STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425380	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKES AT LITCHFIELD	**120 LAKES AT LITCHFIELD DRIVE PAWLEYS ISLAND, SC 29585**

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 record review and interview, the facility failed to protect residents from Misappropriation of property for 1 of 1 resident reviewed for Misappropriation. (Resident #8) The findings included: The facility admitted Resident #8 on 10/10/19 with [DIAGNOSES REDACTED]. Record review revealed the facility submitted an Initial 24-Hour Report of an allegation of Misappropriation of resident property to the State Agency on 10/23/19 concerning Resident #8. The report indicated, Resident had money in possession on admission 10/10/19. Money was locked in medication cart until someone could pick up. Money was found to be missing 10/23/19. Investigation initiated, unsure if money was picked up by friend/family at this time. The Five-Day Follow-Up Report for Resident #8 indicated the resident had a 'pouch' which contained money, a credit card and Medicare card. There was no one that was able to pick up money at time of admission; therefore pouch was locked in medication cart for safety. Money was found to be missing (entire pouch) 10/23/19. Review of the Summary Report of Facility Investigation revealed, Resident was reimbursed missing money by facility. Social Services & appropriate insurance company notified for replacement cards. Investigation could not prove or identify anyone taking money. Review of the Social Services documentation dated 10/24/19 indicated, Late Entry for 10/23: On the afternoon of 10/23/19, it was reported to SW (Social Worker) by nursing staff that Resident had a large amount of money locked in the narcotics cart which had been placed there upon admission. Resident inventory checklist done at time of admission which includes notation of 2 credit cards and $481.00 in cash. Nursing staff then told SW in that same conversation that the bag containing (Resident #8's) items and money was no longer in the drawer. SW interviewed (Resident #8) who stated (he/she) did not authorize anyone to remove (his/her) belongings from the drawer. The notation further indicated that the Sheriff's office was notified, and an officer responded to the facility to take a report. Statement taken from resident in presence of SW where (he/she) stated there was a (.) bag that contained (his/her) wallet with Medicare card, credit cards, and cash. Staff interviews conducted, and ongoing investigation of security footage is occurring. Report to be filed to appropriate agencies. SW will continue to monitor and assist. Additional documentation indicates that, In the future, money/valuable items will be given to the Business Office Manager to keep in safe until family can retrieve to take home. Social Worker re-educated staff on abuse/neglect to include misappropriation of property. The facility provided a copy of a receipt dated 10/25/19 showing re-imbursement of the missing money to Resident #8. Review of the Police Incident Report indicated that the resident states (he/she) gave no one permission to take (his/her) money. Record review further indicates that the SW assisted Resident #8 to contact the insurance companies, the bank, and credit card company on 10/24/19. SW followed-up with Resident #8 after discharge from the facility, and the resident reported that nothing has changed with (his/her) accounts and that he/she had received a replacement debit card and was waiting for the replacement credit card in the mail. The facility interviewed staff members who worked during the timeframe that Resident #8's property was discovered missing. No staff had any knowledge related to the missing property. The facility provided inservice training related to misappropriation of property to all staff following the incident. During an interview on 3/12/20 at approximately 11:00 AM, the Director of Nursing (DON) stated that Resident #8 had confirmed that no one had pick-up the bag for him/her. The DON further confirmed that the facility had been unable to determine what had happened to Resident #8's missing bag and property.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility's policies on Abuse and Neglect, the facility failed to implement its policies related to preventing misappropriation of resident property for 1 of 1 resident reviewed for Misappropriation. (Resident #8) The findings included: The facility admitted Resident #8 on 10/10/19 with [DIAGNOSES REDACTED]. Record review revealed the facility submitted an Initial 24-Hour Report of an allegation of Misappropriation of resident property to the State Agency on 10/23/19 concerning Resident #8. The report indicated, Resident had money in possession on admission 10/10/19. Money was locked in medication cart until someone could pick up. Money was found to be missing 10/23/19. Investigation initiated, unsure if money was picked up by friend/family at this time. The Five-Day Follow-Up Report for Resident #8 indicated the resident had a 'pouch' which contained money, a credit card and Medicare card. There was no one that was able to pick up money at time of admission; therefore pouch was locked in medication cart for safety. Money was found to be missing (entire pouch) 10/23/19. Review of the Summary Report of Facility Investigation revealed, Resident was reimbursed missing money by facility. Social Services & appropriate insurance company notified for replacement cards. Investigation could not prove or identify anyone taking money. Review of the Social Services documentation dated 10/24/19 indicated, Late Entry for 10/23: On the afternoon of 10/23/19, it was reported to SW (Social Worker) by nursing staff that Resident had a large amount of money locked in the narcotics cart which had been placed there upon admission. Resident inventory checklist done at time of admission which includes notation of 2 credit cards and $481.00 in cash. Nursing staff then told SW in that same conversation that the bag containing (Resident #8's) items and money was no longer in the drawer. SW interviewed (Resident #8) who stated (he/she) did not authorize anyone to remove (his/her) belongings from the drawer. The notation further indicated that the Sheriff's office was notified, and an officer responded to the facility to take a report. Statement taken from resident in presence of SW where (he/she) stated there was a (.) bag that contained (his/her) wallet with Medicare card, credit cards, and cash. Review of the Police Incident Report indicated that the resident states (he/she) gave no one permission to take (his/her) money. Review of the facility's policies on Abuse and Neglect revealed the policy entitled, Abuse Prevention Program indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Review of the policy entitled, Investigating Incidents of Theft and/or Misappropriation of Resident Property stated under Policy Interpretation and Implementation 1. Residents have the right to be free from theft and/or misappropriation of personal property. and 2. 'Misappropriation of resident property' is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. During an interview on 3/12/20 at approximately 11:00 AM, the Director of Nursing (DON) stated that Resident #8 had confirmed that no one had pick-up the bag for him/her. The DON further confirmed that the facility had been unable to determine what had happened to Resident #8's missing bag and property.

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

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.