STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI) MS #21338, CI MS #21213, and CI MS #20907, at the facility from 7/11/23 through 7/12/23. The SA investigated CI MS #21338, a facility reported incident, for Misappropriation, and determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F602.The SA investigated CI MS #21213 for resident not turned or repositioned/resident neglect and CI MS #20907 for environmental and pharmaceutical services. There were no citations related to CI MS #21213 and CI MS #20907. Based on the facility's corrective actions initiated on 4/13/23 and completed on 4/18/23, prior to the SA's entrance on 7/11/23, the SA determined F602 was past noncompliance. At the time of the survey, the facility had a census of 118 residents and was licensed for 132 beds.	F 000	Past noncompliance: no plan of correction required.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to protect a resident from misappropriation of property for one	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 07/20/2023

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(1) of five (5) sampled residents. Resident #5

Findings include:

Review of the facility's policy, "Abuse, Neglect and Exploitation" with a review/revision date 5/1/23, revealed "Policy: It is the policy of this facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent ...misappropriation of resident property ...Definitions: ...Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent ..."

Record review of the Facility Investigation, dated 4/18/23, revealed, "On April 13th, 2023, (Proper Name of Resident #5) reported to ADON (Assistant Director of Nursing) that her bank card was missing and she had noted some unauthorized charges on her account. The (Proper Name of Local police department) was contacted and a report was made ...Upon Investigation: on April 6th, 2023 between 8:00am and 8:55am, (Proper Name of Resident #5) had requested that a staff member use her bank card to go get her and her roommate some donuts. (Proper Name of Resident #5) stated that the staff member returned her bank card, the donuts and her receipt. Later that evening the following unauthorized charges were made ...April 6th @ (at) 1523 (3:23 PM) (Proper Name of Local Gas Station) April 6th @ 1742 (5:42 PM) (Proper Name of Local Daquari establishment), April 6th @ 2106 (9:06 PM) (Proper Name of Local Gas Station). The unauthorized charges continued

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over the next few days, these charges are as follows: April 7th @ 0532 (5:32 AM) (Proper Name of Local Gas Station) and April 11th @12:08 (PM) (Proper Name of Local Gas Station). (Proper Name of Resident #5) did not realize the bank card was missing until April 13th, 2023. At that time she requested her niece ...go by the bank and get a print out of her recent transactions due to the changes on her statement ...Conclusion: Substantiated: Misappropriation of funds ..."

On 7/12/23 at 12:15 PM, an interview with Resident #5 revealed she discovered that her debit card was missing after her niece had contacted her on 4/13/23 and asked about questionable charges to the resident's checking account. Resident #5 stated she reported to the Assistant Director of Nursing (ADON) that the card was missing and there were questionable charges on her account. She said she obtained a copy of the ATM/Debit Card Details from her bank and identified four transactions which she had not made or authorized. She stated that she did not see anyone take the debit card from her room and she was told by the facility administration that Certified Nurse Aide (CNA) #1 had taken the debit card. She said that since the transactions were reported to her bank as fraudulent, her bank had reimbursed her account for the total amount. She stated that she did recall giving her card to CNA #1 on 4/06/23 "to go get us some donuts" and she recalled the CNA returned her card the same day, along with the donuts. She stated that she could not recall if CNA #1 observed her take her card out of her wallet or replace it upon return.

On 7/12/23 at 12:35 PM, during an interview with

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the ADON, she said she had been notified by Resident #5 on 4/13/23 at approximately 4:40 PM that the resident's debit card was missing and that there had been unauthorized charges/purchases made using her debit card. The ADON stated that she had immediately reported the allegation to the Director of Nursing (DON) and the Administrator. She stated that she had participated in the investigation which had been initiated immediately. She stated that Resident #5 had told her that the last time she saw her debit card was when she put the card back into her wallet after she had given it to CNA #1 to purchase some donuts for her and her roommate.

On 7/12/23 at 8:42 PM, during a telephone interview with CNA #1, he stated that on 4/06/23, Resident #5 had provided her debit card and requested donuts from the store. He went to the store on his break, used the card to purchase donuts, delivered them, and returned the card to Resident #5. He stated that he was interviewed by the ADON a week or two later regarding the whereabouts of the debit card and he was notified on 4/14/23 that he was suspended pending investigation of the allegation and should not return to the facility. He stated that on the afternoon of 4/17/23 he was notified by the DON that his employment at the facility was terminated. CNA #1 stated he had not taken or used the debit card. CNA #1 confirmed that the facility provided an in-service training regarding misappropriation of resident funds, abuse, and neglect on 4/13/23.

On 7/12/23 at 12:00 PM, an interview with the DON revealed that she had been made aware of the allegation of misappropriation by the ADON at

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approximately 4:45 PM on 4/13/23 and an investigation was initiated immediately. She confirmed that all staff that had entered the room of Resident #5 on the last day the resident reported seeing her debit card were interviewed. She said she had also interviewed Resident #5. She stated the results of the investigation included the suspension of CNA #1 pending conclusion of the investigation. She said she had spoken with the police department investigator following his investigation and was told that charges were being processed against CNA #1 for "credit card fraud" based on the conclusion of the police investigation.

On 7/13/23 at 9:19 AM, during a telephone interview with the investigator of the local sheriff's office, he confirmed that he had been assigned to investigate what he described as "credit card fraud against a resident at the nursing home". He stated that after review of the unauthorized transactions conducted with Resident #5's debit card, he had visited one of the establishments involved and viewed security camera footage recorded at the time of the transaction. He stated the footage clearly showed CNA #1 conducting the transaction. He stated he had also interviewed the "bartender" and obtained a statement in which the "bartender" confirmed the identity of CNA #1. The investigator confirmed that the total amount of unauthorized purchases made on 4/06/23 using Resident #5's debit card totaled thirty-five dollars and fifty-nine cents ($35.59). The investigator said he had filed a felony warrant request with the county justice court clerk against CNA #1 on 4/18/23 and a felony arrest warrant had been issued.

Record review of the "Face Sheet" revealed the

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facility admitted Resident #5 on 1/14/22 with diagnoses including of Chronic Obstructive Pulmonary disease and Osteoarthritis.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/23 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.

The SA validated through record review of the In-Service Sign-In sheet dated 4/13/23 and staff interviews that the facility provided in-service training related to Misappropriation of Residents Funds, Abuse and Neglect on 4/13/23.

The SA validated through record review of the Quality Assurance and Assessment QAPI) Sign-In Sheet dated 4/18/23 that the QAPI committee met on 4/18/23 and discussion included "Abuse, Neglect and Misappropriation of Funds" with review of current practices and new practices designed to prevent recurrence of misappropriation; In-Service training for employees; and incident investigation. The QAPI Sign-In Sheet confirmed attendance by the Administrator, DON, Medical Director and other attendees including department supervisors.

The SA validated through record review of the personnel file for CNA #1 revealed his employment at the facility was officially terminated on 4/18/23.

The SA validated that the facility had taken all necessary measures to be at past noncompliance by 4/18/23 with the deficient practice that occurred on 4/6/23.