STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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 -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to protect resident property and thoroughly investigate an allegation of missing $500 cash for 1 of 2 residents (R1) reviewed for financial exploitation. Findings include: R1's current [DIAGNOSES REDACTED]. R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had moderate cognitive impairment, adequate hearing and vision, clear speech, was understood and could understand. R1 required extensive assistance of one staff for bed mobility, transfers, walking, dressing and toileting. R1's care plan printed on 6/30/20, indicated R1 had cognitive loss with short-term memory deficient; does not always know the year, was new to the facility and had recent surgery. R1's facility risk management report dated 6/30/20, indicated R1 reported missing five, $100 bills from his billfold. R1 reported having the money when he arrived to the facility on [DATE] and last saw the money in his billfold five or six days prior. Following the allegation of missing money, a progress note dated 6/30/20, by social worker (SW) indicated R1 was encouraged not to have cash in his room. R1 gave consent to lock up his billfold and this was done by SW and director of nursing (DON). R1 was informed he could ask for his billfold back or access his money at any time. R1's incident report folder included a document by SW dated 6/30/20, indicated she spoke to R1 about his allegation of missing money. R1 told SW when he came to the facility he had six $100 bills, four $20 bills, 1 $10 bill, 2 $5 bills and 4 $1 bills. R1 told SW he noticed on 6/30/20 he was missing five $100 bills, but the rest of his cash was in his billfold. R1 told SW he last looked in his billfold about five or six days ago, so knew the money was taken at the facility and not when he was in the hospital. R1 was asked if there was anyone they could call to verify the amount of cash he had in his billfold; R1 stated he managed his finances independently as he had no family. R1 was informed the police department would be contacted regarding potential theft. Further documentation indicated SW spoke to an officer about the missing money; SW also encouraged R1 not to have cash in his room. R1 gave SW permission to lock up his billfold. A facility report titled IDT (interdisciplinary team) post investigative review dated 7/1/20, and signed by director of nursing (DON) indicated R1 had an allegation of misappropriation of property with R1 reporting $500 missing from his billfold in his room. The final outcome was R1 being educated not to keep money in his room, and the rest of his money was locked up. The facility five-day investigative report dated 7/2/20, indicated that on 6/30/20, at approximately 10:30 a.m. R1 reported missing money out of his billfold. R1 told facility staff he had six $100 bills, four $20 bills, 1 $10 bill, 2 $5 bills and 4 $1 bills when he arrived to the facility. R1 informed staff he noticed that morning he was missing five $100 bills for a total of $500. R1 informed staff the rest of the cash was still in his billfold and staff confirmed this. The report indicated R1 managed his own finances, had no family or power of attorney. The report indicated R1 had some confusion and memory impairment. Following the discovery of missing cash, R1 was encouraged not to have any cash in his room and his billfold was locked up. The report indicated one staff person was interviewed regarding the missing cash; the nursing assistant who reported the allegation. During an interview on 8/4/20, at 2:40 p.m. licensed practical nurse (LPN)-A stated the facility did not conduct an inventory of personal items for newly admitted residents, and did not ask a resident if they had a large sum of money or valuables with them. Furthermore, LPN-A stated if a resident reported something missing, they assumed the resident was missing it, even if they don't know. LPN-A stated if a resident reported something missing, it was reported to the DON, then reviewed at IDT and followed up by the DON and SW. During an interview on 8/4/20, at 2:45 p.m. nursing assistant (NA)-A stated if a resident reported something missing from their room, they would look for it and if couldn't find it, report it to a nurse or DON. NA-A stated you always assume the resident is right and go through the process. During an interview on 8/5/20, at 9:15 a.m. registered nurse (RN)-A stated R1 was discharged to home yesterday and stated his money was counted when his billfold was returned to him. According to RN-A s, R1 stated the money was all there except for the five, $100 bills. RN-A stated R1's billfold had been sitting on his bedside table at the time the money went missing. RN-A added this occurred while R1 was in quarantine due to Covid19 and limited staff were going in and out of his room. RN-A was not aware if anyone called the hospital where R1 had knee replacement surgery prior to being admitted , to ask if an inventory of his cash was done during their admission process. RN-A stated no one was able to verify the amount of cash R1 had in his billfold when he was admitted . RN-A stated their admission assessment does not require an inventory of personal items, such as contents of a billfold or purse, jewelry or clothing. RN-A stated there was not a form staff initiated when a resident reported missing property. During a telephone interview on 8/5/20, at 9:24 a.m. friend (F)-C answered R1's phone, stating R1 was still in bed; F-C was there to check on him. F-C was aware R1 alleged to have missing cash when at the facility. R1 had told F-C he had $600 in cash and $500 went missing at the nursing home. F-C stated he drove R1 to the hospital for double knee surgery and suggested to R1 that he (F-C) take the billfold home for safekeeping, but R1 wanted to keep it with him. F-C did not see the money and could not verify the amount. F-C stated R1 might not be able to prove a withdrawal of the money from his bank account as he may have had the cash at home. F-C stated R1 was upset the money was missing and was positive the money was with him in his billfold at the nursing home. F-C will also ask R1 if he remembered if the hospital accounted for the money while he was there. F-C stated he was glad someone was looking into this on R1's behalf. During an interview on 8/5/20, at 9:42 a.m. the DON stated R1 reported he was missing $500 in cash, all in $100 dollar bills. DON stated we looked around his room, asked him if he had done anything with it, and asked if he was sure he had the money. DON stated they were unable to locate the missing money and stated they asked staff if they knew anything about it, but no one was able to verify R1 had the money. The local police were notified, but didn't come to the facility. DON stated we always believe what the resident said is what happened. DON stated she doesn't know if staff took the money. DON stated the facility had cameras in the hallways, but had not looked at the footage and stated we could go back and look. Unaware if anyone called the hospital to see if they accounted for the money in R1's billfold when he was a patient there. DON stated staff interviews regarding the allegation of missing money were done by the SW and if documented, would be in the risk management folder. During a telephone interview on 8/5/20, at 9:48 a.m. SW stated she had no conversation with R1 about personal processions, including money in his billfold when he was admitted . R1 informed her he managed his own finances and had no power of attorney. SW stated after the cash was reported missing, she typed up a summary, and stated she asked R1 questions such as if he had his billfold in the hospital, was his billfold ever unattended, and when did he see it last. R1 informed SW his money was present in his billfold after he arrived to the facility. SW stated the police were called, but they didn't come to facility; they talked to R1 on the phone. SW stated no one called the hospital to ask them if they inventoried R1's money at the time of his admission there. SW stated they did not look at facility camera footage; there were so many people going in and out of his room. SW talked to the NA who reported the money missing but couldn't recall talking to other employees. SW stated I mostly questioned R1 and asked if he saw anything suspicious. When asked how many staff she questioned during the investigation, SW stated she didn't know. When asked if it was one or two employees, she stated yes. During an interview on 8/5/20, at 10:54 a.m. with the administrator and DON, when asked if there was a formal process for investigating an allegation of missing property, the DON referenced the facility form titled Checklist for Misappropriation of Property but stated this form/process was not used when R1

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SLEEPY EYE CARE CENTER	**1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085**

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 -** Few	(continued... from page 1) reported money missing. DON stated they don't always follow the form; depends on who and what it is. When asked what role the administrator played in the investigation, he acknowledged he didn't play a part. When asked how many employees were interviewed following the report of missing cash, DON stated she didn't know and stated the social worker interviewed staff and she was pretty thorough. DON stated the documentation of interviews would be in R1's risk management folder. (No documentation of employee interviews were found in this folder nor otherwise produced by the facility). DON stated the facility could have interviewed more staff. DON stated the facility had security cameras in the hallways but footage was not looked at following the incident. The administrator added it would only show who went in and out of R1's room. DON confirmed the facility did not do an admission inventory of a residents personal possessions, and also stated the facility did not have anything in resident rooms to safeguard personal items such a safe or lock box. DON stated they did not go through a resident's billfold or purse, stating we would not know if they had a substantial amount of money unless they told us. DON added if we do see a resident has a large amount of money, it would go in the residents trust with their permission. DON stated she did not know if R1 had the five $100 bills in his billfold; I'm not sure, adding that his cognition was very poor. DON stated could staff have taken it? I can't prove it one way or another. Stated she felt under the circumstances, they did a full and through investigation. The administrator verbalized agreement. DON stated R1 was indifferent about the missing money; he was not like oh my gosh, where's my money? DON stated they did not call the hospital to ask if they could verify whether or not R1 had this amount of cash when he was an inpatient there; I didn't think of that. Facility Checklist for Misappropriation of Property, revised 11/2016 indicated: The checklist outlined seven steps in process of investigating missing property and listed a examples of report of stolen property, item, or money of any value, with the alleged perpetrator possibly being staff, resident representative, visitors, other residents,improper use of resident funds. 1. Included in the various steps were: --Attempt to interview staff prior to leaving. --Have written statements from staff on duty prior to leaving facility. --Contact potential witness via telephone for statements. --Contact laundry, dietary, housekeeping for items search. --Utilize credit report, photos of property, bank statements, insurance documents to assist with investigation. --Report to ombudsman. --Utilize all collected data to complete all sections of the form.