #2. These deficient practices could place residents at risk of harm by not having theft or misappropriation of resident property investigated.Findings included: 1. Record review of Resident #1's admission record, dated 04/02/2026, reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included type 2 diabetes mellitus (a metabolic disorder that occurs when the body becomes resistant to insulin), unspecified dementia (associated with a decline in cognitive function severe enough to interfere with daily life), and cognitive communication deficit (refers to difficulties in communication that arise from impaired cognitive functions, such as attention, memory, reasoning, and problem-solving). Record review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE] and signed 03/02/2026 as completed, reflected a BIMS score of 14, indicating intact cognition, organized thinking and did not reveal concerns of short-term or long-term memory. Resident #1 was documented as dependent on staff for toileting hygiene and independent for eating, showering, and mobility functions. Record review of Resident #1's care plan, initiated 03/17/2026, indicated Resident #1 had impaired cognitive function/dementia or impaired thought process. Resident #1 was unavailable for observation or interview. Record review of Resident #1's Grievance/Concern Report - Residents and Families, dated 03/06/2026 revealed the date of occurrence of her submitted grievance was on 03/02/2026. Concern/Details: [Resident #1] stated her daughter called her and stated that her credit card was charged for $152.00 at [grocery store's] curbside. She stated she did not make a purchase that day (3/2/26) from [grocery store] . The grievance was received by the Social Services Director. Action Taken: [Resident #1] stated she has the credit card in her wallet and it is not missing. Her daughter is canceling this credit card and will get a new one. Record review of Resident #1's Statement, dated 03/10/2026 reflected the Health Information Manager's account of the incident, On February 28th, 2026 I made a curbside order and resident [Resident #1] credit card was used in error. Reason credit card was used in error I had previously ordered subway for resident [Resident #1] x2 [twice] using cc [credit card] which saved into my [phone] wallet account. I failed to change the cc [credit card] and pick MY own cc [credit card] and that is when a charge of $152.42 was charged to resident [Resident #1] . I reached out to RP [Responsible Party] and advised her [grocery store] had contacted me. I explained to her in detail what happened and she understood and I offered to fix this immediately. I purchased money order for RP [Responsible Party], and we agreed to pos it to resident account. Once I confirmed money was posted to report to administrator situation. However, she beat me to this pulled me in office, and we discussed the entire situation. RP [Responsible Party] is not going to press charges, is not upset, she fully understood this was an innocent mistake. We agreed that she would tell resident that she has taken care of issue.Reason for this is because we agreed resident to be at peace knowing nobody took advantage of her and no details given to her so that she would not be given information that was not full story, added to or changed in any way. [sic] 2. Record review of Resident #2's admission record, dated 04/02/2026, reflected a [AGE] year-old male admitted [DATE]. His diagnoses included atherosclerotic heart disease (condition where the coronary arteries become narrowed or blocked due to buildup, which reduces blood flow to the heart muscle), personal history of transient ischemic attack (temporary blockage of blood flow to the brain), and seizures (a sudden burst of electrical activity in the brain). Record review of Resident #2's quarterly Minimum Data Set (MDS), dated [DATE] and signed 01/28/2026 as completed, reflected a BIMS (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score of 13, indicating intact cognition, organized thinking and did not reveal concerns of short-term or long-term memory. Resident #2's functional abilities were documented as being independent for self-care and mobility. Record review of Resident #2's care plan, created on 12/29/2023 and revised on 01/15/2024, indicated Resident #2 was able to participate in activities of my choice with my physical cognitive ability. Record review of Resident #2's Grievance/Concern - Residents and Families, dated 03/13/2026 revealed the date occurrence of his submitted grievance was on 03/09/2026 - 03/11/2026. Concern/Details: Missing 57 dollars from locked drawer, with resident remembering it was locked, with the key being in another drawer, that was not locked, with resident's socks, in the corner, where it is visible. Social Worker was the team member receiving report from Resident #2 and actions taken on 03/13/2026, Social worker examined drawer, not broken, and can not be opened without a key. Key visible where it was kept in other drawer, despite resident covering it w/ socks. No money found. Resident #2 notified in person of the facility response to his grievance, Response: educated resident on proper key use for locking drawer, that he has right to keep key on person, have a log for spending, and that no one else has access to his drawer when locked, and that he has the right to file a police report. He stated he understood and did not want to file a police report at this time. The Administrator was made aware of the grievance and on 03/16/2026 signed off on the actions and response taken by the Social Worker followed by a secondary review on 03/18/2026 by the On Site Representative, veteran's advocate on 03/18/2026. Resident #2 was unavailable for observation or interview. During an interview on 04/02/2026 at 3:00 p.m. the DON said all staff were expected to report allegations of ANE immediately to the Abuse Coordinator, the Administrator. She said she did recall Resident #1's grievance of unauthorized use of her credit card, but as this was an unintentional occurrence the incident was not reported to the State, but perhaps it should have been. She said as this allegation was not reported to the State Survey Agency an investigation did not occur. She said she was not notified of Resident #2's grievance on theft of funds from his room that was reported on 03/16/2026. She said she was not aware if the incident was investigated any further by the Administrator. During a phone interview on 04/02/2026 at 8:54 p.m. the Administrator said she was the Abuse and Neglect Coordinator for the facility. She said she was responsible for following the State Survey Agency provider letter and investigating allegations of ANE within 5 days of being notified. She said she recalled the grievance Resident #1 submitted on the unauthorized use of her credit card. She said the incident was not reported to the State as it was not intentional and did not rise to the level of an alleged violation and she did not investigate further. She said she recalled the grievance Resident #2 submitted regarding theft of funds from his room. She said the grievance was handled by the Social Worker and she was not familiar with the details. She said not all grievances involving money were allegations to be reported to the State Survey Agency and felt it did not warrant reporting. She said she did not investigate the grievance as it was not an official allegation. Record review of document titled, Code of Conduct, undated, reflected the following: I will respect resident rights. I will not mistreat, neglect or abuse residents, and I will not take any resident property. I will immediately report any resident mistreatment, abuse, neglect, or theft of resident property, to my supervisor. I will report any actual or suspected violations of applicable laws, or this Code of Conduct, to my supervisor, community administrator. Record review of document titled, Grievances, dated 01/2023 reflected the following: The investigation of complaints and grievances is a vital function to protect the health, safety, and welfare of residents. Each resident has the right to receive prompt resolution of grievances, including those regarding the behavior of other residents. Record review of document titled, Statement of Resident Rights, dated January 2023 reflected the following: Resident/Patient Rights include: 3. To be free from abuse and exploitation; 14. To keep and use personal property, secure from theft or loss. Record review of document titled, Abuse Guidance: Preventing, Identifying and Reporting dated January 2024 reflected the following: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, community team (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members. It is the responsibility of our team members, Community consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to Community management.Reporting/Response- All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individuals as may be required by law and per the current state/federal reporting requirements. Types of abuse Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful (whether temporary or permanent) use of a resident's belongings or money without the resident's consent. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Record review of QAPI Collaboration: The facility will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI Committee.Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about.Tracking patterns of similar occurrences.