STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WHITLOCK PLACE	1719 S ELM ST CRAWFORDSVILLE, IN 47933

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00390133. Complaint IN00390133- Substantiated. State deficiencies related to the allegation(s) are cited at R0055, R0090, R0091, and R0304. Survey date: September 15, 2022 Facility number: 004419 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 26, 2022.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility or the trust of any facts alleged, or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, interview, and record review, the facility failed to ensure residents' right to privacy when a nurse under the influence of alcohol was knowingly left in the facility to wander with a master key and entered a locked residential apartment uninvited during the night	R 0055	1. /b> Resident H was assessed by nursing on 8/26/2022. Resident H had indicated she felt safe in the community. LPN 9 was placed on administrative leave on 8/26/2022	10/15/2022

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

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	for 1 of 56 residents residing at the facility (Resident H). Findings include: During an observation and interview on 9/15/22 at 2:46 p.m., Resident H was observed watching television in her apartment situated several doors from the medication room. Resident H indicated she had moved in last month. There was an episode when LPN 9, who was a "nice evening nurse," used her key and entered the resident's apartment during the middle of the night. The nurse was walking around the kitchen/living area of the apartment. When questioned what she needed or why she was in the apartment, LPN 9 acted confused and vague with her responses. Having the nurse enter the apartment in the middle of the night kind of scared her, and as the nurse started to exit the apartment the resident got up and shut the door locking it behind the nurse. Resident H was later told by staff the nurse had a UTI (urinary tract infection) making her confused. Resident H's record was reviewed on 9/15/22 at 3:16 p.m. Diagnoses on Resident H's profile included but were not limited to hypertension, orthostatic hypotension (drop in blood pressure upon rising), anxiety, insomnia, pericardial effusion (build-up of too much fluid in the saclike structure around the heart), and syncope collapse (fainted). The resident record lacked documentation of Progress Notes during the month of August 2022. An Assessment and Negotiated Service Plan Summary, dated 8/25/22, indicated Resident H was alert and oriented, and did not require assistance with Activities of Daily Living to include		pending investigation and subsequently terminated 8/29/2022. 2. /b> Staff that were present during this event were interviewed on 8/26/2022, 8/27/2022, and 8/28/2022 by Regional Director of Care Services (RDCS) and Executive Director (ED) and no other resident's apartments were entered by LPN 9. Full house audit of interviewable residents will be performed by 10/11/2022 by ED to ensure they feel they have been treated with consideration and respect for their privacy. Findings will be reviewed with RDCS as necessary. 3. /b> Interim Care Service Manager (CSM) and ED were retrained on 10/5/2022 by RDCS regarding abuse, resident rights, and reporting guidelines (Attachment 1). Current staff were in-serviced on resident rights, abuse, and reporting guidelines on 10/6/2022 by interim CSM and ED (Attachment 4). (Attachment 2 and 3 are policies). The ED or designee will review resident rights and the abuse policy during the resident council meeting by the end of October. 4. /b>	

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	ambulation, bathing, or dining services. Staff would administer the resident's medications. An Investigation Interview/Witness Form, dated 8/26/22 at 2:45 p.m., written by the Director of Nursing (DON) indicated she had received a call about 2:40 a.m. from the night shift Resident Care Partner(RCP) on 8/26/22. The RCP reported that Licensed Practical Nurse (LPN) 9 had been in Resident H's apartment. The DON asked if LPN 9 was still at the facility, and the RCP reported LPN 9 had gone back to the medication room. The DON told staff to call if they needed her. At 6:00 a.m. the DON received a call from the day shift nurse that the medication cart/room keys were not present. LPN 9 was in the parking lot in her car sleeping and had the medication cart/room keys. The DON arrived at the community about 8:30 a.m. and LPN 9 was gone. An Investigation Interview/Witness Form, dated 8/26/22 at 3:30 p.m., written by Resident H indicated the resident was asleep and woke to someone entering her apartment. She called out two times, "who is it?" and no one answered. The third time the resident called out the person replied, "it's just me". The resident asked, "what do you want?" They replied, "I don't know." Resident H pushed her pendent and staff arrived to assist LPN 9 out of her apartment. The resident locked the door. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by RCP 12 indicated around 2:00 a.m. on 8/26/22. Resident H called and said LPN 9 was in her room. After LPN 9 was out of Resident H's room and observed going back to the medication room, RCP 12 went around and locked all residents' apartment doors. LPN 9 came out of the medication room about 3:30 a.m. and		The ED is responsible for sustained compliance. The ED or designee will interview 3 residents weekly x 3 months to ensure the residents feel they are being treated as individuals with consideration and respect for their privacy. Results of the interviews will be reviewed at monthly QI meeting x 3 months. The QI committee will determine if continued interviews are necessary based on 3 consecutive months with no findings. Monitoring will be on-going. 5. /b>: Completion date 10/15/2022.	

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	RCP 12 escorted her to her car in the parking lot, and she stayed in her car at that point. LPN 9 was still sitting in her car in the parking lot when RCP 12 left after her shift about 6:30 a.m. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by LPN 7 indicated Resident H reported someone went into her room about 2:00 a.m. When the resident asked who it was "the girl" responded, "it is me". It was "the girl" that gave her medications, LPN 9. The resident stated that she had to "push the door to get the person out of her apartment ..." An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by LPN 9 indicated, "The 2:00 p.m. - 10:00 p.m. shift was fine and then I chose to drink in my car. I am unsure what time that was. I remember somebody at my car, but I am not sure who it was. I am not sure what time that was either. I think I finished the shift. I do not remember [the DON] coming to the community. I do not remember falling in the hallway. I do not think I drank any during my shift, but I honestly do not remember...." An Investigation Interview/Witness Form page 1, dated 8/29/22 at 11:15 a.m., written by RCP 13 indicated when she arrived at the facility to get report, she was told by the agency aide, LPN 9 was falling down drunk. Around 15 to 20 minutes later the DON was observed passing medications. About 2:30 a.m. Resident H rang, and LPN 9 was in front of the resident's door. "I asked if she had answered the call light and the nurse said yes. There was another resident, Resident K in the hallway. I approached the other resident and LPN 9 continued to stand there and stare at the original resident's door. The nurse was gone when I turned around. I went in and she [Resident H] was			

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	very upset asking why the nurse from the other shift was in her apartment. The resident asked me to call [the DON]...." During an interview on 9/15/22 at 12:30 p.m., LPN 7 indicated she routinely worked the day shift that started at 6:00 a.m. On 8/26/22 when she arrived Resident H wanted to speak with her and relayed that the evening nurse, LPN 9, had been in her room at approximately 2:30 a.m. and she had to push her out. The LPN 7 could not find the medication room keys and learned they were still on the evening nurse who was supposedly still in the parking lot. RCP 14 went out to the parking lot and retrieved the keys from LPN 9. LPN 7 indicated she had no firsthand knowledge of events, but her understanding was LPN 9 had been found on the medication room floor drunk the prior evening. The DON had been called and she had come into finish passing medications to residents who had not received their medications on the evening shift. The DON had used her personal set of keys to access the medication cart/room and resident apartments. The DON then went home and left LPN 9 in the facility during the night in the medication room with the nurse's set of keys that included a master key to all resident apartments, and keys to the medication cart and medication room. On 9/15/22 at 4:30 p.m., the interim Administrator provided a Drug & Alcohol-Free Workplace policy from the employee handbook, undated, and indicated the policy was the current policy being used by the facility. The policy indicated, " ...We are committed to maintaining a drug and alcohol-free workplace to provide a safe, efficient, and effective workforce. The use, sale, manufacture, cultivation, distribution, or possession of illegal drugs or other unauthorized,			

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	intoxicating, or controlled substances is prohibited on company property or while engaged in company business. You are prohibited from having any alcohol or drugs [whether illegal or improperly used prescription drugs] in your system, or from being otherwise intoxicated or impaired from such substances while on duty ...You are expected to behave in an appropriate manner and comply with [company] policies including the Policy Against Harassment & Offensive Behavior Alcohol consumption by [company] employees under the age of 21 is prohibited ...By accepting employee with [company name] you consent to drug and alcohol testing ...You must comply with an support this policy. If you are aware of a violation of the policy, you must report it to your immediate supervisor or Human Resources ...Employees who violate this policy, or knowingly make false reports, will be subject to discipline, up to and including immediate termination ..." Cross reference tag R0091. This State finding relates to Complaint IN00390133.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by			

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	electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview, and record review, the facility failed to ensure the Administrator reported on unusual occurrence of	R 0090	1. /b> On 8/26/2022 the former CSM	10/15/2022

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	a nurse working while under the influence of alcohol to the Indiana Department of Health in a timely manner. This deficient practice had the potential to affect 56 of 56 residents residing in the facility. Findings include: An Indiana State Department of Health Survey Report System report, dated 9/11/22, indicated on 8/25/22 at 10:30 p.m., staff reported that Licensed Practical Nurse (LPN) 9 was in the medication room with the door locked and was not responding. Staff observed LPN 9 asleep in the medication room with a liquor bottle. Staff reported being unable to awake the LPN. LPN 9 admitted to drinking at the community and was terminated. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by LPN 9 indicated, "The 2:00 p.m. - 10:00 p.m. shift was fine and then I chose to drink in my car. I am unsure what time that was. I remember somebody at my car, but I am not sure who it was. I am not sure what time that was either. I think I finished the shift. I do not remember [the Director of Nursing] coming to the community. I do not remember falling in the hallway. I do not think I drank any during my shift, but I honestly do not remember...." During an interview with the interim Director of Nursing (DON) on 9/15/22 at 3:37 p.m., indicated she had been hired 8/30/22 after the prior DON was terminated for improper handling of the situation when LPN 9 was supposedly inebriated in the facility. She had no firsthand knowledge of the incident. There had been a delay in state reporting the incident, and it was not reported from the facility but by the regional team on		reported the incident with LPN 9 to RDCS. On 9/11/2022 the RDCS reached out to ISDH regarding the need to report LPN 9's license and was told to report the incident through the SRS Gateway. RDCS reported the incident on 9/11/2022 as instructed. 2. /b> By 10/11/2022 the interim CSM will conduct an audit of incident reports completed in the past 90 days to ensure incidents of unusual occurrence that directly threatens the welfare, safety, or health of a resident were reported to ISDH in the required time frame. Findings will be reviewed with RDCS as necessary. 3. /b> RDCS was retrained on 10/5/2022 by Divisional Vice President of Care Services (DVPCS) regarding reportable incidents and the ISDH reporting guidelines (Attachments 5). The Interim CSM and ED were retrained on 10/5/2022 by RDCS regarding reportable incidents and the ISDH reporting guidelines (Attachment 6). Staff were in-serviced on incident reporting guidelines on 10/7 by interim CSM and ED (Attachment 7). (Attachment 8 and 9 are policy/reporting guidelines)	

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	9/9/22. She understood on 8/25/22 the prior DON had come into the facility around 10:30 p.m. when called by staff and had completed the bedtime medication pass that LPN 9 had not finished. During an interview on 9/15/22 at 3:55 p.m., the interim Administrator indicated she had called the prior DON on the morning on 8/26/22 for an unrelated issued and was told LPN 9 had been found drinking while on duty the prior evening. The prior DON indicated she had to go to work during the night due to LPN 9 being drunk. The DON had been told LPN 9 had fallen a couple of times. When she arrived LPN 9 was in the medication room with the door closed and locked, and LPN 9 was passed out. The DON had been able to enter using her own keys. The DON said she had checked medications, passed what needed finished, and checked the narcotic count. The DON asked LPN 9 if she could drive her home or follow her home and LPN 9 said no. LPN 9 was still incoherent in the medication room and the DON left her there and went home. The DON had made a comment that she thought about just brushing the whole incident under the rug but then decided to report it to the interim Administrator. The Resident Care Provider (RCP) had reported to the DON that LPN 9 was drunk. The DON was placed on administrative leave pending investigation of events and was subsequently terminated for failure to follow the drug and alcohol policy. The interim Administrator had found out during the investigation that LPN 9 had been left in facility with medication room/carts keys and a master key to residents' rooms. The interim Administrator indicated LPN 9 should not have been left in the facility to "sleep it off" and should have been escorted out of the facility and off the premises whether on her own or by 911. The DON should		4. /b> The ED is responsible for sustained compliance. The ED or designee will audit incident reports weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure incidents of unusual occurrence that directly threatens the welfare, safety, or health of a resident are reported to the Indiana Department of Health in the required timeframe. Audits will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be ongoing 5. /b> Completion date 10/15/2022.	

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	have stayed in the facility. Poor decisions were made which put all the residents at risk. During an interview on 9/15/22 at 5:00 p.m., the interim Administrator indicated there was no formal termination paperwork for the DON, she was terminated over the phone then allowed to come to the facility to clean out her office and return her phone and keys. The DON was terminated for leaving a drunk employee in the medication room and not getting her out of the facility. She did not follow company guidelines to handle the situation. During an interview on 9/15/22 at 5:02 p.m., the interim Administrator indicated LPN 9 had been called to get her statement and to tell her she was suspended and on administrative leave pending investigation. When they attempted to call her back after the conclusion of the investigation, LPN 9 did not answer the phone and never called back. During an interview on 9/15/22 at 5:45 p.m., the Regional Director of Care Services (RDCS) indicated management had not considered the situation a reportable incident as there were no residents involved except for Resident H's room being entered during the night. So, upon contacting the Indiana Department of Health (IDOH) to report the DON's license on 9/9/22, the RDCS was informed the incident should have been reported through the portal. By that time the incident was reported 2 weeks late. Cross reference R0055. Cross reference R0091. Cross reference R0304. This State finding relates to Complaint			

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R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, interview, and record review, the facility failed to follow the Drug & Alcohol-Free Workplace policy when a Licensed Practical Nurse (LPN) was found drunk in the facility and allowed to remain on the premises with keys to access the medication carts, medication room, and resident apartments putting the care and safety of residents at risk for 56 of 56 residents reviewed for neglect (Resident H). Findings include: An Indiana State Department of Health Survey Report System report, dated 9/11/22, indicated on 8/25/22 at 10:30 p.m. staff reported that Licensed Practical Nurse (LPN) 9 was in the medication room with the door locked and was not responding. Staff observed LPN 9 asleep in the medication room with a liquor bottle. Staff reported being unable to awake the LPN. LPN 9 admitted to drinking at the community and was terminated. An Investigation Interview/Witness Form, dated 8/26/22 at 2:45 p.m., written by the Director of	R 0091	**1.** /b> Resident H was assessed by nursing on 8/26/2022. Resident H indicated she felt safe in the community. LPN 9 and DON were placed on administrative leave on 8/26/2022 pending investigation and subsequently terminated on 8/29/2022. **2.** /b> Staff that were present during this event were interviewed on 8/26/2022, 8/27/2022, and 8/28/2022 by RDCS and ED and no other resident's apartments were entered by LPN 9. A full house audit of current staff will be completed by 10/11/2022 by ED to ensure no other staff have allegedly worked to their knowledge while under the influence of alcohol. Findings will	10/15/2022

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	Nursing (DON) indicated she had received a call about 10:00 p.m. from the night shift Resident Care Partner (RCP) reporting LPN 9 had locked herself in the medication room and would not open the door. LPN 9 had also been seen by an agency RCP falling 2 or 3 times in the hallways during the 2:00 p.m. to 10:00 p.m. shift. The DON went to the facility and was unable to enter the medication room door, LPN 9 said "okay" but never moved. The DON gave administered medications to 3 or 4 residents who still needed their meds. The DON went back to the medication room about 11:30 p.m. and LPN 9 was sitting on the chair with her head on the desk still sleeping. The DON rolled the medication carts into the medication room and told LPN 9 everything was done. The DON took a short break and came back in about 12:00 a.m. and told LPN 9 she would take her home, and the nurse said no. The DON asked LPN 9 if she would at least let her follow her home to ensure she got home safely, and the nurse said no. The DON told the night shift RCP not to let LPN 9 sleep in the med room all night and to be sure she woke her up and got her out before day shift showed up. The DON then left the community about 12:45 a.m. and LPN 9 was still sleeping in the medication room. The DON got a phone call about 2:40 a.m. from the night shift RCP. The RCP reported that LPN 9 had been in Resident H's apartment. The DON asked if LPN 9 was still there, and the CNA reported the nurse had gone back to the medication room. The DON told staff to call if they needed her. At 6:00 a.m. the DON got a call from the day shift nurse that the medication cart/room keys were not present. LPN 9 was in the parking lot in her car sleeping and had the medication cart/room keys. The DON arrived at the community about 8:30 a.m. and LPN 9 was gone. An Investigation Interview/Witness Form, dated		be reviewed with RDCS as necessary. **3.** /b> Interim CSM and ED were retrained on 10/5/2022 by RDCS regarding the drug and alcohol-free workplace policy. (Attachment 10). Staff were in-serviced on the drug and alcohol-free workplace policy on 10/6/2022 by interim CSM and ED (Attachment 11). The ED or designee will ensure all employees are educated on the drug and alcohol policy upon hire. **4.** /b> The ED is responsible for sustained compliance. The ED or designee will conduct random observations of 5 employees to ensure the Drug & Alcohol-Free Workplace policy is being followed and enforced weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure compliance. Audits will be reviewed at the monthly QI meeting. The QI committee will determine if continued audits are necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. **5.** /b> Completion date 10/15/2022.	

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	8/26/22 at 2:25 p.m., written by the Administrator indicated she had received a call from the DON at approximately 1 a.m. with a report of a staff nurse asleep in the medication room. The DON arrived at the community to find LPN 9 asleep on the medication room floor with a liquor bottle visible. The DON was unable to awaken the nurse. At this time, the DON told the Administrator that if the nurse didn't wake up in the next hour she would come back. The DON reported she had taken the medication cart keys and locked them up. An Investigation Interview/Witness Form, dated 8/26/22 at 3:30 p.m., written by Resident H indicated Resident H was asleep and woke to someone entering her apartment. She called out two times "who is it", and no one answered. The 3rd time she called out the person replied, "it's just me." The resident asked, "what do you want?" They replied, "I don't know." Resident H pushed her pendent and staff arrived to assist LPN 9 out of her apartment. The resident locked the door. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., by RCP 12 indicated when she arrived to work on 8/25/22 for her night shift she was told something was wrong with the evening nurse LPN 9 and she did not know if all the residents got their evening medications. The DON was notified the nurse would not answer the medication room door, and the DON came to the facility and finished passing the evening medications. "LPN 9 was passed out asleep in the med [medication] room. The DON told RCP 12 to make sure LPN 9 was out of there by 3:00 a.m. or 4:00 a.m." Then Resident H called and said LPN 9 was in her room. After LPN 9 was out of Resident H's room and seen going back to the medication room, RCP 12 went around and locked all resident doors. LPN 9 came out of the medication room			

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	about 3:30 a.m. and RCP 12 escorted her to her car in the parking lot, and she stayed in her car at that point. LPN 9 was still sitting in her car in the parking lot when RCP 12 left after her shift about 6:30 a.m. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by LPN 7 indicated on 8/26/22 the medication carts were outside the medication room door, and they did not have keys to get into the carts. Resident H wanted to talk to her. One of the RCP's went out and got the keys from LPN 9 in the parking lot. Resident H reported someone went into her room about 2:00 a.m. When the resident asked who it was "the girl" responded, "it is me." It was "the girl" that gave her medications, LPN 9. The resident states that she had to "push the door to get the person out of her apartment...." An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., written by LPN 9 indicated, "The 2:00 p.m. - 10:00 p.m. shift was fine and then I chose to drink in my car. I am unsure what time that was. I remember somebody at my car, but I am not sure who it was. I am not sure what time that was either. I think I finished the shift. I do not remember [the DON] coming to the community. I do not remember falling in the hallway. I do not think I drank any during my shift, but I honestly do not remember...." An Investigation Interview/Witness Form page 1, dated 8/28/22 at 12:00 p.m., written by LPN 5 indicated after she clocked in for her shift on 8/26/22, she went to the medication room and there were no keys in the medication room for the medication carts in the lock box. She texted LPN 9 to ask if she had accidentally taken the keys home and after no response called and left a voicemail.			

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	The DON was then called, and she gave LPN 5 instructions to ask RCP 12 if she knew anything about the keys. RCP 12 indicated she did not know anything about any keys, so LPN 5 called the DON back and was told she would head into the facility. RCP 12 mentioned to LPN 5 there had been an incident on the 2:00 p.m. - 10:00 p.m. shift. She reported, the medication carts had still been out after 10:00 p.m., so RCP 12 called the DON, and she came in. RCP 12 indicated LPN 9 was drunk and had locked herself in the medication room. When the DON came in LPN 12 was passed out on the floor in the medication room. LPN 9 had gone into Resident H's apartment and was rummaging around and scared the resident. RCP 12 physically removed LPN 9 from the apartment and told her to get out. An Investigation Interview/Witness Form page 2, dated 8/28/22 at 12:00 p.m. written by LPN 5 indicated about 6:30 a.m. on 8/26/22, RCP 12 was leaving the community due to finishing her shift. RCP came back in and brought the medication cart keys from the parking lot. RCP reported that LPN 9 was still in the parking lot and had the keys. About 7:00 a.m. the DON responded to her text and stated that the keys were in the lock box. The DON came in about 8:45 a.m. and told them staff LPN 9 had been on the medication room floor drunk and that she had to get her up off the floor. The DON reported LPN 9 had an empty 5th of vodka in the medication room. "I just didn't understand why everyone left [LPN 9] in the community at that point." An Investigation Interview/Witness Form page 1, dated 8/29/22 at 11:15 a.m., written by RCP 13 indicated when she arrived at the facility on 8/25/22 to get report, she was told by the agency aide LPN 9 was falling down drunk. About 15 - 20			

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	minutes later the DON was observed passing medications. About 2:30 a.m. Resident H rang, and LPN 9 was in front of the resident's door. "I asked if she had answered the call light and the nurse said yes. There was another resident, Resident K in the hallway. I approached the other resident and LPN 9 continued to stand there and stare at the original resident's door. The nurse was gone when I turned around. I went in and she [Resident H] was very upset asking why the nurse from the other shift was in her apartment. The resident asked me to call [the DON]...." An Investigation Interview/Witness Form page 2, dated 8/29/22 at 11:15 a.m., written by RCP 13 indicated, "After I left [the DON's] office I went to find the RCP on shift and reported that I called [the DON] and what had happened. After this I did not see the nurse anymore during this shift. The other RCP banged on the door of the med room several times trying to get the nurse to open the door. No answer, however, about 4:30 a.m., the other RCP spotted the nurse walking in the hallways again and escorted her out of the community...." During an interview on 9/15/22 at 12:30 p.m., LPN 7 indicated she routinely worked the day shift that started at 6 am. On 8/26/22 when she arrived, she observed the medication carts sitting outside the medication room, they were supposed to be locked up at night in the med room as there were only aides working the night shift, and she assumed the other day nurse LPN 5 had already gotten them out per their normal routine. Resident H wanted to speak with her and relayed the evening nurse LPN 9 had been in her room at approximately 2:30 a.m. and she had to push her out. The days nurse could not find the medication room keys and learned they were still on the			

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	evening nurse who was supposedly still in the parking lot. The day RCP 14 went out to the parking lot and retrieved the keys from LPN 9. LPN 7 indicated she had no firsthand knowledge of events, but her understanding was LPN 9 had been found on the medication room floor drunk the prior evening. The DON had been called and she had come into finish passing medications to residents who had not received their medications on the evening shift. The DON had used her personal set of keys to access the medication cart/room and resident apartments. The DON then went home and left LPN 9 in the facility during the night in the medication room with the nurse's set of keys that included a master key to all resident apartments, and keys to the medication cart and med room. During an observation and interview on 9/15/22 at 2:46 p.m., Resident H was observed watching television in her apartment situated a few doors from the medication room. The resident indicated she had moved in last month. There was an episode when LPN 9, who was "a nice evening nurse," used her key and entered the resident's apartment during the middle of the night. The nurse was walking around the kitchen/living area of the apartment and when questioned what she needed or why she was in the apartment acted confused and vague with responses. Having the nurse enter the apartment in the middle of the night kind of scared her, and as the nurse started to exit the apartment the resident got up and shut the door locking it behind the nurse. Resident H was later told by staff the nurse had a UTI (urinary tract infection) making her confused. During an interview on 9/15/22 at 3:00 p.m., RCP 8 indicated she worked the evening shift on 8/25/22 until 8:00 p.m. and had not observed LPN 9 to be			

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	in an impaired state. She indicated was told by the other RCP that LPN 9 was observed stumbling into the wall in the hallway and then was heard as she fell on the floor in the medication room. RCP 8 indicated staff were not able to enter the medication room to check on the nurse as only nurses had keys to enter the medication room, and despite knocking on the door several times got no response from the nurse to open the door. During an interview with the interim DON on 9/15/22 at 3:37 p.m., indicated she had been hired 8/30/22 after the prior DON was terminated for improper handling of the situation when LPN 9 was supposedly inebriated in the facility, so she had no firsthand knowledge of incident. On 8/25/22 the prior DON had come into the facility around 10:30 p.m. when called by staff and had completed the bedtime medication pass that LPN 9 had not finished. During an interview on 9/15/22 at 3:55 p.m., the interim Administrator indicated she had called the prior DON on the morning of 8/26/22 for an unrelated issued and was told LPN 9 had been found drinking while on duty the prior evening. The prior DON indicated she had to go to work during the night due to a report of a drunk nurse. The DON had been told LPN 9 had fallen a couple of times, when she arrived LPN 9 was in the medication room with the door closed and locked, and the nurse was passed out. The DON had been able to enter using her own keys. The DON said she had checked medications, passed what needed finished, and checked the narcotic count. The DON asked LPN 9 if she could drive her home or follow her home and LPN 9 said no. LPN 9 was still incoherent in the medication room and the DON left her there and went home. The DON had made a comment that she thought about just			

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	"brushing the whole incident under the rug" but then decided to report it to the Administrator. The RCP had reported to the DON that LPN 9 was drunk. The DON was placed on administrative leave pending investigation of events and was subsequently terminated for failure to follow the drug and alcohol policy. The Administrator had found out during the investigation that LPN 9 had been left in facility with medication room/carts keys and a master key to resident rooms. The interim Administrator indicated LPN 9 should not have been left in the facility to "sleep it off" and should have been escorted out of the facility and off the premises whether on her own or by 911. The DON should have stayed in the facility. Poor decisions were made which put all the residents at risk. Employee Documents to include a Drug and Alcohol Policy was electronically signed by LPN 9 on 8/3/21 during on-boarding. A General Orientation Record to include Employee Handbook-electronic acknowledgement was signed by LPN 9. Employee Documents to include Employee Handbook were electronically signed by the DON on 2/12/19 and an updated Employee Handbook electronically signed 8/20/20. During an interview on 9/15/22 at 5:00 p.m., the interim Administrator indicated there was no formal termination paperwork for the DON, she was terminated over the phone then allowed to come to the facility to clean out her office and return her phone and keys. The DON was terminated for leaving a drunk employee in the medication room and not getting her out of the facility. She did not follow company guidelines to			

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	handle the situation. During an interview on 9/15/22 at 5:02 p.m., the interim Administrator indicated LPN 9 had been called to get her statement and to tell her she was suspended and on administrative leave pending investigation. When they attempted to call her back after the conclusion of the investigation, LPN 9 did not answer the phone and never called back. During an interview on 9/15/22 at 6:00 p.m., the interim DON indicated continuing education to include review of the Drug & Alcohol-Free Workplace policy from the employee handbook had not been offered to staff following the incident on 8/26/22. On 9/15/22 at 4:30 p.m., the interim ADM provided a Drug & Alcohol-Free Workplace policy from the employee handbook, undated, and indicated the policy was the current only being used by the facility. The policy indicated, "We are committed to maintaining a drug and alcohol-free workplace to provide a safe, efficient, and effective workforce. The use, sale, manufacture, cultivation, distribution, or possession of illegal drugs or other unauthorized, intoxicating, or controlled substances is prohibited on company property or while engaged in company business. You are prohibited from having any alcohol or drugs [whether illegal or improperly used prescription drugs] in your system, or from being otherwise intoxicated or impaired from such substances while on duty...You are expected to behave in an appropriate manner and comply with [company] policies including the Policy Against Harassment & Offensive Behavior Alcohol consumption by [company] employees under the age of 21 is prohibited...By accepting employee with			

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	[company name] you consent to drug and alcohol testing...You must comply with an support this policy. If you are aware of a violation of the policy, you must report it to your immediate supervisor or Human Resources...Employees who violate this policy, or knowingly make false reports, will be subject to discipline, up to and including immediate termination...." This State finding relates to Complaint IN00390133.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to ensure a nurse under the influence of alcohol did not have access to the medication room or medications stored in medications carts to include scheduled narcotic medications for 1 of 1 incident reviewed for medication storage. Findings include: An Indiana State Department of Health Survey Report System report, dated 9/11/22, indicated on 8/26/22 at 10:30 a.m., staff reported that Licensed Practical Nurse (LPN) 9 was in the medication room with the door locked and was not responding. Staff observed LPN 9 asleep in the medication room with a liquor bottle. Staff reported being unable to awake the LPN. LPN 9	R 0304	**1.** /b> LPN 9 and DON were placed on administrative leave on 8/26/2022 pending investigation and subsequently terminated on 8/29/2022. **2.** /b> On 8/26/2022 medications were stored appropriately when audited by oncoming nurse. Medication cart keys were returned to the community on 8/26/2022. A narcotic count audit was performed on 8/26/2022 by the oncoming LPN Carla to ensure no	10/15/2022

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	admitted to drinking at the community and was terminated. An Investigation Interview/Witness Form, dated 8/26/22 at 2:45 p.m. by the Director of Nursing (DON), indicated she had gotten a call about 10:00 p.m. from the night shift Resident Care Partner (RCP) reporting LPN 9 had locked herself in the medication room and would not open the door. LPN 9 had also been seen by an agency RCP falling 2 or 3 times in the hallways during the 2:00 p.m. to 10:00 p.m. shift. The DON went to the facility and was unable to enter the medication room door, LPN 9 said "okay" but never moved. The DON administered medications to 3 or 4 residents who still needed their medications. The DON went back to the medication room about 11:30 p.m. and LPN 9 was sitting on the chair with her head on the desk still sleeping. The DON rolled the medication carts into the medication room and told LPN 9 everything was done. The DON took a short break and came back in about 12:00 a.m. and told LPN 9 she would take her home, and the nurse said no. The DON asked LPN 9 if she would at least let her follow her home to ensure she got home safely, and the nurse said no. The DON told the night shift RCP not to let LPN 9 sleep in the medication room all night and to be sure she woke her up and got her out before day shift showed up. The DON then left the community about 12:45 a.m. and LPN 9 was still sleeping in the medication room. The DON got a phone call about 2:40 a.m. from the night shift RCP. The RCP reported that LPN 9 had been in Resident H's apartment. The DON asked if LPN 9 was still there, and the CNA reported the nurse had gone back to the medication room. DON told staff to call if they needed her. At 6:00 a.m. the DON got a call from the day shift nurse that the medication cart/room keys were not present. LPN		missing medications with no discrepancies identified. **3.** /b> Interim CSM and ED were retrained on 10/5/2022 by RDCS regarding the Medication Storage Policy. (Attachment 13). Med passing staff were in-serviced on the medication storage policy on 10/7/2022 by interim CSM and ED (Attachment 14). (Attachment 15 is the policy) **4.** /b> The ED is responsible for sustained compliance. The CSM or designee conduct observation of 3 employees during medication administration and medication storage weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure employees are not under the influence of alcohol while having access to resident medications. Audits will be reviewed at the monthly QI meeting. The QI committee will determine if continued audits are necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. **5.** /b> Completion date 10/15/2022.	

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	9 was in the parking lot in her car sleeping and had the medication cart/room keys. The DON arrived at the community about 8:30 a.m. and LPN 9 was gone. An Investigation Interview/Witness Form, dated 8/26/22 at 2:25 p.m., by the Administrator indicated she had gotten a call from the DON at approximately 1 a.m. with a report of a staff nurse asleep in the medication room. The DON arrived at the community to find LPN 9 asleep on the medication room floor with a liquor bottle visible. The DON was unable to awaken the nurse. At this time, the DON told the Administrator that if the nurse didn't wake up in the next hour she would come back. The DON reported she had taken the medication cart keys and locked them up. An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., by RCP 12 indicated when she arrived to work on 8/25/22 for her night shift she was told something was wrong with the evening nurse LPN 9 and she did not know if all the residents got their evening medications. The DON was notified the nurse would not answer the medication room door, and the DON came to the facility and finished passing the evening medications. "LPN 9 was passed out asleep in the med [medication] room. The DON told RCP 12 to make sure LPN 9 was out of there by 3:00 a.m. or 4:00 a.m." Then Resident H called and said LPN 9 was in her room. After LPN 9 was out of Resident H's room and seen going back to the medication room, RCP 12 went around and locked all resident doors. LPN 9 came out of the medication room about 3:30 a.m. and RCP 12 escorted her to her car in the parking lot, and she stayed in her car at that point. LPN 9 was still sitting in her car in the parking lot when RCP 12 left after her shift about 6:30 a.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	An Investigation Interview/Witness Form, dated 8/28/22 at 11:35 a.m., by LPN 7 indicated the medication carts were outside the medication room door, and they did not have keys to get into the carts. Resident 8 wanted to talk to her. One of the RCP's went out and got the keys from LPN 9 in the parking lot. An Investigation Interview/Witness Form dated 8/28/22 at 11:35 a.m. by LPN 9 indicated, "The 2:00 p.m. - 10:00 p.m. shift was fine and then I chose to drink in my car. I am unsure what time that was. I remember somebody at my car, but I am not sure who it was. I am not sure what time that was either. I think I finished the shift. I do not remember [the DON] coming to the community. I do not remember falling in the hallway. I do not think I drank any during my shift, but I honestly do not remember ..." An Investigation Interview/Witness Form page 1, dated 8/28/22 at 12:00 p.m. by LPN 5 indicated, after she clocked in for her shift, she went to the medication room and there were no keys in the medication room for the medication carts in the lock box. She texted LPN 9 to ask if she had accidentally taken the keys home and after no response called and left a voicemail. The DON was then called, and she gave LPN 5 instructions to ask RCP 12 if she knew anything about the keys. RCP 12 indicated she did not know anything about any keys, so LPN 5 called the DON back and was told she would head into the facility. RCP 12 mentioned to LPN 5 there had been an incident on the 2:00 p.m. - 10:00 p.m. shift. She reported, the medication carts had still been out after 10:00 p.m., so RCP 12 called the DON, and she came in. RCP 12 indicated LPN 9 was drunk and had locked herself in the medication room. When the DON			

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	came in LPN 12 was passed out on the floor in the medication room. An Investigation Interview/Witness Form page 2, dated 8/28/22 at 12:00 p.m. by LPN 5 indicated, about 6:30 a.m. RCP 12 was leaving the community due to finishing her shift. RCP came back in and brought the medication cart keys from the parking lot. RCP reported that LPN 9 was still in the parking lot and had the keys. About 7:00 a.m. the DON responded to her text and stated that the keys were in the lock box. The DON came in about 8:45 a.m. and told them staff LPN 9 had been on the medication room floor drunk and that she had to get her up off the floor. The DON reported LPN 9 had an empty 5th of vodka in the med room. "I just didn't understand why everyone left [LPN 9] in the community at that point." During an interview on 9/15/22 at 12:30 p.m., LPN 7 indicated, indicated she routinely worked the days shift that started at 6:00 a.m. On 8/26/22 when she arrived, she observed the medication carts sitting outside the medication room, they were supposed to be locked up at night in the medication room as there were only aides working the night shift, and she assumed the other day nurse LPN 5 had already gotten them out per their normal routine. The days nurse could not find the medication room keys and learned they were still on the evening nurse who was supposedly still in the parking lot. The day RCP 14 went out to the parking lot and retrieved the keys from LPN 9. LPN 7 indicated she had no firsthand knowledge of events, but her understanding was LPN 9 had been found on the medication room floor drunk the prior evening. The DON had been called and she had come into finish passing medications to residents who had not received their medications on the evening shift. The DON had used her			

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	personal set of keys to access the medication cart/room and resident apartments. The DON then went home and left LPN 9 in the facility during the night in the medication room with the nurses' set of keys that included a master key to all resident apartments, and keys to the medication cart and med room. On 9/15/22 at 4:57 p.m., the DON provided a Storage of Medication Policy, dated 3/1/22, and indicated the policy was the one currently being used by the facility. The policy indicated, "All medications stored by the facility must be maintained in a clean, neat, and locked container or area...The keys to the medication storage area and transferred to the on-coming nurse or trained designee at the end of the shift ...No employee must leave the community with the keys...." Cross reference tag R091. This State finding relates to Complaint IN00390133.			