

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2015
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NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802
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R000000	<p>This visit was for the Investigation of Complaint IN00165118.</p> <p>Complaint IN 00165118 Substantiated. State deficiency related to the allegations is cited at R0241.</p> <p>Survey dates: February 9, and 10, 2015</p> <p>Facility number: 012288 Provider number: 012288 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 136 Total: 136</p> <p>Census payor type: Medicaid: 89 Other: 47 Total: 136</p> <p>Sample: 3</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on February</p>	R000000		
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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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R000241	<p>12, 2015 by Randy Fry RN.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (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: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for 3 of 3 residents reviewed for physician's order compliance in a sample of 3 (Resident # E, Resident #F and Resident #G).</p> <p>Findings include:</p> <p>1. Resident #E's record was reviewed 2-9-2015 at 10:23 AM. Resident #E's diagnoses included, but were not limited to high blood pressure, lupus, and COPD.</p>	R000241	<p>Facility will have a Medication Box Dispense Log that will be kept in the front of each resident's MAR that self-medicates. This will include a space to document all PRN medications, and non-auto-fill medications such as nasal sprays, inhalers and eye drops. The nurse will then initial that they have filled the Medication box and ordered any PRN or medications that are not on auto-fill. Nursing management on a weekly basis for the next 6 weeks will monitor this. Following the 6 week period, the DON will audit the log's monthly. Ongoing,</p>	03/02/2015

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	<p>In an interview on 2-9-2015 at 10:45 AM, the Assistant Director of Nursing indicated Resident #E was alert, oriented, and interviewable.</p> <p>A review of Resident #E's Self Medication Assessment dated 10-8-2014 indicated Resident #E could correctly read the instructions for the medications, state what the medication was for, what time the medication was to be taken, and demonstrate secure storage of the medication.</p> <p>A review of Resident #E's Medication Administration Record (MAR) dated 1-2015 indicated initials in every medication time for the month of January.</p> <p>In an interview on 2-9-2015 at 2:14 PM, Resident #E indicated she had not received her medication box set up by the nursing staff on the dates of 1-21, 1-22, 1-23, 1-24, and 1-25-2015. Resident #E further indicated she had requested the medication box from the nursing staff repeatedly on those dates, therefore missing her medication dosages on those days. Further, Resident #E indicated she was to receive Felons, a nasal spray, daily, to be kept at bedside, but when the medication had run out in September</p>		<p>the facility will have a member of the nursing staff round with the phlebotomist each lab day to ensure the ordered labs are drawn. A log will be kept and monitored by the nursing staff documenting what labs were drawn on whom. Including any refusals. Nursing management will monitor this weekly for the next 6 months.</p>	

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	<p>2014, it was never refilled by the nursing staff despite repeated requests.</p> <p>In an interview on 2-9-2015 at 2:37 PM, Pharmacy Employee #2 indicated the medication Flonase had not been ordered since September 2014, and if used as directed would have been needed to be refilled in October 2014, therefore missing her Flonase medication from the first of October 2014 through 2/9/15.</p> <p>In an interview 2-9-2015 LPN #1 indicated residents that are on self administration had their medication boxes filled weekly, then, the desk nurse was to see the resident received the filled box at the appropriate time. LPN #1 indicated the initials on the MAR indicated the box had been filled, but not that the box had been taken to the resident or that the resident had taken the medication. LPN #1 further indicated the facility did not monitor if the resident had received or was taking their medications. LPN #1 further indicated if the resident did not receive their medications, they should have asked more than once.</p> <p>2. Resident #F's record was reviewed 2-10-2015 at 10:57 AM. Resident #F's diagnoses included, but were not limited to diabetes, heart failure, and stroke.</p>			

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	<p>In an interview on 2-9-2015 at 10:45 AM, the Assistant Director of Nursing indicated Resident #F was alert, oriented, and interviewable.</p> <p>A review of Resident #F's Self Medication Assessment dated 1-8-2015 indicated Resident #F could correctly read the instructions for the medications, state what the medication was for, what time the medication was to be taken, what the side effects of each medication were.</p> <p>A review of Resident F's Medication Administration Record (MAR) dated 1-2015 indicated initials in every medication time for the month of January.</p> <p>In an interview on 2-10-2015 at 12:05 PM, Resident #F indicated she had not received her medication box set up by the nursing staff on the dates of 1-22, and 1-23-2015. Resident #F further indicated she had requested the medication box from the nursing staff on those dates, and on 1-23-2015, had waited in the Nursing office until the medication box was given to her, therefore missing her medications all day on 1-22, and all but the evening medications on 1-23.</p> <p>3. Resident #G's record was reviewed</p>						

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	<p>2-10-2015 at 11:25 AM. Resident #G's diagnoses included but were not limited to dementia, high blood pressure, and high cholesterol.</p> <p>In an interview on 2-9-at 10:32 AM, Ombudsman employee #3 indicated there was a concern with Resident #G receiving psychiatric services as ordered by the physician.</p> <p>A review of physician orders dated 10-14-2014 indicated Resident #G was to be referred to psychiatric services.</p> <p>In an interview on 2-10-2015 at 12:02 PM, LPN #4 indicated the Power of Attorney had requested the facility not seek any further psychiatric services for Resident #G. When queried about documentation of the request, LPN #4 indicated the request had not been documented.</p> <p>A review of physician's orders dated 1-2-2015 indicated Resident #G was to have lab work completed on 1-5-2015 consisting of Basic Metabolic Panel (BMP), a Liver Function Test (LFT), a Lipid Panel, a Thyroid Stimulating Hormone level (TSH) and a Complete Blood Count (CBC).</p> <p>A review of Resident #G's lab results</p>						

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	<p>indicated labs were completed and results communicated to the physician for the BMP, LFT, TSH, and CBC. A result for the Lipid panel was not available for review.</p> <p>In an interview on 2-10-2015 at 12:02 PM, LPN #4 indicated the Lipid panel had not been drawn by the lab. LPN #4 further indicated a CNA is now assigned to double check labs as they are drawn to assure labs are drawn as ordered, then the CNA reviews the results with the orders to assure results are received and communicated to the physicians.</p> <p>This deficiency was cited on 10/31/14 and again on 12/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This State tag relates to Complaint IN00165118.</p>						