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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>12/03/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LAMPLIGHT INN AT THE LELAND | STREET ADDRESS, CITY, STATE, ZIP CODE<br>900 SOUTH A STREET<br>RICHMOND, IN 47374 |
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| R000000            | <p>This visit was for the Investigation of Complaint IN00138315.</p> <p>Complaint IN00138315 -- Substantiated. State residential deficiency related to the allegations is cited at R0306.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: December 2 and 3, 2013</p> <p>Facility number: 012497<br/>Provider number: 012497<br/>AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type:<br/>Residential: 83<br/>Total: 83</p> <p>Census Payor type:<br/>Other: 83<br/>Total: 83</p> <p>Sample: 3<br/>Supplemental Sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> | R000000       | <p>This Plan of Correction (POC) is prepared and executed because it is required by the provisions of State and Federal Law, and not because Lamplight Inn at the Leland agrees with the allegations contained there-in. We respectfully request paper compliance for these citations. Please let these POC responses serve as the facility's Credible Allegation of Compliance.</p> |                      |

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.

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|   | Quality review completed on December 4, 2013 by Randy Fry RN.  |   |   |   |  |   |  |

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| R000241            | <p>410 IAC 16.2-5-4(e)(1)<br/>Health Services - Offense<br/>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br/>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 7 residents observed during 1 of 2 medication pass observations with 1 of 3 licensed nurses received medications only as ordered by the resident's physician.<br/>(Resident #D, LPN #2)</p> <p>Findings include:</p> <p>On 12-2-13 at 11:40 a.m., LPN #2 was observed to prepare the following medications for Resident #D and place them in a medication cup for administration to the resident:</p> <ul style="list-style-type: none"> <li>- probiotic, one tablet.</li> <li>- anti-gas, one tablet.</li> <li>- aspirin 81 mg (milligrams), one tablet.</li> <li>- fish oil 1000 mg, one capsule.</li> <li>- vitamin D-3 2000 IU (international units), one tablet.</li> </ul> <p>LPN #2 indicated Resident #D was out of her supply of multi-vitamins, but the family was aware of this and was to bring the vitamins in.</p> | R000241       | <p>a. The resident in question was not affected by this occurrence. The medications were not dispensed to resident. Order clarification was sent out.</p> <p>b. There were not any other resident involved.c. The facility will make it a necessary to have a current signed medication list from the residents being admitted by their current physician. OTC medications will be clarified to read 'dispense as directed on container' and physician will sign to clarify this. Two nurses will be responsible for signing and verifying new admission orders. If any discrepancies the will clarify immediately. Families will be educated to the administration of medication requirements.d. The monitoring of these correction actions will be over seen by the DON. After each admission the DON will review medication lists and chart the findings. DON will review compliance quarterly with Administrator.e. Date of Compliance - 12/16/2013.</p> | 12/16/2013           |

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|   | <p>LPN #2 was queried to the dosages of the fish oil and vitamin D-3. She indicated the medications were brought in for use by the family and what was available for the facility to use for Resident #D. LPN #2 indicated the medication list that was provided by the family and was located in the resident's clinical record. The family list of medications indicated the following medications were taken by the resident while still at home for her lunch time dosing:</p> <ul style="list-style-type: none"> <li>- aspirin 81 mg, one tablet.</li> <li>- vitamin D-3 3000 IU, one tablet.</li> <li>- multivitamin, one tablet.</li> <li>- fish oil 1200 mg, one capsule.</li> <li>- probiotic, one tablet.</li> <li>- anti-gas, one tablet.</li> </ul> <p>LPN #2 indicated she would need to clarify the medication orders with the physician prior to administering the fish oil and vitamin D-3 due to the discrepancy between the family's list of medications and the medications available to administer. LPN #2 then prepared a new cup of medications which included the following medications:</p> <ul style="list-style-type: none"> <li>- probiotic, one tablet.</li> <li>- anti-gas, one tablet.</li> <li>- aspirin 81 mg (milligrams), one tablet.</li> </ul> |   |   |   |  |   |  |

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|  | <p>Review of the physician orders for medications for Resident #D included the following medication orders related to the medications prepared by LPN #2:</p> <ul style="list-style-type: none"> <li>- aspirin 81 mg daily by mouth.</li> <li>- vitamin D-3 3000 IU daily by mouth.</li> <li>- multivitamin daily by mouth.</li> <li>- fish oil one capsule daily by mouth (no strength indicated.)</li> <li>- anti-gas, one tablet daily by mouth.</li> </ul> <p>No order was indicated for the use of the probiotic tablet.</p> <p>On 12-3-13 at 2:20 p.m., the Director of Nursing provided a copy of a policy entitled, "Resident Self-Administration of Medications with Assistance from Assisted Living Facility Staff." This policy indicated, "Regardless of the level of medication assistance provided by the ALF/RF [Assisted Living Facility/Residential Facility], the staff responsible for medication assistance must qualified [sic] to identify:</p> <ul style="list-style-type: none"> <li>- Common drug interactions.</li> <li>- Signs and symptoms of adverse medication effects.</li> <li>- The five R's of medication administration: Right drug, right dose, right resident, right route of administration, and right time of administration...Before the resident</li> </ul> |  |  |  |
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|                    | takes their medication, the medication and dosage schedule on the resident's Medication Administration Record is compared with the medication label. If the label and the Medication Administration Record are different or if there is any other reason to question the dosage and directions, this should be reported to the ALF/RF or designee immediately prior to the resident taking the medication. Medications should not be taken until the situation is clarified." |               |   |                      |

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| R000297   | <p>410 IAC 16.2-5-6(c)(1)<br/>Pharmaceutical Services - Noncompliance<br/>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br/>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation, interview and record review, the facility failed to ensure the licensed nurse administering medications to 2 of 7 residents observed during 2 of 2 medication pass observations with 1 of 3 licensed nurses remained with each resident to observe the resident taking the medication. (Resident #E, Resident #F, LPN #1)</p> <p>Findings include:</p> <p>1. On 12-3-13 at 7:20 a.m., LPN #1 was observed to prepare the following medications for Resident #E in the facility's medication room:</p> <ul style="list-style-type: none"> <li>- aspirin 81 mg (milligrams), one tablet.</li> <li>- balsalazide 750 mg, two tablets.</li> <li>- Phillips caplet, one tablet.</li> <li>- metoprolol tartrate 50 mg, one tablet.</li> <li>- furosemide 80 mg, one-half tablet or 40 mg.</li> <li>- potassium chloride 20 meq (milliequivalents), one tablet.</li> </ul> | R000297   | <p>a. The residents in questioned were not affected by this occurrence. The residents were administered the proper medications, however the nurse failed to observe the residents consuming them. b. There were no other residents affected by these occurrences. c. The nursing staff will be re-educated on proper technique of medication administration. A monthly meeting between nursing and DON will be conducted to review this. Each Nurses/ QMAs will be required to meet one on one with the DON for monthly concerns or refreshers to where this will be addressed each month.d. The DON will maintain sign in sheets and the Nurses/ QMAs will sign for each meeting. The DON will review compliance quarterly with Administrator.e. Date of Compliance - 12/16/2013.</p> | 12/16/2013  |  |   |  |

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|                    | <p>- Centrum Silver, one-half tablet.</p> <p>- prednisone 5 mg, one-half tablet or 2.5 mg.</p> <p>- Miralax 17 grams or one cap-full, placed in 8 ounces of water and mixed well with a spoon.</p> <p>LPN #1 was then observed to pick up the cup of pills and cup of liquid and exit the medication room and enter the lobby area of the facility where Resident #E was located. LPN #1 was then observed to hand the cup of pills and the cup of liquid to Resident #E, say something to her, and then turned around and returned to the medication room. She did not remain with Resident #E while she took the medications.</p> <p>2. On 12-3-13 at 7:30 a.m., LPN #1 was observed to prepare the following medications for Resident #F in the facility's medication room:</p> <ul style="list-style-type: none"> <li>- ranolazine 1000 mg, one tablet.</li> <li>- omeprazole 20 mg, one tablet.</li> <li>- potassium chloride 20 meq, one-half tablet, or 10 meq.</li> </ul> <p>LPN #1 was then observed to pick up the cup of pills and exit the medication room and enter the lobby area of the facility where Resident #F was located. LPN #1 was then observed to hand the cup of pills to</p> |               |   |                      |

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|                    | <p>Resident #F, say something to him, and then turned around and returned to the medication room. She did not remain with Resident #F while he took the medications.</p> <p>In interview with LPN #1 on 12-3-13 at 1:10 p.m., she indicated that she did not stay with Resident #E or Resident #F to observe them take their medications. She indicated staff normally remain with residents while they take their medications to ensure they do take the medications. She indicated during this time, several residents were lining up to receive their medications and she was in a hurry.</p> <p>On 12-3-13 at 2:20 p.m., the Director of Nursing provided a copy of a policy entitled, "Procedures for Medication Assistance." This policy indicated, "Observe the resident taking the medication."</p> |               |   |                      |

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| R000306   | <p>410 IAC 16.2-5-6(g)(1-9)<br/>Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:<br/>(1) The name of the resident.<br/>(2) The name and strength of the drug.<br/>(3) The prescription number.<br/>(4) The reason for disposal.<br/>(5) The amount disposed of.<br/>(6) The method of disposition.<br/>(7) The date of the disposal.<br/>(8) The signature of the person conducting the disposal of the drug.<br/>(9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on record review and interview, the facility failed to ensure a record of medication disposition was documented in the resident's clinical record upon discharge from the facility for 1 of 1 residents reviewed for disposition of medications in a sample of 3.<br/>(Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 12-2-13 at 2:01 p.m. His clinical record indicated he discharged from the facility on 9-13-13 to a private residence. Review of the nursing progress notes</p> | R000306   | <p>a. Resident in question was not affected by this occurrence. Citing is for documentation error only.b. No other residents have been affected by this occurrence.c. The nursing staff will be educated on proper discharge paperwork. The drug disposal sheet will start being initiated upon discharge. The residents will have to sign forms stating if they took their medications with them or if the facility were to dispose of medications. The required information will be on paperwork; The residents name, name and strength of drug, the prescription number (when available), method of disposal, the signature of the nurse completing request, witness if needed.d. DON will</p> | 12/16/2013  |  |   |  |

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|   | <p>for 9-13-13 indicated the only entry, at 3:00 p.m. indicated, "Left building for DC [discharge]." There was no indication in the nursing progress notes regarding the disposition of his medications. No additional documentation was located in the clinical record as to what medications, if any, were sent with the resident or what instructions, if any, for use of any medications were provided to the resident.</p> <p>In interview with the Director of Nursing on 12-2-13 at 3:05 p.m., she indicated Resident #A discharged with "2 bags" of medications and supplies, but the facility did not document what those items were, nor the amounts or types of any of the items.</p> <p>In interview with the Director of Nursing on 12-3-13 at 12:05 p.m., she indicated she was unaware of any policy that required documentation of medication disposition for residents who discharge to home. She indicated it would be very difficult to be able to provide a record of any medications that residents discharge with, as many times, residents choose to leave or discharge from the facility without providing a specific date or time to the facility staff.</p> |   | <p>oversee any discharges for completion to verify proper paperwork was completed. The DON will review compliance quarterly with Administrator.e. Date of Compliance - 12/16/2013.</p> |   |  |   |  |

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|   | This State tag relates to Complaint IN00138315.  |   |   |                      |   |