STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235248	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP VILLAGE	1400 N DRAKE RD KALAMAZOO, MI 49006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 270. Based on interview and record review, the facility failed to prevent misappropriation of resident property in 1 of 1 resident (Resident #100) reviewed for misappropriation of property, resulting in theft of resident property. Findings include: Review of the Abuse Prevention Program dated February 2020, Procedures for Prevention -It is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide personnel (including consultants, contractors, volunteers, and other caregivers who provide care and services to residents) with the knowledge to further ensure each resident is treated with individual respect and dignity. II. Orientation and Training of Employees i. Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings without the resident's consent. Review of a Face Sheet revealed Resident #100 was a [AGE] year-old male, originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 1/13/20, revealed a Brief Interview for Mental Status (BI[CONDITION]) score of 10, out of a total possible score of 15, which indicated Resident #100 was moderately cognitively intact. Review of the Incident Report dated 2/12/20 at 7:30 AM, There was a zip-lock with $180.00 cash in med cart. I was not prompted to count it at start of shift 2/11/20 and did not know it was still in narcotic drawer when I came in (it was on side of narcotic Back up Box (BUB) and not visible). At shift change (2/12/20 0730) while counting narcotics (name of nurse) noted money was still in drawer - there was only $80.00. Last counted on 2/9/20. Management notified immediately. Type of Accident/Incident (theft). During an interview on 3/3/20 at 10:37 AM, Registered Nurse (RN) C reported that when she left on 2/9/20 she counted the money $180.00 that was locked in the narcotic drawer. RN C reported that the money to be counted each shift, but was in a baggy by the BUB of narcotics and could possibly be missed. RN C reported that she was the oncoming nurse 2/12/20 that discovered the discrepancy in the count, finding $80.00 with the denominations of bills rearranged and immediately turned it in to her supervisor. RN C reported that the Count Log had not be filled out since she had last counted on 2/9/20. During an interview on [DATE] at 3:58 PM, RN I reported that she had been working at the facility for 3 months, she worked and there was a plastic bag that contained cash and papers in the narcotic lock box. RN I reported that there was papers with (name of Resident #100) and money in the bag and I took some of the money, $100.00, and I went home and I immediately felt guilty. RN I reported that I was not made aware that there was an inventory of the money that was in the locked medication drawer where the money for Resident #100 was kept. RN I stated I worked 2/10/20 and 2/11/20 day shift, no one had count the night of 2/9/2020. Review of a Letter of Resignation dated (no date), RN I stated In a moment of complete thoughtlessness and lack of judgement, I made the decision to take something that did not belong to me. During an interview on [DATE] at 4:20 PM, RN G reported that one of the Certified Nursing Aid's (CNA's) came and told her there was quite a bit of money in the residents room. RN G reported that Resident #100 had been to an appointment earlier in the day and must have stopped and picked up the money on his way back to the facility. RN G reported that the resident was asked about placing the money in the nurses cart, RN G stated the resident and I counted the money $180.00. RN G reported that when residents have personal belongings we ask if they would like them locked up in the narcotic box until their family could pick them up. RN G took the $180.00 and went to the nurse on duty and counted the money with her, put the money in a zip-loc baggy, and filled out a piece of notebook paper to serve as a Count Log sheet for each shift, the money was place in the narcotic box, and the count log was placed on the left hand side of the narcotic book. Review of a Count Log dated 1/29/20 at 5:00 PM, revealed nurse and resident had signed $180.00. Review of the log revealed inconsistent accounting of Resident #100's funds during shift opportunities (1/30 ,1/31) both shifts (2/1, 2/2) 1 person on days counted (2/4, 2/8, 2/9, 2/12) 1st shift counted only, 2/1, 2/2, 2/4, 2/8, 2/9 (2nd shift did not count) 2/3, 2/5, 2/6, 2/7, 2/10, 2/11 (no shift counted). During an interview on [DATE] at 4:56 PM, Nursing Home Administrator (NHA) A reported that she was not aware that staff were keeping money and personal items for residents in the narcotic drawer. NHA A reported that we have a policy now to prevent this from happening again.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE