STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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 - 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** 48235 Based on observation, interview, and record review, the facility failed to ensure residents were free from Misappropriation of property for 1 (Resident # 1) of 8 residents reviewed for misappropriation of property. The facility failed to protect Resident #1 from misappropriation of property from CNA A. CNA A used Resident #1's Debit card for unauthorized transactions. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 08/24/2024 and ended on 09/03/2024. The facility had corrected the noncompliance before the Incident investigation began on 02/04/2025. This failure could place residents at risk of Exploitation/Misappropriation of Property and loss of lifelong earnings. Findings included: Record review of Resident #1's face sheet dated 02/05/2025 revealed he was a [AGE] year-old male with an admitted [DATE]. His diagnoses included mild cognitive impairment of uncertain or unknown etiology (exact cause of the memory/cognitive decline cannot be determined) Primary Open Angle Glaucoma, (Increased pressure inside eye which may cause gradual damage to the optic nerve), Hypertension (blood pressure in the arteries is consistently elevated). Record review of Resident #1's MDS assessment dated [DATE] revealed he had a BIMS score of 14, which indicated he had an intact cognition. Resident #1 needed extensive assistance with ADLs for toileting and personal hygiene. Record review of Resident #1's progress note dated 08/24/2024 at 04:24 PM created by RN supervisor reflected Resident #1 reported to RN supervisor about missing credit card and RN supervisor reported it immediately to the administrator. Resident's [family member] was in the room with the resident, they searched for the card but could not find it. On further noted the credit card has been used to make several purchases including Greyhound ticket to Los Angeles California. Police was called, awaiting dispatch to the facility. Review of the PIR dated 09/03/2024 for incident report # 527680 reflected the date this incident was reported to HHSC was on 08/26/2024 and the date the PIR submitted to the state was on 09/03/2024. (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
	676270	A. Building B. Wing	02/05/2025

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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 PIR (Form 3613-A of Texas Health and Human Services) dated 09/03/2024 reflected the incident date as 08/26/2024. The PIR summary reflected the Resident #1 reported to the facility staff that his debit card went missing after he last used it at the facility front desk. Upon further investigation by the facility, [department store] surveillance camera captured one of the facility employees making unauthorized purchases, totaling $161.60 with Resident #1's debit card. [Department store] was unable to release the video footage without police involvement. [Local] police was notified, online report was created with a report dated 08/27/2024 at 01:42 PM. The resident #1's family, MD, Ombudsman were also notified. Based on the facility investigation findings, it was determined that the incident involving the theft and unauthorized use of Resident #1's debit card was the result of actions taken by an individual staff member. An initial interview with the facility administrator on 02/04/2025 at 12:41 PM revealed she learned that Resident #1's debit card was missing on 08/26/2024. She stated Resident #1 was a new admission. On the next day, Resident #1's family member came and reported to her that Resident #1's debit card was missing, the last time Resident #1 used it was at the front desk. Resident #1's family member told her that she noticed several charges on the card transaction history, and transactions took place on [NAME] Avenue, the same street where the facility was located. The Administrator stated she went over to the gas station where the card was used but they refused to provide any information. Intereview revealed she then went to department store where the card was used for unauthorized transaction The Administrator stated the store let her see the video footage of the person , who was using the card. Interview revealed the Adminstrator recognized the facility employee, CNA A as the person who was making the unauthorized transaction. The department store refused to provide her a copy of the video footage without police involvement. The Administrator stated she called the police and reported the incident. The Administrator stated she tried calling CNA A on her cell phone, but CNA A never answered or returned her call, CNA A never came back to the facility to collect her remaining check for the time she worked and so she was not able to talk to the CNA A about the alleged incident. She stated she did not know how CNA A got hold of Resident #1's debit card. The Administrator stated she immediately acted, called a staff meeting and provided in service on elder justice act, abuse/ neglect, resident rights, misappropriation of resident property, a QAPI meeting with department heads and discussed how to prevent such incidents, held a resident council meeting notifying them of not sharing card or card info with any staff, Educated on misappropriation, if a resident had to buy something from the vending machine inside the facility, a staff will assist the resident to the vending machine and resident did transaction themselves . She stated those residents who received trust fund money had a shopping day and they used cash only for transactions. Those residents who wanted to buy something from outside, most of them used the family assistance, the facility had a facility credit card for resident purchases and used that for some residents, the residents never gave their card to the employees. CNA A was terminated on 09/03/24. The Administrator stated Resident lost a total of $161.60. The facility gave the lost money back to the resident, completed audit on debit credit card holders among residents, sent letter out to those residents who had debit /credit card asking them to check for unauthorized transactions and to notify facility if they noticed any, completed a survey among residents who managed own money and there were no other concerns. The Administrator stated she was the abuse coordinator; she expected all the employees to not take any of resident belongings and she expected all employees to notify her of any suspicion of abuse/neglect/misappropriation immediately. (continued on next page)

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	An interview with CNA B on 02/04/2025 at 02:15 PM revealed misappropriation was, taking the resident's valuable things without their permission. She stated she received in service on abuse/neglect/misappropriation within the past month. She stated she was not aware of any resident who lost their bank debit/credit card. She stated she would immediately report to the administrator of any such abuse/neglect/misappropriation concerns. CNA B stated she never accepted cash or bank card from a resident, she stated if a resident wanted to purchase anything from outside, they had to get permission from the administrator and work with the activity director. An interview with CNA C on 02/04/2025 at 02:52 PM revealed misappropriation was taking the resident's belongings, he stated he was not supposed to accept any cash, credit/debit card from residents and he would direct the resident to the nurse if they wanted to purchase something. He stated he would not go through resident's belongings unless resident wanted him to search for something missing. He stated he was not aware of any resident who lost their bank card at the facility. He stated none of the staff were supposed to misappropriate a resident's cash or valuable things and he would notify the administrator/abuse coordinator about misappropriation immediately. He stated he received in service training on misappropriation within the past one month. An interview with the Corporate Business Office Consultant on 02/04/2025 at 03:11 PM revealed the facility's business manager was on medical leave and she came to the facility a few days to complete the work. She stated she was aware of the incident involving Resident #1 and CNA A. She stated Resident #1 managed his own money, bank cards and he reported to the administrator that his bank card got stolen. She stated the police was notified, the resident's card was cancelled, and he received a new debit card. She stated none of the employees were expected to accept cash/bank cards from residents, only the Activity Director was responsible to assist residents in purchasing outside goods with cash payment and the administrator was involved in the process. She stated she was not aware of any other incidents of missing bank cards; she stated the employee/CNA A stole the debit card and then used it for unauthorized transactions. An interview with the Dietary Manager on 02/05/2025 at 09:35 AM revealed Misappropriation was taking resident's clothes, belongings without their permission. She stated she received in service on Misappropriation within the past few weeks. She stated she heard about the alleged misappropriation incident from other employees, she stated she would not accept debit/credit cards/cash from the residents, she would direct them to the activity department for any purchases. She stated she would notify the administrator of any misappropriation concerns immediately. She stated she was not aware of any resident lost their card or money. She stated CNA A no longer worked at the facility. An interview with the MA on 02/05/2025 at 09:43 AM revealed she was working at the facility for 2 years. The MA stated misappropriation was taking a resident's belongings such as money, clothes, valuables without their permission. The MA stated she received in services on misappropriation within the past one month. The MA stated she was not aware of any misappropriation of credit/debit cards. She stated she would never accept any bank card or cash from a resident, she would direct the resident to the activity director for any purchases. She stated she was not aware of the alleged misappropriation incident. She stated she would immediately report the administrator of any suspicion of abuse/neglect/misappropriation. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Dietary Aide on 02/05/2025 at 09:52 AM revealed misappropriation was taking resident's belongings without their permission, and she received in service on Misappropriation within the past month. She stated she would not accept cash/bank cads from the residents, the activity director was responsible to assist residents with purchases. She stated she would immediately report of any misappropriation concerns to the administrator. An interview with Resident #1 over the phone on 02/05/2025 at 11:06 AM revealed he was currently staying at his residence. He stated he stayed for few weeks at the facility for rehab and at that time his debit card went missing from the facility front desk. Resident stated he left the card at the front desk and returned to his room to pick up something, by the time he came back to the front desk, the card went missing. Resident stated he could not remember the exact date, but he immediately reported this to the facility staff, and he called the police and reported the incident. Resident stated he noticed on the online bank transaction history that his card was used at some stores close by the facility, he stated the transactions included a department store, restaurants, and a bus ticket to California. Resident stated he learned from the police that one of the facility employees stole his card and used it initially, later the police caught a man from California using his card. He stated he lost a total of $800, and the facility did not pay him anything so far. He stated he did not have a copy of his bank statement ready to send to the investigator at that time. Resident stated he filed fraud charges with the bank, he received new debit card, and his finances were safe now. Resident stated he did not go without any of his immediate needs due to the theft. An attempt for a telephone interview with CNA A was made on 02/05/2025 at 11:19 AM on her cell. A man answered and stated that was a wrong number for CNA A and that he did not know CNA A. An attempted telephone interview with RN supervisor was made on 02/05/2025 at 12:16 PM on her cell phone, but received no answer, left voice mail requesting a call back. An interview with the Activity Director on 02/05/2025 at 01:40 PM revealed she was working at the facility for 4 years. She stated misappropriation was taking/using resident's valuables for unauthorized use. She stated administrator informed her about the alleged incident and she was not involved in it. She stated none of the residents gave credit/debit card to the employees. She went to the store to purchase things for residents on every second Thursdays and those residents who wanted to purchase something would give her the list. Residents who had trust fund account collected money from the business office and gave the money to the activity director. The activity director verified each resident transaction with the facility administrator before and after the purchase, showed receipts, returned balance amount and items to the residents. The Activity director stated she never accepted debit/credit card from residents, and she was not aware of card theft/misappropriation other than the one involving Resident #1. She stated she would immediately report to the administrator of any suspicion of abuse/neglect/misappropriation. An interview with LVN D on 02/05/2025 at 03:30 PM revealed misappropriation was a type of abuse, taking resident's valuables without their permission was misappropriation. She stated she received in service on misappropriation within one week. She stated she would immediately report to the abuse coordinator/administrator of any concerns of misappropriation. She stated she was not aware of any resident missing their cash or bank debit/credit cards. She stated none of the employees were supposed to accept cash or debit/credit cards from residents and she would direct them to the activity director for any purchases. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the administrator on 02/05/2025 at 04:51 PM revealed she was working at the facility as the administrator for a year and she was the abuse coordinator. She stated, once she learned about misappropriation, she had 24 hours to report it to the state, she had 5 days to submit the report of her investigation to the state and that was the policy of their facility. The investigator observed the administrator referring the PIR regarding this incident, and she stated this misappropriation incident was reported to her on 08/26/2024 and she reported this incident to the state on the same day. She stated as soon as she learned about the allegation, she suspended CNA A, removed her from the schedule, CNA A was working 6 AM 2 PM shift that week. The Administrator stated CNA A did not work at the facility or answer her call after the alleged incident of Resident #1's missing debit card. During the interview, the administrator was observed reading Resident #1's progress note dated 08/24/2024 at 04:24 PM, entered by RN supervisor, that the incident was reported to the RN supervisor by the resident and that she had immediately reported this to the abuse coordinator/administrator. The administrator initially stated the resident's family member told her that the debit card was missing, and administrator did not consider it as misappropriation until 08/26/2024, since she wanted to give the family enough time to search for the missing card. The Administrator later stated learned about this misappropriation on 08/24/2024 and she was responsible to report this to the state within 24 hours, which could have been by 08/25/2024 at 04:24 PM. The Administrator stated she was responsible to submit her investigation report to the state within 5 days per policy, she stated even if the incident was reported to her on 08/26/2024, she was supposed to submit the investigation report by 08/30/2024, but per the PIR the investigation report was submitted to the state on 09/03/2024. The Administrator stated she did not follow policy on reporting the misappropriation incident to the state within 24 hours and did not follow policy on submitting the investigation report to the state within 5 days from the date of reporting. An interview with the corporate administrator on 02/05/2025 at 05:36 PM revealed the facility administrator was the abuse coordinator, Resident #1 reported this incident to the facility staff on 08/24/2024 and the administrator was responsible to report the misappropriation incident to the state within 24 hours. The corporate administrator sated the facility administrator was responsible to submit the PIR to the state within 5 days and the facility administrator failed to follow and implement policy since it took longer than 5 days. An interview with the DON on 02/05/25 at 06:10 PM revealed he was working at the facility for 3 months. The DON stated misappropriation was recognized as abuse, needed to be reported immediately to the administrator by him or any employee who had the knowledge of that incident. He stated the facility staff received in service on misappropriation regularly, he could not remember the most recent Inservice date. He stated if a resident reported missing item such as a debit card, he would immediately assist the resident in searching the room and ask family members about it. If it was not found, then he would immediately notify the administrator. He stated he did not want any employees to take resident's belongings, he stated it was important to report misappropriation incidents immediately and take precautionary action to prevent further occurrence of the incident. Record review of CNA A's personal file revealed her date of hire was 02/15/2024. Last day at work was on 08/25/2024, involuntary termination date was on 09/03/2024, for violation of policy and procedure. Record review of in-service attendance record dated 08/30/2024 revealed employees received in service on topic: resident rights, elder justice act, abuse/ neglect, misappropriation. (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 the facility policy titled, Abuse Prevention and Prohibition Program revised October 24,2022 reflected, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235 Based on observation, interview, and record review, the facility failed to implement their written policies and procedures regarding allegations of abuse/neglect for 1(Resident#1) of 8 residents reviewed for abuse/neglect. The facility failed to report a suspicion of misappropriation of property within 24 hours to the state agency as required by their policy. This failure could place all residents at risk of misappropriation of property. Findings included: Record review of Resident #1's face sheet dated 02/05/2025 revealed he was a [AGE] year-old male with an admitted [DATE]. His diagnoses included mild cognitive impairment of uncertain or unknown etiology (exact cause of the memory/cognitive decline cannot be determined) Primary Open Angle Glaucoma, (Increased pressure inside eye which may cause gradual damage to the optic nerve), Hypertension (blood pressure in the arteries is consistently elevated). Record review of Resident #1's MDS assessment dated [DATE] revealed he had a BIMS score of 14, which indicated he had an intact cognition. Resident #1 needed extensive assistance with ADLs for toileting and personal hygiene. Record review of Resident #1's progress note dated 08/24/2024 at 04:24 PM created by RN supervisor reflected Resident #1 reported to RN supervisor about missing credit card and RN supervisor reported it immediately to the administrator. Resident's [family member] was in the room with the resident, they searched for the card but could not find it. On further noted the credit card has been used to make several purchases including Greyhound ticket to Los Angels California. Police was called, awaiting dispatch to the facility. Review of the PIR dated 09/03/2024 for incident report # 527680 reflected the date this incident was reported to HHSC was on 08/26/2024, date the PIR submitted to the state was on 09/03/2024. Record review of PIR (Form 3613-A of Texas Health and Human Services) dated 09/03/2024 reflected the incident date as 08/26/2024. The PIR summary reflected the Resident #1 reported to the facility staff that his debit card went missing after he last used it at the facility front desk. Upon further investigation by the facility, [department store] surveillance camera captured one of the facility employees making unauthorized purchases, totaling $161.60 with Resident #1's debit card. [Department store] was unable to release the video footage without police involvement. [Local] police was notified, online report was created with a report dated 08/27/2024 at 01:42 PM. The resident #1's family, MD, Ombudsman were also notified. Based on the facility investigation findings, it was determined that the incident involving the theft and unauthorized use of Resident #1's debit card was the result of actions taken by an individual staff member. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An initial interview with the facility administrator on 02/04/2025 at 12:41 PM revealed she learned that Resident #1's debit card was missing on 08/26/2024. She stated Resident #1 was a new admission, the next day Resident #1's family member came and reported to her that Resident #1's debit card was missing, the last time Resident #1 used it was at the front desk. Resident #1's family member told her that she noticed several charges on the card transaction history, and transactions took place on [NAME], the same street where the facility was located. The Administrator stated she went over to the gas station where the card was used but they refused to provide any information, she then went to department store where the card was used for unauthorized transaction, they let her see the video footage of the person who was using the card and she recognized the facility employee, CNA A as the person who was making the unauthorized transaction. The department store refused to provide her a copy of the video footage without police involvement. The Administrator stated she called the police and reported the incident. The Administrator stated she tried calling CNA A on her cell phone, but CNA A never answered or returned her call, CNA A never came back to the facility to collect her remaining check for the time she worked and so she was not able to talk to the CNA A about the alleged incident. She stated she did not know how CNA A got hold of Resident #1's debit card. The Administrator stated she immediately acted, called a staff meeting and provided in service on elder justice act, abuse/ neglect, resident rights, misappropriation of resident property, a QAPI meeting with department heads and discussed how to prevent such incidents, held a resident council meeting notifying them of not sharing card or card info with any staff, Educated on misappropriation, if a resident had to buy something from the vending machine inside the facility, a staff will assist the resident to the vending machine and resident did transaction themselves . She stated those residents who received trust fund money had a shopping day and they used cash only for transactions. Those residents who wanted to buy something from outside, most of them used the family assistance, the facility had a facility credit card for resident purchases and used that for some residents, the residents never gave their card to the employees. CNA A was terminated on 09/03/24. The Administrator stated Resident lost a total of $161.60. The facility gave the lost money back to the resident, completed audit on debit credit card holders among residents, sent letter out to those residents who had debit /credit card asking them to check for unauthorized transactions and to notify facility if they noticed any, completed a survey among residents who managed own money and there were no other concerns. The Administrator stated she was the abuse coordinator; she expected all the employees to not take any of resident belongings and she expected all employees to notify her of any suspicion of abuse/neglect/misappropriation immediately. An interview with CNA B on 02/04/2025 at 02:15 PM revealed misappropriation was, taking the resident's valuable things without their permission. She stated she received in service on abuse/neglect/misappropriation within the past month. She stated she was not aware of any resident who lost their bank debit/credit card. She stated she would immediately report to the administrator of any such abuse/neglect/misappropriation concerns. CNA B stated she never accepted cash or bank card from a resident, she stated if a resident wanted to purchase anything from outside, they had to get permission from the administrator and work with the activity director. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with CNA C on 02/04/2025 at 02:52 PM revealed misappropriation was taking the resident's belongings, he stated he was not supposed to accept any cash, credit/debit card from residents and he would direct the resident to the nurse if they wanted to purchase something. He stated he would not go through resident's belongings unless resident wanted him to search for something missing. He stated he was not aware of any resident who lost their bank card at the facility. He stated none of the staff were supposed to misappropriate a resident's cash or valuable things and he would notify the administrator/abuse coordinator about misappropriation immediately. He stated he received in service training on misappropriation within the past one month. An interview with the Corporate Business Office Consultant on 02/04/2025 at 03:11 PM revealed the facility's business manager was on medical leave and she came to the facility a few days to complete the work. She stated she was aware of the incident involving Resident #1 and CNA A. She stated Resident #1 managed his own money, bank cards and he reported to the administrator that his bank card got stolen. She stated the police was notified, the resident's card was cancelled, and he received a new debit card. She stated none of the employees were expected to accept cash/bank cards from residents, only the Activity Director was responsible to assist residents in purchasing outside goods with cash payment and the administrator was involved in the process. She stated she was not aware of any other incidents of missing bank cards; she stated the employee/CNA A stole the debit card and then used it for unauthorized transactions. An interview with the Dietary Manager on 02/05/2025 at 09:35 AM revealed Misappropriation was taking resident's clothes, belongings without their permission. She stated she received in service on Misappropriation within the past few weeks. She stated she heard about the alleged misappropriation incident from other employees, she stated she would not accept debit/credit cards/cash from the residents, she would direct them to the activity department for any purchases. She stated she would notify the administrator of any misappropriation concerns immediately. She stated she was not aware of any resident lost their card or money. She stated CNA A no longer worked at the facility. An interview with the MA on 02/05/2025 at 09:43 AM revealed she was working at the facility for 2 years. The MA stated misappropriation was taking a resident's belongings such as money, clothes, valuables without their permission. The MA stated she received in services on misappropriation within the past one month. The MA stated she was not aware of any misappropriation of credit/debit cards. She stated she would never accept any bank card or cash from a resident, she would direct the resident to the activity director for any purchases. She stated she was not aware of the alleged misappropriation incident. She stated she would immediately report the administrator of any suspicion of abuse/neglect/misappropriation. An interview with Dietary Aide on 02/05/2025 at 09:52 AM revealed misappropriation was taking resident's belongings without their permission, and she received in service on Misappropriation within the past month. She stated she would not accept cash/bank cads from the residents, the activity director was responsible to assist residents with purchases. She stated she would immediately report of any misappropriation concerns to the administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #1 over the phone on 02/05/2025 at 11:06 AM revealed he was currently staying at his residence. He stated he stayed for few weeks at the facility for rehab and at that time his Debit card went missing from the facility front desk. Resident stated he left the card at the front desk and returned to his room to pick up something, by the time he came back to the front desk, the card went missing. Resident stated he could not remember the exact date, but he immediately reported this to the facility staff, and he called the police and reported the incident. Resident stated he noticed on the online bank transaction history that his card was used at some stores close by the facility, he stated the transactions included a department store, restaurants, and a bus ticket to California. Resident stated he learned from the police that one of the facility employees stole his card and used it initially, later the police caught a man from California using his card. He stated he lost a total of $800, and the facility did not pay him anything so far. He stated he did not have a copy of his bank statement ready to send to the investigator at that time. Resident stated he filed fraud charges with the bank, he received new debit card, and his finances were safe now. Resident stated he did not go without any of his immediate needs due to the theft. An attempt for a telephone interview with CNA A was made on 02/05/2025 at 11:19 AM on her cell. A man answered and stated that was a wrong number for CNA A and that he did not know CNA A. An attempted telephone interview with RN supervisor was made on 02/05/2025 at 12:16 PM on her cell phone, but received no answer, left voice mail requesting a call back. Record review of CNA A's personal file revealed her date of hire was 02/15/2024. Last day at work was on 08/25/2024, involuntary termination date was on 09/03/2024, for violation of policy and procedure. Record review of in-service attendance record dated 08/30/2024 revealed employees received in service on topic: resident rights, elder justice act, abuse/ neglect, misappropriation. An interview with the Activity Director on 02/05/2025 at 01:40 PM revealed she was working at the facility for 4 years. She stated misappropriation was taking/using resident's valuables for unauthorized use. She stated administrator informed her about the alleged incident and she was not involved in it. She stated none of the residents gave credit/debit card to the employees. She went to the store to purchase things for residents on every second Thursdays and those residents who wanted to purchase something would give her the list. Residents who had trust fund account collected money from the business office and gave the money to the activity director. The activity director verified each resident transaction with the facility administrator before and after the purchase, showed receipts, returned balance amount and items to the residents. The Activity director stated she never accepted debit/credit card from residents, and she was not aware of card theft/misappropriation other than the one involving Resident #1. She stated she would immediately report to the administrator of any suspicion of abuse/neglect/misappropriation. An interview with LVN D on 02/05/2025 at 03:30 PM revealed misappropriation was a type of abuse, taking resident's valuables without their permission was misappropriation. She stated she received in service on misappropriation within one week. She stated she would immediately report to the abuse coordinator/administrator of any concerns of misappropriation. She stated she was not aware of any resident missing their cash or bank debit/credit cards. She stated none of the employees were supposed to accept cash or debit/credit cards from residents and she would direct them to the activity director for any purchases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	02/05/2025

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Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the administrator on 02/05/2025 at 04:51 PM revealed she was working at the facility as the administrator for a year and she was the abuse coordinator. She stated, once she learned about misappropriation, she had 24 hours to report it to the state, she had 5 days to submit the report of her investigation to the state and that was the policy of their facility. The investigator observed the administrator referring the PIR regarding this incident, and she stated this misappropriation incident was reported to her on 08/26/2024 and she reported this incident to the state on the same day. She stated as soon as she learned about the allegation, she suspended CNA A, removed her from the schedule, CNA A was working 6 AM 2 PM shift that week. The Administrator stated CNA A did not work at the facility or answer her call after the alleged incident of Resident #1's missing debit card. During the interview, the administrator was observed reading Resident #1's progress note dated 08/24/2024 at 04:24 PM, entered by RN supervisor, that the incident was reported to the RN supervisor by the resident and that she had immediately reported this to the abuse coordinator/administrator. The administrator initially stated the resident's family member told her that the debit card was missing, and administrator did not consider it as misappropriation until 08/26/2024, since she wanted to give the family enough time to search for the missing card. The Administrator later stated learned about this misappropriation on 08/24/2024 and she was responsible to report this to the state within 24 hours, which could have been by 08/25/2024 at 04:24 PM. The Administrator stated she was responsible to submit her investigation report to the state within 5 days per policy, she stated even if the incident was reported to her on 08/26/2024, she was supposed to submit the investigation report by 08/30/2024, but per the PIR the investigation report was submitted to the state on 09/03/2024. The Administrator stated she did not follow policy on reporting the misappropriation incident to the state within 24 hours and did not follow policy on submitting the investigation report to the state within 5 days from the date of reporting. An interview with the corporate administrator on 02/05/2025 at 05:36 PM revealed the facility administrator was the abuse coordinator, Resident #1 reported this incident to the facility staff on 08/24/2024 and the administrator was responsible to report the misappropriation incident to the state within 24 hours. The corporate administrator sated the facility administrator was responsible to submit the PIR to the state within 5 days and the facility administrator failed to follow and implement policy since it took longer than 5 days. An interview with the DON on 02/05/25 at 06:10 PM revealed he was working at the facility for 3 months. The DON stated misappropriation was recognized as abuse, needed to be reported immediately to the administrator by him or any employee who had the knowledge of that incident. He stated the facility staff received in service on misappropriation regularly, he could not remember the most recent Inservice date. He stated if a resident reported missing item such as a debit card, he would immediately assist the resident in searching the room and ask family members about it. If it was not found, then he would immediately notify the administrator. He stated he did not want any employees to take resident's belongings, he stated it was important to report misappropriation incidents immediately and take precautionary action to prevent further occurrence of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Abuse Prevention and Prohibition Program revised October 24,2022 reflected, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. D. The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime. See AN - 01 - Form E - Initial Report - Facility Reported Incidents. ii. No later than 24 hours after forming the suspicion - if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation).

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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 - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235 Based on observation, interview and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and the alleged violation is verified appropriate corrective action was taken for 1 of 8 residents (Residents #1) reviewed for Misappropriation of property. The facility failed to investigate and submit the results of their investigation within 5 days as per their policy, after Resident #1 reported his debit card was missing on 08/24/2024. This failure could place residents at risk of Misappropriation of property. Findings included: Record review of Resident #1's face sheet dated 02/05/2025 revealed he was a [AGE] year-old male with an admitted [DATE]. His diagnoses included mild cognitive impairment of uncertain or unknown etiology (exact cause of the memory/cognitive decline cannot be determined) Primary Open Angle Glaucoma, (Increased pressure inside eye which may cause gradual damage to the optic nerve), Hypertension (blood pressure in the arteries is consistently elevated). Record review of Resident #1's MDS assessment dated [DATE] revealed he had a BIMS score of 14, which indicated he had an intact cognition. Resident #1 needed extensive assistance with ADLs for toileting and personal hygiene. Record review of Resident #1's progress note dated 08/24/2024 at 04:24 PM created by RN supervisor reflected Resident #1 reported to RN supervisor about missing credit card and RN supervisor reported it immediately to the administrator. Resident's [family member] was in the room with the resident, they searched for the card but could not find it. On further noted the credit card has been used to make several purchases including Greyhound ticket to Los Angels California. Police was called, awaiting dispatch to the facility. Review of the PIR dated 09/03/2024 for incident report # 527680 reflected the date this incident was reported to HHSC was on 08/26/2024, date the PIR submitted to the state was on 09/03/2024. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of PIR (Form 3613-A of Texas Health and Human Services) dated 09/03/2024 reflected the incident date as 08/26/2024. The PIR summary reflected the Resident #1 reported to the facility staff that his debit card went missing after he last used it at the facility front desk. Upon further investigation by the facility, [department store] surveillance camera captured one of the facility employees making unauthorized purchases, totaling $161.60 with Resident #1's debit card. [Department store] was unable to release the video footage without police involvement. [Local] police was notified, online report was created with a report dated 08/27/2024 at 01:42 PM. The resident #1's family, MD, Ombudsman were also notified. Based on the facility investigation findings, it was determined that the incident involving the theft and unauthorized use of Resident #1's debit card was the result of actions taken by an individual staff member. An initial interview with the facility administrator on 02/04/2025 at 12:41 PM revealed she learned that Resident #1's debit card was missing on 08/26/2024. She stated Resident #1 was a new admission, the next day Resident #1's family member came and reported to her that Resident #1's debit card was missing, the last time Resident #1 used it was at the front desk. Resident #1's family member told her that she noticed several charges on the card transaction history, and transactions took place on [NAME], the same street where the facility was located. The Administrator stated she went over to the gas station where the card was used but they refused to provide any information, she then went to department store where the card was used for unauthorized transaction, they let her see the video footage of the person who was using the card and she recognized the facility employee, CNA A as the person who was making the unauthorized transaction. The department store refused to provide her a copy of the video footage without police involvement. The Administrator stated she called the police and reported the incident. The Administrator stated she tried calling CNA A on her cell phone, but CNA A never answered or returned her call, CNA A never came back to the facility to collect her remaining check for the time she worked and so she was not able to talk to the CNA A about the alleged incident. She stated she did not know how CNA A got hold of Resident #1's debit card. The Administrator stated she immediately acted, called a staff meeting and provided in service on elder justice act, abuse/ neglect, resident rights, misappropriation of resident property, a QAPI meeting with department heads and discussed how to prevent such incidents, held a resident council meeting notifying them of not sharing card or card info with any staff, Educated on misappropriation, if a resident had to buy something from the vending machine inside the facility, a staff will assist the resident to the vending machine and resident did transaction themselves . She stated those residents who received trust fund money had a shopping day and they used cash only for transactions. Those residents who wanted to buy something from outside, most of them used the family assistance, the facility had a facility credit card for resident purchases and used that for some residents, the residents never gave their card to the employees. CNA A was terminated on 09/03/24. The Administrator stated Resident lost a total of $161.60. The facility gave the lost money back to the resident, completed audit on debit credit card holders among residents, sent letter out to those residents who had debit /credit card asking them to check for unauthorized transactions and to notify facility if they noticed any, completed a survey among residents who managed own money and there were no other concerns. The Administrator stated she was the abuse coordinator; she expected all the employees to not take any of resident belongings and she expected all employees to notify her of any suspicion of abuse/neglect/misappropriation immediately. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with CNA B on 02/04/2025 at 02:15 PM revealed misappropriation was, taking the resident's valuable things without their permission. She stated she received in service on abuse/neglect/misappropriation within the past month. She stated she was not aware of any resident who lost their bank debit/credit card. She stated she would immediately report to the administrator of any such abuse/neglect/misappropriation concerns. CNA B stated she never accepted cash or bank card from a resident, she stated if a resident wanted to purchase anything from outside, they had to get permission from the administrator and work with the activity director. An interview with CNA C on 02/04/2025 at 02:52 PM revealed misappropriation was taking the resident's belongings, he stated he was not supposed to accept any cash, credit/debit card from residents and he would direct the resident to the nurse if they wanted to purchase something. He stated he would not go through resident's belongings unless resident wanted him to search for something missing. He stated he was not aware of any resident who lost their bank card at the facility. He stated none of the staff were supposed to misappropriate a resident's cash or valuable things and he would notify the administrator/abuse coordinator about misappropriation immediately. He stated he received in service training on misappropriation within the past one month. An interview with the Corporate Business Office Consultant on 02/04/2025 at 03:11 PM revealed the facility's business manager was on medical leave and she came to the facility a few days to complete the work. She stated she was aware of the incident involving Resident #1 and CNA A. She stated Resident #1 managed his own money, bank cards and he reported to the administrator that his bank card got stolen. She stated the police was notified, the resident's card was cancelled, and he received a new debit card. She stated none of the employees were expected to accept cash/bank cards from residents, only the Activity Director was responsible to assist residents in purchasing outside goods with cash payment and the administrator was involved in the process. She stated she was not aware of any other incidents of missing bank cards; she stated the employee/CNA A stole the debit card and then used it for unauthorized transactions. An interview with the Dietary Manager on 02/05/2025 at 09:35 AM revealed Misappropriation was taking resident's clothes, belongings without their permission. She stated she received in service on Misappropriation within the past few weeks. She stated she heard about the alleged misappropriation incident from other employees, she stated she would not accept debit/credit cards/cash from the residents, she would direct them to the activity department for any purchases. She stated she would notify the administrator of any misappropriation concerns immediately. She stated she was not aware of any resident lost their card or money. She stated CNA A no longer worked at the facility. An interview with the MA on 02/05/2025 at 09:43 AM revealed she was working at the facility for 2 years. The MA stated misappropriation was taking a resident's belongings such as money, clothes, valuables without their permission. The MA stated she received in services on misappropriation within the past one month. The MA stated she was not aware of any misappropriation of credit/debit cards. She stated she would never accept any bank card or cash from a resident, she would direct the resident to the activity director for any purchases. She stated she was not aware of the alleged misappropriation incident. She stated she would immediately report the administrator of any suspicion of abuse/neglect/misappropriation. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Dietary Aide on 02/05/2025 at 09:52 AM revealed misappropriation was taking resident's belongings without their permission, and she received in service on Misappropriation within the past month. She stated she would not accept cash/bank cads from the residents, the activity director was responsible to assist residents with purchases. She stated she would immediately report of any misappropriation concerns to the administrator. An interview with Resident #1 over the phone on 02/05/2025 at 11:06 AM revealed he was currently staying at his residence. He stated he stayed for few weeks at the facility for rehab and at that time his Debit card went missing from the facility front desk. Resident stated he left the card at the front desk and returned to his room to pick up something, by the time he came back to the front desk, the card went missing. Resident stated he could not remember the exact date, but he immediately reported this to the facility staff, and he called the police and reported the incident. Resident stated he noticed on the online bank transaction history that his card was used at some stores close by the facility, he stated the transactions included a department store, restaurants, and a bus ticket to California. Resident stated he learned from the police that one of the facility employees stole his card and used it initially, later the police caught a man from California using his card. He stated he lost a total of $800, and the facility did not pay him anything so far. He stated he did not have a copy of his bank statement ready to send to the investigator at that time. Resident stated he filed fraud charges with the bank, he received new debit card, and his finances were safe now. Resident stated he did not go without any of his immediate needs due to the theft. An attempt for a telephone interview with CNA A was made on 02/05/2025 at 11:19 AM on her cell. A man answered and stated that was a wrong number for CNA A and that he did not know CNA A. An attempted telephone interview with RN supervisor was made on 02/05/2025 at 12:16 PM on her cell phone, but received no answer, left voice mail requesting a call back. Record review of CNA A's personal file revealed her date of hire was 02/15/2024. Last day at work was on 08/25/2024, involuntary termination date was on 09/03/2024, for violation of policy and procedure. Record review of in-service attendance record dated 08/30/2024 revealed employees received in service on topic: resident rights, elder justice act, abuse/ neglect, misappropriation. Record review of An interview with the Activity Director on 02/05/2025 at 01:40 PM revealed she was working at the facility for 4 years. She stated misappropriation was taking/using resident's valuables for unauthorized use. She stated administrator informed her about the alleged incident and she was not involved in it. She stated none of the residents gave credit/debit card to the employees. She went to the store to purchase things for residents on every second Thursdays and those residents who wanted to purchase something would give her the list. Residents who had trust fund account collected money from the business office and gave the money to the activity director. The activity director verified each resident transaction with the facility administrator before and after the purchase, showed receipts, returned balance amount and items to the residents. The Activity director stated she never accepted debit/credit card from residents, and she was not aware of card theft/misappropriation other than the one involving Resident #1. She stated she would immediately report to the administrator of any suspicion of abuse/neglect/misappropriation. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LVN D on 02/05/2025 at 03:30 PM revealed misappropriation was a type of abuse, taking resident's valuables without their permission was misappropriation. She stated she received in service on misappropriation within one week. She stated she would immediately report to the abuse coordinator/administrator of any concerns of misappropriation. She stated she was not aware of any resident missing their cash or bank debit/credit cards. She stated none of the employees were supposed to accept cash or debit/credit cards from residents and she would direct them to the activity director for any purchases. An interview with the administrator on 02/05/2025 at 04:51 PM revealed she was working at the facility as the administrator for a year and she was the abuse coordinator. She stated, once she learned about misappropriation, she had 24 hours to report it to the state, she had 5 days to submit the report of her investigation to the state and that was the policy of their facility. The investigator observed the administrator referring the PIR regarding this incident, and she stated this misappropriation incident was reported to her on 08/26/2024 and she reported this incident to the state on the same day. She stated as soon as she learned about the allegation, she suspended CNA A, removed her from the schedule, CNA A was working 6 AM 2 PM shift that week. The Administrator stated CNA A did not work at the facility or answer her call after the alleged incident of Resident #1's missing debit card. During the interview, the administrator was observed reading Resident #1's progress note dated 08/24/2024 at 04:24 PM, entered by RN supervisor, that the incident was reported to the RN supervisor by the resident and that she had immediately reported this to the abuse coordinator/administrator. The administrator initially stated the resident's family member told her that the debit card was missing, and administrator did not consider it as misappropriation until 08/26/2024, since she wanted to give the family enough time to search for the missing card. The Administrator later stated learned about this misappropriation on 08/24/2024 and she was responsible to report this to the state within 24 hours, which could have been by 08/25/2024 at 04:24 PM. The Administrator stated she was responsible to submit her investigation report to the state within 5 days per policy, she stated even if the incident was reported to her on 08/26/2024, she was supposed to submit the investigation report by 08/30/2024, but per the PIR the investigation report was submitted to the state on 09/03/2024. The Administrator stated she did not follow policy on reporting the misappropriation incident to the state within 24 hours and did not follow policy on submitting the investigation report to the state within 5 days from the date of reporting. An interview with the corporate administrator on 02/05/2025 at 05:36 PM revealed the facility administrator was the abuse coordinator, Resident #1 reported this incident to the facility staff on 08/24/2024 and the administrator was responsible to report the misappropriation incident to the state within 24 hours. The corporate administrator sated the facility administrator was responsible to submit the PIR to the state within 5 days and the facility administrator failed to follow and implement policy since it took longer than 5 days. An interview with the DON on 02/05/25 at 06:10 PM revealed he was working at the facility for 3 months. The DON stated misappropriation was recognized as abuse, needed to be reported immediately to the administrator by him or any employee who had the knowledge of that incident. He stated the facility staff received in service on misappropriation regularly, he could not remember the most recent Inservice date. He stated if a resident reported missing item such as a debit card, he would immediately assist the resident in searching the room and ask family members about it. If it was not found, then he would immediately notify the administrator. He stated he did not want any employees to take resident's belongings, he stated it was important to report misappropriation incidents immediately and take precautionary action to prevent further occurrence of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Abuse Prevention and Prohibition Program revised October 24,2022 reflected, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. D. iv. The Administrator will provide the state survey agency, law enforcement and the Ombudsman (if applicable per state regulation) with a copy of the investigative report within 5 days of the incident.