STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445112	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREVECCA CENTER FOR REHABILITATION AND HEALING LLC	**329 MURFREESBORO RD NASHVILLE, TN 37210**

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** Based on interview and record review, the facility failed to ensure Resident #1 was free from misappropriation of personal property by allowing unknown person to pick up 1 box of personal items left at the facility without signing the inventory sheet when the resident was transferred to another facility. The findings include: Review of undated facility policy titled, Resident's Rights Agreement, revealed .Present grievances on behalf of himself/herself or others concerning resident abuse, neglect, behavior of other residents and/or misappropriation of resident property in the Facility .Retain and use personal clothing and other personal possessions in a reasonably secure manner .The facility shall prepare a written inventory on the day of Resident's admission and shall update as needed. A copy of said inventory shall be given to the Resident. The facility shall promptly investigate complaints of losses .The facility shall obtain a signed receipt from the person to whom the Resident's property is transferred . Review of the medical record showed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident # 1 was no longer at the facility. No observation or interview could be completed. During an interview conducted on 8/10/2020 at 11:00 AM with the Social Worker in the conference room confirmed she was very familiar with Resident #1 and his family. Continued interview confirmed both nieces, Family members #1 and #2 were the current POA (Power of Attorney) for Healthcare and Living Will. The Social Worker went on to say she had spoken with both nieces on several occasions concerning Resident #1's belongings. Continued interview confirmed the wallet was picked up by Family member #2 and the rest of his things were picked up by a man in a green truck but no one got his name or had him sign for the box of items that belonged to Resident #1. Further interview confirmed sometime in April of 2020 she witnessed seeing a document signed by Family member #2 and signed by Resident #1 giving Family member #2 permission to pick up his wallet. Continued interview with the Social Worker revealed the wallet was not listed on the inventory list because it had been taken on admission and locked up until family could pick it up which was the process for items of value. Further interview confirmed the Social Worker stated the process for Residents belongings revealed those were to be on an inventory sheet on admission and signed for when picked up. Any items of value were locked up until family could pick them up and they would sign for them at that time. During an interview conducted on 8/10/2020 at 2:00 PM by phone with Family member #1 confirmed she had not received any of Resident #1's belongings back at this time. She stated she had made several calls to the facility and spoke with the Social Worker with no results in finding the items. She was told someone in a green truck came and picked them up. Continued interview with Family member #1 confirmed that a police report had been filed. During an interview on 8/10/2020 at 2:40 PM in the conference room with the DON (Director of Nursing) confirmed she was familiar with Resident #1 and the issues with the missing property that the family states they never received. Continued interview confirmed the DON was told by the Unit manger that Resident #1's wallet had been locked up and Family member #2 came by and picked it up. Further interview with the DON confirmed the Unit Manager stated she had Family member #2 and Resident #1 sign for the wallet but no sheet with any signatures can be found. Continued interview with the DON revealed all she knew about the other items was staff stated they were picked up by a man in a green truck. During an interview conducted on 8/10/2020 at 3:20 PM by phone with Family member #2 confirmed she did come by the facility and picked up Resident #1's wallet sometime in April of 2020 but does not remember signing a paper. Continued interview with Family member #2 confirmed she did not pick up any other belongings of Resident #1 at any time. She went on to say she brought the wallet back and gave to Resident #1 when he was sent out to the hospital and never saw it again. During an interview on 8/10/2020 at 3:35 PM by phone with a staff member who no longer works at the facility confirmed she gave a box of Resident #1's belongings to a man in a green truck. Continued interview revealed she did not know who the man was and she did not have him sign for the box of items. Further interview with revealed the man in the green truck told her he was a family member and he was there to pick up Resident #1's belongings and she gave them to him. During an Interview on 8/10/2020 at 3:50 PM in the conference room with the facility Administrator confirmed he was notified by staff a family members of Resident #1 were inquiring about Resident #1's box of belongings. Continued interview confirmed staff is required to fill out an inventory list sheet on admission and any valuables are locked up until family comes to pick up or is signed out with Resident at discharge. Further interview from the Administrator confirmed no investigation was done on Residents #1's belongings because staff said a family member came to pick them up. Continued interview with the administrator confirmed he could not find a signed inventory sheet for the items in Resident #1's medical file. Further interview with the Administrator on his expectations on the process of inventory and retrieval of residents' belongings confirmed that staff should make a list of items on an inventory sheet on admission, any valuables would be locked up and any items picked up would be signed for by the person picking up said items.

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