STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE MANOR NURSING HOME	**1109 E NATIONAL HIGHWAY WASHINGTON, IN 47501**

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** Based on interview and record review, the facility failed to prevent the misappropriation of a resident's narcotic medication, for 1 of 5 residents reviewed for abuse/misappropriation. (Resident G) Findings include: On 3/12/20 at 10:55 A.M., during an interview with the Administrator, she indicated she had reported to the Indiana State Department of Health (ISDH) an incident in which a staff member had taken a resident's narcotics. The staff member had taken the card of medication, and also the document on which the medication was recorded and counted. The Administrator indicated she had reported the incident to the local sheriff's department, and the Attorney General's office. The staff member no longer worked at the facility. On 3/12/20 at 12:30 P.M., the Administrator provided documentation of an emailed ISDH reportable incident and the investigation into the incident. The ISDH document indicated the facility reported the following incident: Incident date: 02/15/2020, Incident time: 10:01 AM .Residents Involved: (Resident G) .Staff Involved: (LPN 1) .Description added - 2/26/2020 Possible diversion of narcotics. We are currently conducting an internal investigation of [MEDICATION NAME] 7.5-325 (also known as [MEDICATION NAME]-[MEDICATION NAME]) tab (sic) gone without reason .Recd (sic) a call from another nurse stating that she has a concern over an entire card of narcotics missing. (LPN 1) had told this nurse that the Dr. had discontinued the drug and that the Dr. had come in the facility over the weekend and that another nurse came in to help destroy the meds. None of that actually happened. After discussing with the Dr., the medication has never been discontinued. The other nurse did not come in over that weekend and the Dr. did not come in as well as evidenced by the facility video cameras. However, this ADM (administrator) did witness via cameras (LPN 1) taking an entire sheet out of the narcotic binder and an entire card from the narcotic drawer and take it into the nursing ADMN (administration) office and (LPN 1) did not come out of the office with anything in her hands nor did she file the sheet. We are conducting interviews and investigation. We have notified (county name) sheriffs dept .Type of preventative measures added - Complete audit of facility narcotic books and count logs. Follow up added - 3/11/2020 (Name of facility) has turned all video evidence and documents over to the Attorney generals (sic) office A written statement by LPN 3, dated 2/24/20, included: I worked [DATE]p-7A, On Saturday AM @ 7 A (Resident G) had approx (approximately) 27/28 [MEDICATION NAME] in drawer . On Tues (2/18/20) another nurse was counting (with) me and (LPN 2) asked (LPN 1) about where [MEDICATION NAME] card went. (LPN 1) told (LPN 2) that (name of physician) had come in over wkend (sic) et (and) asked (Resident G) if still in pain et supposedly res (resident) stated 'No.' (LPN 1) told (LPN 2) that (LPN 1) et (RN 1) destroyed them D/T (due to) D/C (discontinue) order. Again, there was (no) D/C order on MAR (Medication Administration Record)/Phys (Physician) orders/ or Narc (narcotic) Sheet in back of chart. A written statement by LPN 2, dated 2/24/20, included: On Thursday night shift (2/14/20) 7p-7A (Resident G's) [MEDICATION NAME] was in the locked Narcotic box in nurses cart. I counted off with day shift nurse. I then left for the (sic) Friday, Sat, Sun et Monday. Upon my return on [DATE] (sic) I was doing count (with) off going nurse (LPN 3), she asked me about (Resident G's) [MEDICATION NAME] et card where were they .The count was correct et number of cards matched the number in the narc book. When (LPN 1) came in to work .she stated (name of physician) came in et stated they were D/C'd .(LPN 1) said did I not write the order to D/C the [MEDICATION NAME], I answered no, stated stated I bad, laughed et said she will write the order. (LPN 1) also stated that she et (RN 1) destroyed the meds over the weekend. According to schedule (RN 1) was not working this weekend. A written statement by RN 1, undated, included: When I arrived at work Monday 2/24/20 I was advised that a fell ow nurse, who had abruptly resigned without notice Thursday 2/20/20, had stated that I had come in over the weekend of 2/15-2/16/20 to destroy narcotic medications that had been discontinued by the resident's doctor. I did NOT, in fact, come to the facility at all on either 2/15 or 2/16. Said nurse did not work Monday 2/17, therefore the medications were also not destroyed that day. A written statement by RN 2, dated 2/26/20, included : This is in regards to an order for [REDACTED]. I only accounted for 1 (one) active card of [MEDICATION NAME] for (Resident G) prior to card and sheet missing. The employee file of LPN 1 was included with the investigation. A facility (Code of Conduct), dated 6/11/18 and signed by LPN 1, included: The following code of conduct shall be reviewed and signed by all new employees. Violation of any of the following acts will be cause for discharge .Stealing or willfully destroying any property of the facility, it's patient's (sic), or visitor's (sic) The clinical record of Resident G was reviewed on 3/12/20 at 4:00 P.M. A physician's orders [REDACTED]. On 3/12/20 at 11:20 A.M., the Administrator provided the current facility Abuse/Neglect Policy, dated 5/16/16. The policy included: (Name of facility) shall be responsible for the personal possessions of all residents 3.1-28(a)

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