

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Demille Road Lapeer, MI 48446	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake # MI00148568</p> <p>Based on interview and record review the facility failed to prevent misappropriation of resident property for one resident (#218) of one reviewed for abuse, resulting in Resident #218 missing \$448.00 while at the facility.</p> <p>Findings Include:</p> <p>Resident #218</p> <p>Personal Property</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #218 was admitted to the facility on [DATE] with diagnoses: Crohn's disease, colitis, acute kidney failure, chronic kidney disease, atrial fibrillation, arthritis, neuropathy, hearing loss, history of a mini stroke. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status score of 15/15 and the resident needed some assistance with care.</p> <p>On 1/15/2025 at 11:44 AM, a Facility Reported Incident/FRI was reviewed for Resident #218 identifying the following:</p> <p>On 11/18/2024 Resident #218 reported she had \$548.00 missing from her purse that was in a locked bedside drawer. The Administrator was notified, and the facility began an investigation. Including calling the local police and interviewing the resident, staff and family.</p> <p>An admission inventory list titled, Inventory of Personal Items, dated recorded on 10/28/2024 was included in the investigation file and indicated the resident had \$440 in \$20 bills, 1 \$5 bill, 3 \$1 bills=\$448 dollars, in a wallet in her purse. Nurse Aide L documented on the form On admission reviewed guideline that the Facility cannot assume responsibility for valuables left in my possession (Nurse Aide L). This document was not signed by the resident.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/15/2025 at 4:35 PM, the Administrator was interviewed. She reviewed the FRI investigation for Resident #218's missing money. She said the resident was provided a key on a stretchy bracelet for a locked drawer in her bedside dresser. She said the resident said she placed her purse into the locked drawer and did not look into her purse again until 10/18/2025 when she identified the money was missing. The Administrator reviewed there were staff interviews documented in the FRI investigation folder and some of the staff had identified the resident did not always wear the bracelet and it had been seen on the bedside dresser. The resident had also confirmed that the key was on the bedside dresser at times.</p> <p>During the interview with the Administrator on 1/15/2025 at 4:35 PM, the Administrator was asked about the report from the local police as it was not included in the Investigation folder. The Administrator said a female police officer had arrived on 11/19/2025 to investigate. The Administrator said the officer interviewed the resident and did not pursue it further. The Administrator was asked to review the police report and she said there wasn't one because they weren't going to pursue it. Reviewed with the Administrator there would still be a police report identifying the complaint and results of the interview.</p> <p>On 1/15/2025 at 4:35 PM, during the interview with the Administrator she was asked what was done to ensure a similar incident didn't occur again and she said education had been provided to the staff after the incident. Reviewed it was not located in the FRI investigation. The Administrator was asked which staff were educated and what were they educated about related to the missing money. She said she would have to get a copy of the education. The Administrator was asked if she was notified on admission that Resident #218 admitted with a large amount of money. She said she had not been notified. She said the facility had a Trust fund that residents could place their money in and the resident chose not to do that. The Administrator was asked who provided this information to the resident, she said it was in the admission Packet.</p> <p>On 1/15/2025 at 4:58 PM, the Administrator obtained a police report for the interview with Resident #218. The report was written on 11/19/2024 after Officer M investigated the incident. The facility did not obtain a copy of the police report until asked about it during the survey on 1/15/2025, it had been 2 months since the incident.</p> <p>The investigation report titled Case Report indicated Officer M interviewed Resident #218 at the facility on 11/19/2024 at approximately 3:00 PM. Officer M indicated she spoke with the manager because a patient had reported a theft. The Officer said the manager said it was unclear when the money went missing or how much was missing. The manager told the Officer that the patient's/resident's family had been contacted and reported the resident had not given the money to them. The Officer indicated she was told the resident did not have memory issues.</p> <p>The Officer interviewed Resident #218 who told her she looked in her purse/wallet on 11/18/2024 and her money was missing. She said the purse was in a locked drawer, but there were times it may have been unlocked. The resident said she did not have need for money in the facility and was going to send some home with her son, but when she looked it was gone. The Officer said it was unclear how much money the resident had or when it went missing sometime between 10/28/2024-11/18/2024.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/2025 at 1:30 PM, the Administrator was asked to see the education provided to the staff related to Resident #218's missing money, she said she forgot, education was not provided to all of the staff but was reviewed with the Interdisciplinary Team/IDT during a Quality/QAPI meeting; no further information was provided related to the facility's plan to prevent other residents from missing money.</p> <p>On 1/16/25 at 2:56 PM, Confidential Person J was interviewed via telephone. The Confidential Person said Resident #218 had taken money to the facility and the resident said they counted it, and the resident said she kept it in a locked drawer, but when she looked on 11/18/2024 it was missing. The Confidential Person J said the resident did not have memory issues and she handled her own money that she kept with her.</p> <p>On 1/16/25 at 4:14 PM, the Director of Nursing/ DON was interviewed about Resident #218's missing money. The DON was asked who completed the Inventory of Personal Items when a resident was admitted to the facility. She said the Nurse Aides completed the inventory list on paper and then they handed it to the nurse who typed it into the electronic medical record. The DON was asked if the Nurse Aides received training related to the Resident's Trust Fund, so they would know the residents didn't have to keep their money in their room. The DON said the Nurse Aides did not have training on this. The DON was asked if she was made aware that Resident #218 had brought a large amount of money into the facility, and it was in her room. She said she was not aware of the money until it was reported missing. The DON was asked if any additional training for staff was provided or measures were enacted to ensure resident belongings including money were kept safe after Resident #218's money disappeared. She said she wasn't sure if anything else had been done.</p> <p>A record review of the facility admission Packet revealed it was a 38-page document provided to the residents or their representative on admission. The document included information about a Resident Trust Fund on page 14 which provided You may elect to open a resident trust fund with the business office. Please complete an authorization to open a trust with the Business Office manager if you are interested in this option . There was no mention of alternatives for safe storage of valuables, including money.</p> <p>A review of the facility policy titled, Abuse and Neglect Procedural Guidelines, dated updated 12/16/2024 provided, . Misappropriation of Property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent . Reporting/Response . A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies .</p>		