STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Healthcare Center	7805 Southcrest Parkway Southaven, MS 38671

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** 45598 Based on staff and resident interviews, record review and facility policy review the facility failed to protect a resident's right to be free from misappropriation of property for Resident #1 who was one (1) of three (3) sampled residents. Based on the facility's implementation of corrective actions taken on 10/11/24, this was determined to be Past Non-Compliance (PNC). Findings Include: Record review of the facility policy, Abuse, Neglect, and Exploitation with revision date of 10/10/22 revealed, Policy: This facility's policy is to protect each resident's health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. On 11/25/24 at 9:15 AM an interview with the Administrator (ADM) revealed that on the night shift (3-11) of 10/10/24, the Registered Nurse (RN) #1 notified the Administrator and Director of Nursing (DON) by phone that Resident #1's debit card was lost. The ADM revealed that the next morning, Social Worker (SW) talked to Resident #1, encouraged him to cancel his debit card and she assisted him with the phone call to the bank. When the SW spoke with the bank it was revealed that there had been recent charges on the resident's debit card that totaled $242.82 that was not made by the resident. The ADM confirmed that they immediately initiated an investigation and discovered that there were two clothing companies where the orders were placed. One of the clothing companies was able to give the name of the person who placed the order and the shipping address where the items would be delivered. ADM revealed that they concluded that it was an agency Certified Nursing Assistant (CNA) #1 who had used Resident #1's debit card to make the purchases and that it was her home address that matched the address where the items were to be shipped. ADM revealed that the first and only shift that the agency CNA #1 had worked at the facility was on 10/08/24, and she made those purchases using Resident #1's debit card. ADM revealed that he tried to call CNA #1 on two separate phone numbers they had on file, and was unable to reach her to obtain a statement. (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 9:30 AM, an interview with Resident #1 revealed that he kept his debit card on his overbed table because he had been getting staff to use it to get him drinks and snacks out of the vending machine. He revealed that his debit card was lost one night in October. He revealed that staff looked all over for it and never found it. He stated that he didn't want his debit card turned off at first, but agreed to it the next morning and the SW came to his room and made the call to the bank for him. Resident #1 revealed that he had to verify with the bank representative the last purchases made on his debit card and found out that someone had made two transactions that totaled over two hundred dollars. Resident #1 revealed that they fired the aide who had used his debit card and he thought she had been arrested because the police came out and talked to him. Resident #1 revealed that the facility went out of their way to make things right and done way more than they should have to take care of this. On 11/25/24 at 10:00 AM, an interview with the DON, revealed that during the night shift on 10/10/24, RN #1 notified her and the ADM that they couldn't find Resident #1's debit card. She revealed that the ADM told them to report the debit card as lost or missing. She also revealed that RN #1 encouraged Resident #1 to cancel his debit card, but he declined due to the hassle. DON revealed that the next morning, SW encouraged Resident #1 to stop payment on the debit card, he agreed, and she assisted him. DON revealed that while the SW and Resident #1 were on the phone with the bank, Resident #1 had to confirm the last purchases made with the debit card and found that there were two charges that he had not made which totaled over two hundred dollars. DON revealed that the SW called the two companies and verified the name and shipping address of the person who had made the purchases and traced it to agency staff member CNA #1, who had worked on a previous night on the 3-11 shift. On 11/25/24 at 10:25 AM, an interview with SW revealed that Resident #1 told her that his debit card was lost. SW revealed that she encouraged him to cancel his debit card and request a new one. SW revealed that she assisted him with this and while on the phone with the bank, Resident #1 had to verify the last purchases he had made. SW revealed that they found out during the call to the bank, there were two other purchases on the card that he did not make which totaled over $200. She revealed that she reported this to ADM and DON, and they initiated an immediate investigation. SW revealed that she contacted the two companies from which the unapproved purchases were made, and one company verified the name and the shipping address of the person who made the purchase. She revealed that the shipping address matched the name and home address of an agency staff CNA who had worked the night before the card went missing. The SW revealed that both purchases were made on the same date and around the same time. On 11/25/24 at 2:20 PM, an interview with DON revealed that they tried to make sure they employed the best staff and that they had the right person for the job and stated, This CNA should never be allowed to work in a facility again with these vulnerable residents. She revealed that these residents had so little, and it angered her to find out that a staff member took from one of them. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Report to MSDH (Mississippi Department of Health) revealed under Investigation of Incident that on 10/10/24 at 9:28 PM, ADM and DON were notified by RN #1 that Resident #1's debit card was missing, they looked for it but could not find it. ADM instructed RN #1 to request that Resident #1 report the debit card missing to his bank. Resident stated, That is a hassle. The next morning (10/11/24) at approximately 9:22 AM, Resident #1 with the encouragement and assistance from the SW, contacted (Proper Name) bank to cancel his lost debit card and received notification that there were erroneous charges dated 10/09/24. These charges occurred before the debit card was lost on 10/10/24. Resident #1 with the assistance of SW contacted one of the companies where fraudulent orders were placed in order to locate the shipping address and the name of the individual placing the order. The address and name matched agency staff, CNA #1 with (Proper Name) Staffing Agency who worked on 10/08/24. This is the only shift that had been worked by this individual. She was immediately made a do not return to the facility. She has not and will not return. Record review of the typed Statement by SW, revealed that on 10/11/24, the social worker spoke with Resident #1 to confirm that his card was canceled and that a replacement card had been ordered. Resident #1 expressed the need for a phone to facilitate the cancellation process. At approximately 9:38 AM, this SW and Resident #1 contacted (Proper Name) Bank. The representative spoke with Resident #1 and requested verification of Resident #1's information which included confirming the last three transactions made. Resident #1 listed charges for a drink machine and (Proper Name) purchases but the representative indicated that these were not the most recent transactions. SW informed the representative that Resident #1's card was lost and they needed details about the transactions. The representative revealed that the latest charges included (Proper Name) for $37.40 and (Proper Name) for $205.42. Resident #1 confirmed that he had not made these purchases, his debit card was canceled and a new one ordered. The bank representative provided them with a contact number to dispute the unauthorized charges. The SW and Resident #1 contacted (Proper Name) Bank Dispute Department, provided information about the unauthorized transactions and Resident #1 was informed that he would receive a credit back to his account within ten (10) days. The representative emailed a bank statement copy to his email, detailing the date and time of the transactions. Staff members were notified of the situation. The SW and Resident #1 then reached out to (Proper Name) to obtain the name and address associated with the order. The (Proper Name) representative successfully provided the date order was placed, name on the order, and the shipping address. The information was relayed to ADM and DON. Signed by SW. Record review of the Nursing Home (Proper Name) Agency Orientation In-service Log revealed, Topic: I have been inserviced on the agency binder of my duties and responsibilities, abuse, neglect, and exploitation, emergency codes, resident's rights, infection control and prevention, HIPPA, and Lift Protocol. I understand if I have any questions, I am to ask a nursing home (proper name) employee. This orientation log was signed on 10/08/24 by agency staff CNA #1. Record review of Agency CNA's Shift Details form revealed that CNA #1 worked on 10/08/24. Her start time was 15:00 CDT (Central Daylight Time) and her End Time was 23:00 CDT (Central Daylight Time). The recorded time at the facility was 7 hours and 49 minutes. Record review of the facility Daily Route Sheet and Nursing Hours revealed that CNA #1 worked on 10/08/24 from 3:00 PM to 11:00 PM shift and that she was assigned to Resident #1. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Incident Report by the (Proper Name) Police Department dated 10/11/24 revealed that Officer (Proper Name) was dispatched to the facility to follow up on a report taken earlier that day. ADM reported that they discovered fraudulent charges to Resident #1's debit card before the card was lost. It seemed to be only a coincidence that the card was lost shortly after. ADM informed police officer that facility staff members contacted (Proper Name) to inquire about the fraudulent charges and a representative told them that the name on the order was (Proper Name) Agency CNA #1, and that it was being shipped to (Agency CNA's address). ADM informed police officer that they employed a CNA named (Proper Name) through a temp service on 10/08/24, the day before the fraudulent charges were made. ADM revealed that before this staff member worked, they obtained a copy of her driver's license, and the address matched the address that the items ordered were being shipped to. Record review of Resident #1's Account History Inquiry form revealed that transactions totaling $242.82 for (Proper Name) and (Proper Name) were made on 10/09/24 but did not process the bank until 10/10/24. This statement was verified by SW. Record review of Resident #1's Admission Record revealed an admitted [DATE]. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was cognitively intact. The State Agency (SA) validated through interview with the Administrator and record reviews that the facility reported the incident to the State Department of Health, to Attorney General's Office, to the Local Police Department, and to the Staffing Agency (Proper Name) on 10/11/24 and they made her a Do Not Retain status. The final investigation report was submitted to the State Department of Health on 10/14/24. The SA validated through interview and record review with Administrator and DON that on 10/11/24, they conducted an immediate investigation and initiated a mandatory in-service with all staff on Abuse, Neglect, and Exploitation with special emphasis on cash and credit cards. All residents who were under the care of CNA #1 were interviewed and there were no other reports of missing items or concerns. Updated process and in-serviced staff: Anytime a resident requests that facility staff take money/debit card (as in this instance) to the vending machine (or for any other reason) to make a purchase for them the staff is not to take the money/card. The staff will notify the front office or the charge nurse and one of those individuals will handle the resident request with a witness. This in-service was given to all current staff at the time of the event and has been added to new hire orientation for all new employees (of any type) going forward. This is in addition to our more generalized abuse/neglect/misappropriation training that is done for all staff at regular intervals and all new staff at orientation. The implementation of this process was discussed with all residents at the time of the event. All potential grievances (including potential misappropriation) are reported by the facility grievance officer twice daily at the facility standup and standdown meetings. The SA validated through interview with Administrator and Social Worker that on 10/11/24, the facility reimbursed Resident #1 for $242.82, the total amount of the unauthorized debit card purchases made by CNA #1. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SA validated through record review of Reimbursement of Credit Card Charges form, revealed that Resident #1 was given a check on 10/11/24 in the amount of $242.82, for reimbursement of charges made on his personal debit card. The SA validated through interview with Administrator and record review that an Emergency QA (Quality Assurance) Committee Meeting was held on 10/11/24 regarding fraudulent charges found on Resident #1's bank account. The facility reimbursed Resident #1 of all charges, and going forward, the front office or charge nurse is to be notified if a resident needs staff to assist them to use their cash or credit/debit cards to purchase items from the vending machine or store or make on-line purchases for them. Residents are questioned in resident council regarding any potential misappropriation issues. In addition to resident council and grievance program: QA department interviewing two residents per hall weekly for four (4) weeks, then two (2) residents monthly for 2 months then one (1) resident monthly going forward through the calendar year. This process is reviewed monthly in facility QA meeting. No issues have been reported. On 11/25/24 the SA validated facility actions taken on 10/11/24 and determined this was PNC.