

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>555134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/16/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MOUNT MIGUEL COVENANT VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>325 KEMPTON ST. SPRING VALLEY, CA 91977</b>	
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 0584  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<b>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to secure resident's cash. In addition, the inventory containing resident's belongings was updated and cash was secure in a safe place for 1 of 2 sampled residents (1). As a result, Resident 1's belongings and cash were not accounted for. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/11/20 at 2:44 P.M., an interview was conducted with the Activity Aide (AA). The AA stated on 6/9/20 in the morning that he entered Resident 1's room and Resident 1 communicated to him that five thousand dollars was missing while Resident 1 was in the shower. On 6/11/20 at 2:52 P.M., an interview was conducted with a Certified Nursing Assistant (CNA) 2. CNA 2 stated she was the regular CNA for Resident 1 and Resident 1 had cash all the time. CNA 2 stated Resident 1 had a rolled-up bundle of cash that was inserted inside a sock and Resident 1 would tuck the sock between the stomach area and disposable brief. CNA 1 stated Resident 1 had a bundle of cash for a long time and all the staff knew about it. CNA 2 stated she cared for Resident 1 on 6/7/20 and saw Resident 1's rolled-up bundle of cash with him. CNA 2 stated she was off for two days and when she returned to work, she was informed that Resident 1 complained of missing cash. CNA 2 stated after the incident, Resident 1 had two rolled-up bundles of cash with him. CNA 2 could not explain how much money the resident had or how he stored the cash or how much disappeared. CNA 2 stated Resident 1 continued to keep the cash stored under his brief and the facility did not to secure it for the resident. On 6/11/20 at 2:50 P.M., Resident 1 was observed sitting on the chair with eyes closed and a computer laptop on the bedside table. On 6/11/20, a record review was conducted. Per the Inventory Personal Effects, dated 1/7/19 and 6/3/19, the computer laptop was not listed as an item the resident had. Per the Valuables Listings & Waiver Policy, dated 4/18/19, indicated Cash \$600 was given to the nephew and \$400 was placed in the safe. On 6/11/20 at 3 P.M., an interview was conducted with a Licensed Nurse (LN) 1, LN 1 stated she was aware of Resident 1's complaint of missing cash and there was no change made to secure Resident 1's cash. LN 1 stated there was no safety deposit box in Resident 1's room. LN 1 further stated the inventory list should have been updated every time an item, such as a computer laptop was received. LN 1 stated Resident 1 had the computer laptop for a while and it should have been written on the inventory form. On 6/11/20 at 4:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the facility was not aware that Resident 1 had a large amount of cash on-hand until Resident 1 reported that he had missing money. The DON stated Resident 1 preferred to keep his money on him despite the statement that he lost the cash. The DON stated resident belonging's such as a laptop should be documented on the inventory form. The DON further stated Resident 1's inventory was not updated and should have been. Per the facility's policy, dated 8/12, titled Personal Property. .5. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. Per the facility's, dated 5/13/19, titled Theft and Loss Policy, .This facility will protect a resident's personal belongings to the fullest extent possible .		
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.