

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 05/29/2014
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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 a State Residential Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00149926.</p> <p>Complaint IN00149926 substantiated. State deficiencies related to the allegation are cited at R0241 and R0243.</p> <p>Survey dates: May 27, 28 and 29, 2014</p> <p>Facility number: 012288 Provider number: N/A AIM number: N/A</p> <p>Survey Team: Julie Call, RN, TC Sue Brooker, RD Martha Saull, RN Virginia Terveer, RN</p> <p>Census Bed Type: Residential: 128 Total: 128</p> <p>Census payor type: Medicaid: 95 Private: 33 Total: 128</p> <p>These deficiencies reflect state findings</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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R000026	<p>cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on June 3, 2014 by Randy Fry RN.</p> <p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview, the facility failed to ensure the Residents' Rights were available in a publicly accessible area which had the potential to</p>	R000026	On 5/29/14 A copy of the Resident's Rights were posted in the lobby in an enclosed poster frame so it shall not be removed. Beginning 5/30/14, daily	05/29/2014

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	<p>affect the 128 residents who were residents of the facility.</p> <p>Findings include:</p> <p>During observations of the public accessible areas from 5-27-2014 at 9:35 a.m. thru 5-29-2014 at 10:35 a.m., a copy of the Resident Rights was not found posted in any of the public accessible areas.</p> <p>An interview with the Facility Manager on 5-29-2014 at 10:40 a.m., indicated the Residents' Rights for Housing with Service Establishments only was posted on the 2nd floor by the elevators. This did not include all the required resident rights information. The Facility Manager indicated the Residents were given a copy of the Resident Rights at admission and each Resident signed a form to indicate the Rights were received. The Facility Manager indicated the Resident Rights did not have to be posted.</p> <p>During the exit conference on 5-29-2014 at 4:50 p.m., the Facility Manager did not provide any further information regarding the posting of the Residents' Rights.</p>		<p>rounds will be conducted to ensure they have not been removed.</p>				

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R000033	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure the Indiana State Department of Health Complaint number was posted in an area accessible to residents which had the potential to affect 128 residents who reside in the facility.</p> <p>Findings include:  During observations of the public accessible areas from 5-27-2014 at 9:35</p>	R000033	<p>On 5/29/14, Indiana State Department of Health (ISDH) Complaint number was posted in an enclosed poster frame. The office manager/front desk clerk will check daily for the next year during rounds to make sure that it has not been removed.</p>	05/29/2014
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R000090	<p>a.m. thru 5-29-2014 at 10:35 a.m., the Indiana State Department of Health (ISDH) Complaint number was not found posted in any of the public accessible areas.</p> <p>An interview with the Facility Manager on 5-29-2014 at 10:35 a.m., indicated the ISDH Complaint number was posted by the telephones on the 1st floor near the receptionist desk, but the Facility Manager indicated "someone must have removed the posting from the wall." The Facility Manager indicated the ISDH Complaint number was not posted.</p> <p>During the exit conference on 5-29-2014 at 4:50 p.m., the Facility Manager did not provide any further information regarding the posting of the ISDH Complaint number.</p> <p>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</p>			

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	<p>by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks;</p> <p>(B) poisonings;</p> <p>(C) fires; or</p> <p>(D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(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.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(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.</p> <p>(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</p> <p>Based on interview and record review the facility failed to ensure a reportable incident of alleged abuse was reported within 24 hours of the occurrence for 1 of</p>	R000090	All reportable incidents will be reported to the ISDH within 24 hours. All nurses were instructed on how to complete and submit an ISDH Incident Report Form on	06/02/2014

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	<p>3 incident reports reviewed affecting 2 Residents. (Resident #6 and Resident #7)</p> <p>The facility also failed to ensure the posting of the most recent annual survey and subsequent surveys of the facility and were readily accessible to the residents and available for examination. This deficiency had the potential to affect the 128 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. A review of Incident Report Forms provided by the Facility Manager on 5/28/14 at 9:00 a.m., indicated a reportable incident of Resident to Resident altercation occurred on 5/25/14 at 6:00 p.m. and was not reported to ISDH (Indiana State Department of Health) until 5/27/14 at 12:21 p.m..</p> <p>Review of the Report of Incident indicated indicated the following:</p> <p>-Resident #6 became upset with Resident #7 when Resident #7 cut in front of him on the elevator and called him a B!!!!. Resident #6 punched Resident #7 in the face. The report indicated the DON (Director of Nursing), Nurse Practitioner and families were notified.</p> <p>-A review of Nurse's Notes for Resident</p>		<p>6-2-14 in case the administrator is absent. For the next year and ongoing, the staff sending the report to ISDH must also email the fax confirmation page to the administrator at the time of the event to ensure proper notification has been made. According to pg. 8 410 IAC 16.2-5-1.2 (p) Resident's have the right to the examination of the results of the most resent annual survey of the survey conducted by the state surveyors. Although there is no requirement noted in the regulations, the binder was labeled on 5/28/14. On 5/28 the 2013 survey results were placed in the binder which is available for the residents and public. On 6/2/14 the initial findings of the 2014 annual survey were placed in the binder labeled "Indiana State Department of Health Inspections" Daily rounds will be conducted to ensure that the book is intact with the results of the most current survey results.</p>				

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	<p>#7 on 5/25/14 indicated the Resident's right cheek had a bruise and redness, swelling and ice was applied at site.</p> <p>An interview with DON on 5/29/14 at 9:20 a.m., indicated the incident of resident to resident altercation was reported to the ADON on Sunday after the incident occurred. She indicated the report to ISDH was not sent until Tuesday because Monday was a holiday.</p> <p>The Facility Manager provided the Facility's Policy, titled, Elder Abuse Information and Policy, not dated, on 5/28/14 at 9:00 a.m., which indicated, "...The Administrator, Director of Nursing Services and /or designee will report all allegations that a resident has been subjected to abuse, neglect or financial exploitation with 24 hours to...Appropriate State Department of Health (OH or IN).2. During an observation of the public areas of the facility on 5-27-2014 at 3:15 p.m., an unlabeled black binder was located in a plastic container that was secured to the wall across from the receptionist desk. There was no information on the wall, container, or the binder to identify the contents of the binder. The contents of the binder were 2 pages of initial comments for complaint surveys dated 1-17-2014 and 2-10-2014.</p>			

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R000144	<p>An interview with the Receptionist #11 on 5-28-2014 at 2:30 p.m., indicated the unlabeled black binder contained the survey reports.</p> <p>An observation of the contents of the black binder on 5-28-2014 at 2:31 p.m., indicated 2 pages of reports were inside the binder.</p> <p>Copies of the reports provided by the Receptionist #11 on 5-23-2014 at 2:35 p.m., indicated two complaint reports dated January 17, 2014 and February 10, 2014 were in the unlabeled black binder.</p> <p>An interview with the Facility Manager on 5-29-2014 at 10:38 a.m., indicated a resident must have taken the other pages from the binder. The Facility Manager did not provide an explanation for the lack of identification of the binder of survey reports.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>2. On 5/27/14 at 11:05 A.M. the medication room was observed. Residents were observed to enter the</p>	R000144	For the next year and ongoing, elevators will be cleaned daily and inspected daily by supervisor. The tracks on each floor will be	07/16/2014

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	<p>medication room with staff present to received their medications and/or have blood sugars checked.</p> <p>On 5/27/14 at 1:20 P.M., the medication refrigerator was observed. A 4 inch long dark hair strand was observed on the interior base of the refrigerator. There were also observed to be dried spills of various colors on the shelves of the refrigerator. On the bottom shelf, there was observed to be a wad of a Kleenex type material in the back of the refrigerator.</p> <p>On 5/27/14 at 2 P.M., the medication room was observed. This room was observed to house the medication carts (3 from which medications were passed and 1 cart which housed overflow medications) and 1 medication refrigerator. The carpet in the medication room was observed to have dark stains extending the width of the doorway to 3 feet inside the door. Scattered throughout the medication room floor were other various sizes of dark stains, which ranged from the size of a quarter to 8 inches in diameter. General dinginess of the carpet in the traffic pattern of the room was observed as evidenced by a darker brownish hue as compared to the carpet along the edges of the wall underneath the counter. Also observed,</p>		<p>vacuumed weekly by 6/13/14 Each entry way will be examined daily to ensure there is no collection of debris. Including the doorways. Daily inspection will be completed by the dietary manager and or staff she appoints starting 5/30/14. This is to ensure proper cleanliness of the food prep area as well as vents, ceiling, light fixtures, entry way and flooring. The curtain in the dining room shall be removed and dry cleaned no later than 6/20/14. The speaker will be covered by 6/18/14. The ceiling tiles will be replaced by 6/20/14. The windows will be free from dust by 6/10/14. They will be monitored daily by the dietary staff. Facility is working with a general contractor to replace the carpet that is stained leading from the first floor to the second floor and the second floor med room. Anticipated completion date is mid-July. A task sheet was assigned to nursing staff on 5/27/14 to ensure *proper cleaning of the medication refrigerator. It is to be cleaned two times per week and logged in a daily task binder. *Carpet will be swept two times per week and logged when completed. *The walls in the Medication room will be wiped down two times per week and logged in the task binder.</p>				

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	<p>along the edges of the carpet at the base of the wall, were bits of paper, dust and syringe caps. The ledges along the edge of the walls and the ledges at approximately waist height were also observed to have a visible accumulation of dust and when wiped with a finger, accumulation of dust was observed throughout the perimeter of the medication room.</p> <p>On 5/28/14 at 9:35 A.M., the medication refrigerator was observed. The 4 inch long dark hair strand was still observed on the interior base of the refrigerator. The dried spills remained as observed on 5/27/14. The condition of the carpet remained unchanged from the observation on 5/27/14.</p> <p>On 5/28/14 at 2:20 P.M., the DON was made aware of the condition of the medication refrigerator. She indicated the refrigerator was cleaned twice a month and the facility does not have a check list for cleaning. She indicated she was unsure the last time the medication refrigerator had been cleaned. The DON indicated at this time, the medication carts are difficult to clean due to the medication passes. She indicated the pills pop out of the medication cards because the carts are so full of medication cards. She indicated when a</p>						

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	<p>loose pill was observed in the medication cart, it should have been disposed of.</p> <p>On 5/29/14 at 9:50 A.M., the DON (Director of Nursing) was interviewed. She indicated prior to yesterday, the facility did not have a cleaning schedule for the medication carts and/or medication refrigerators but they do have a cleaning schedule now.</p> <p>On 5/29/14 at 11:20 A.M., the DON was made aware of the stains and soiled carpet in the medication room. The DON indicated this is a high traffic area. The DON indicated the nurses and QMAs clean the medication room. She indicated there was a sweeper available for use in the medication room. She indicated the medication room gets vacuumed at least every other day. She indicated the carpet was cleaned within the last 3-4 months but the entry way area is a high traffic area. The DON indicated there was no documentation of the room being cleaned and/or vacuumed.</p> <p>On 5/29/14 at 11:45 A.M., the DON provided a copy of the cleaning log to be used for the medication refrigerator and the medication carts.</p> <p>On 5/29/14 at 12:05 P.M. the ADON (assistant Director of Nursing) provided a</p>			

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R000148	<p>current copy of the facility policy and procedure for "medication Storage in the Facility." This policy was dated December 2009. This policy included, but was not limited to the following: "...Contract pharmacy provider:...performs the following pharmaceutical services...overseeing all aspects of pharmacy services related to the medication use process...storing, handling, administering and disposing of medications...inspecting medication storage areas at least every 60 days for proper storage of medications, cleanliness...Assist the Executive Director/Administrator in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control and use of medications...Medication storage areas are kept clean...free of clutter...should maintain a record of all medication destruction/disposal...</p> <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued</p>			

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R000216	<p>upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>4. On 5/27/14 at 2:20 P.M., the room of Resident #5 was observed. The resident was interviewed at this time and indicated she had just moved into the facility on 5/22/14. The top and left side of the resident's bed was in the corner of her room. Observed at the foot of her bed, was a coil of bright orange extension cord with one end plugged into the wall. The cord was observed to extend underneath the length of the bed to the head of the bed. The far end of the extension cord was plugged into a power strip, which was on the right side of the resident's bed, between the bed and the bedside table. Plugged into the power strip was the resident's CPAP (medical device to provide continuous positive airway pressure machine) machine.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs</p>	R000148	Sanitation and Safety Standards Deficiency 410 IAC 16.2-5-1.5(e) (1-4) A. We request a supervisor review for portions of this citation. According to the regulations there is no policy on checking resident's appliances before use. There is no regulation found on the use of extension cords in the residential facility. Also, there was a citation pertaining to 10 electrical room doors being unlocked. Once again, we have found no requirement in the Residential regulations. B. We will conduct an all staff in-service on June 25th, 2014 to cover our policy on the proper storing of potential hazardous products. For the next year and ongoing, Supervisors our completing daily rounds each morning and will be ensuring there are potential hazardous products unsecured.	05/30/2014			

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 05/29/2014
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	<p>assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 8 residents reviewed for self medication administration out of a total sample of 10 had a yearly self-administration evaluation completed. (Resident #2)</p> <p>Findings include:</p> <p>During the initial tour with the DON (Director of Nursing) on 5-27-2014 from 10:08 a.m. to 10:50 a.m., the DON indicated Resident #2 had her medication box filled by the nurse.</p> <p>During an interview on 5-27-2014 at 3:25 p.m. with Resident #2, the resident indicated the nurse filled her medication box each week and she kept the medication box in a drawer beside her bed.</p> <p>A review of Resident #2's chart on</p>	R000216	<p>According to pg 29. 410 IAC 16.2-5-6 (a) Resident's who self medicate can keep their prescriptions and non prescriptions in their unit as long as they are in a secured place fromother residents. Requesting a supervisor review. Surveyor evaluated the pharmacy recommendation on self-administration,not the facilities policy. Lamplight will conduct quarterly assessments on all assisted living residents. If there is a change in cognition, a new self-administration assessment will be conducted. If the resident does not pass, the physician will be notified and their medication will be removed from their apartment. The DON/ADON will be monitoring this on an ongoing basis by conducting the assessments.</p>	06/20/2014

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	<p>5-27-2014 at 2:00 p.m. indicated the following:</p> <ul style="list-style-type: none"> <li>- diagnoses included but were not limited to, diabetes, general muscle weakness and cerebral vascular accident.</li> <li>- physician orders for May 2014 did not indicate the resident was to self administer her medications.</li> <li>- a self medication assessment was done on 4-3-2012 and indicated the resident was deemed able to safely self-administer medications. No further self medication assessment was found in the resident record.</li> <li>- a resident assessment/service form was completed 5-6-2014 and signed only by the DON on 5-6-2014 indicated on page 10 "caregiver administration and/or observation of medications required judgment for necessity, dosage, and/or effect...round the clock need...." This was marked with a "10" which indicated assessed points indicating staff should administer medications.</li> </ul> <p>An interview with LPN #12 on 5-28-2014 at 3:20 p.m., indicated the original medication assessment completed on 4-3-2012 would not be updated unless a change in condition was noted.</p> <p>An interview with the DON on 5-28-2014 at 3:55 p.m. indicated the</p>						

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R000241	<p>medication assessment was done at admission and a 2 week trial would begin. The resident was monitored by nursing during the trial. The DON further indicated if the resident would have pills left in the medication box or if medications were found in the room by staff, the self medication would stop. The DON indicated the self medication assessment would be completed only if there was a change in condition. The DON indicated the resident assessment/service form medication procedure on page 10 which was scored with a "10" was meant for the prn (as needed) medications the resident received.</p> <p>A policy "Medication Storage in the Facility" provided by the DON on 5-29-2014 at 12:05 p.m., indicated "...the resident's ability to continue to safely manage and/or self-administer medications is evaluated at least annually...."</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</p>			

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	<p>on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to ensure medication administration was performed in accordance with physician orders and/or professional recommendations. This deficient practice had the potential to effect all 128 residents in the facility. (Resident #H, Resident #C and Resident #B)</p> <p>Findings include:</p> <p>1. On 5/28/14 at 8:25 A.M., LPN #11 was observed preparing medications for Resident H. LPN #11 was observed to punch the medications from the medication card into a medication cup labeled with the resident's first initial, last name and room number. The resident's MAR (medication administration record) was reviewed at this time. The MAR included, but was not limited to, the following for the resident: "Acetaminophen 500 mg, take...500 mg...three times daily...calcium carb 600 mg + D...take 1 tablet...twice daily...Trusopt...i drop each eye twice daily...keppra 1000 mg...1 tablet...twice daily...Ultram 50 mg...1...four times a day." All of the above medications, with the exception of Ultram, were</p>	R000241	<p>Facility will notify resident, POA/responsible party with verbal communication to current physician as soon as an indication for process of medication/insulin regimen is disrupted. All communication will be documented appropriately under nurse's notes within each resident's charts. The process will be implemented by initial nursing staff being aware of this occurrence. Review of this process will begin weekly to verify all residents have appropriate medications or have a plan in place to help facilitate financial means to receive medications. This process started on 5/30/14. Documentation in-services scheduled for 6/25/14. DON will again educate what should be done for proper documentation. DON will also review the notification process to the physician when the resident's medication regimen has been disrupted. DON will audit MAR's weekly for the next 8 weeks and then monthly times 4 months.</p>	06/25/2014			

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	<p>documented to be given "6-2" and "2-10." The Ultram was documented with the following time frames: "bkfst (breakfast), lunch, Dinner and HS (bedtime)."</p> <p>On 5/28/14 at 11 A.M., LPN #10 was interviewed. He indicated the residents usually get their medications poured at breakfast time, which is around 8 A.M., and the residents come to the medication room (med room) to get their meds after breakfast. LPN #10 indicated if the resident's come to the medication room early they may get their medications early. He indicated the evening meds are pulled at approximately 4 P.M. and given with the evening meal, which is approximately 5 P.M. He indicated the "6-2" indicated 6 A.M. - 2 P.M. and the "2-10" indicated 2 P.M. - 10 P.M.</p> <p>On 5/29/14 at 9:35 A.M., NP (nurse Practitioner) #1, NP #2 and LPN #10 were interviewed. LPN #10 indicated unless the medication was ordered at specific times (i.e. 5 A.M.) the medications were scheduled to be given within the ranges as applicable. For example a bid (twice a day) medication would be given during the 6-2 and 2-10 range. LPN #10 indicated when the nurse initials the range the medication was given, documentation was lacking as</p>			

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	<p>to the specific time the medication was given.</p> <p>At the time, NP #1 indicated if a medication was order to be given bid, she would expect there to be at least 6-8 hours between the doses. NP #1 indicated at this time, she was unaware the medications were given and/or documented in 8 hour ranges.</p> <p>On 5/29/14 at 9:45 A.M., the Pharmacist from (name of pharmacy) was interviewed. He indicated his expectation for a medication ordered BID (twice a day) would be to administer the medication as close to every 12 hours as possible but the actual medication time schedule would be dependent on what the Executive Director and Director of Nursing determine, with input from the Medical Director.</p> <p>On 5/29/14 at 9:50 A.M., the DON was interviewed. She indicated if the physician order doesn't indicate a specific time, i.e. every 8 hours, the medication is put on the 6-2 and/or 2-10 time frames. She indicated for the 6-2 medications, they are pulled at breakfast and for the 2-10 medications, they are pulled with the evening meal, approximately 5 P.M.</p> <p>On 5/29/14 at 9:50 A.M., LPN #11 was</p>			

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	<p>interviewed. She indicated she gave resident Resident H, her medications around noon on 5/29/14, when the resident returned to the facility. These medications were observed to be put in the medication cup by LPN #11 on 5/27/14 at 8:25 A.M. At the time, documentation of the resident's medications were reviewed for 5/27/14. All the medications had been initialed as given for this date for the 8 hour time frame of 6 a.m. - 2 p.m.. Documentation was lacking of the specific time the medications had been administered to the resident.</p> <p>On 5/29/14 at 12:05 P.M., the ADON (Assistant Director of Nursing) provided a current copy of the policy and procedure for "Medication Storage in the facility." This policy was dated December 2009. The policy included, but was not limited to, the following: "...Medications are administered in accordance with written orders of the physician or other authorized prescriber...Medications are administered within one hour of the scheduled time..."</p> <p>On 5/29/14 at 1:50 P.M., LPN #10 was interviewed. He indicated for the "6-2" medication pass, the medications are dispensed into the medication cups at breakfast, which was at 8 A.M. LPN #10</p>			

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	<p>indicated the resident's may receive their morning medications anywhere from 7 A.M. - 9 A.M. LPN #10 indicated some resident's come to the medication room (med room) early for their medications. LPN #10 indicated for the "2-10" med pass, these medications are put into the medication cups at approximately 4 P.M.</p> <p>On 5/29/14 at 2:05 P.M., the DON (Director of Nursing) was interviewed. She indicated the physician and NP (nurse practitioner) sign the physician orders so they know the times the medications are given. She indicated for example, the times of BID (twice a day) are noted on the physician orders as "6-2" and "2-10." The DON indicated it is acceptable practice for the nurses and/or QMAs (qualified medication assistants) to initial the MAR (medication administration record) to indicate the resident was given the medication within the 8 hour range of 6 A.M. - 2 P.M. and/or 2 P.M. - 10 P.M. She also indicated it was acceptable for the nurses and/or QMAs to documented in the MAR as the medications are poured into the medication cups even though the specific time the resident received the medication was not documented on the MAR. The DON indicated the former DON had changed the times of the medication administration from specific times to the</p>			

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	<p>6 a.m.- 2 p.m. and 2 p.m. - 10 p.m. ranges. She indicated this was done as "there was no way they can document the specific time they give all the meds." She indicated since this is an assisted living facility, the residents are out of their rooms frequently and to accommodate the resident's activities the medications are documented in this manner. She indicated this gives the resident's more flexibility with their schedules. The DON indicated this method of medication administration documentation assisted the facility in being compliant with the guidelines. She indicated when the facility had specific medication administration times and they had an hour before or after the specific time to administer the medication, they were not compliant with this standard.</p> <p>The DON indicated when the former DON began the current practice of medication administration documentation, she met with the NP (Nurse Practitioners) to inform them of the new medication times. The current DON indicated this meeting occurred approximately a year ago. The current DON indicated NP #1 was not present at the meeting. At the time, the DON was interviewed regarding NP #1 being made aware of the new medication documentation times, the DON indicated</p>			

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	<p>NP #1's orders were "pretty specific."</p> <p>On 5/29/14 at 3:51 P.M., the DON provided a copy of the "Medication Room/Cart Inspection Report." She indicated this form was completed by the pharmacy. This form indicated the following comment for April 2014: "Metamucil needs to be given 2 hrs (hours) before or 2 hrs. after other medications."</p> <p>On 5/29/14 at 4:02 P.M., QMA (Qualified Medication Assistant) #5 was interviewed. She indicated she had a resident who received Metamucil. At this time, a copy was received of the resident's MAR (medication administration record). The MAR included but was not limited to the following: "SM Fiber Pow (powder) 28.3%...twice daily." The administration times for the medication were documented on the MAR as 6-2 and 2-10. The other medications on the MAR also had the administration times of 6-2 and 2 - 10. Documentation was lacking to indicate the medication was scheduled at a time to be given 2 hours before or 2 hours after other medications. The resident had been documented as refusing this medication. <b>2. Review of the clinical record for Resident #C on 5/29/14 at 9:41 a.m., indicated the</b></p>						

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	<p>following: diagnoses included, but were not limited to, diabetes mellitus, hypertension, and coronary atherosclerosis.</p> <p>Physician orders for Resident #C, dated for the month of March, 2014, indicated Bumex (to decrease water retention) 2 mg (milligrams) daily.</p> <p>The Medication Administration Record (MAR) for Resident #C, dated for the month of April, 2014, indicated staff wrote their initials on 4/1/14, 4/2/14, and 4/3/14, indicating she received the Bumex as ordered. The MAR also indicated from 4/4/14 through 4/17/14, staff wrote their initials surrounded by a circle. The back side of the MAR further indicated from 4/4/14 until her death on 4/18/14, the Bumex was not given due to unavailability.</p> <p>A Healthcare Provider Communication form for Resident #C, dated 4/14/14 and sent from the facility to the resident's physician, indicated "...Res (resident) is on Bumex. Bumex is not being made at (name of) Pharmacy. Can we have an alternative...." A Physician Findings and Recommendations included in the Healthcare Provider Communication form for Resident #C, dated 4/18/14, indicated to discontinue Bumex 2 mg</p>			

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	<p>daily and to start Demadex (to decrease water retention) 20 mg daily.</p> <p>A Progress Note for Resident #C, dated 4/18/14 at 2 :00 p.m., as a late entry for 4/14/14, indicated "...Res still out of Bumex...Dr. (doctor name) contacted by faxed (sic) and message left for nurse to call back...."</p> <p>A Progress Note for Resident #C, dated 4/18/14 at 4:00 p.m., indicated Dr. (doctor name) contacted again regarding Bumex...Message left...."</p> <p>LPN #1 was interviewed on 5/29/14 at 11:10 a.m. During the interview she indicated when orders for medication were received they were faxed to the pharmacy and the facility received them two days later. She also indicated when medication ordered was not received, the pharmacy was contacted. She further indicated nursing staff notified the physician as soon as possible concerning the medication and the physician was continually called until the facility received a response. Documentation of the attempts to contact the physician were recorded in the Progress Notes.</p> <p>3. The Medication Administration Record (MAR), dated for the month of November, 2013, indicated Resident #C</p>						

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	<p>received: Novolog 26 units q (every) morning, Novolog 16 units q day at 11 a. m., Novolog 14 units with dinner, and Lantus 44 units q evening. The MAR also indicated Novolog per sliding scale of: blood sugar of 100 -150 give 2 units, blood sugar 151 - 200 give 4 units, blood sugar of 201 - 250 give 6 units, blood sugar of 251 - 300 give 8 units, and blood sugar &gt;300 give 10 units.</p> <p>Review of the Medication Administration Record (MAR) for Resident #C, for the month of November, 2013, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 11/1/13, 11/4/13, 11/5/13, 11/9/13, 11/10/13, 11/15/13, 11/16/13, 11/17/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/29/13, and 11/30/13.</p> <p>- There was no documentation Novolog 16 units at 11 a. m. was given on: 11/1/13, 11/4/13, 11/5/13, 11/9/13, 11/10/13, 11/15/13, 11/21/13, 11/22/13, 11/23/13, 11/25/13, 11/26/13, 11/27/13, and 11/29/13.</p> <p>- There was no documentation Novolog 14 units q with dinner was given on: 11/10/13, 11/11/13, 11/24/13, and</p>			

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 05/29/2014	
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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	<p>11/30/13.</p> <p>- There was no documentation Lantus 44 units q evening was given on: 11/10/13, 11/24/13, and 11/26/13.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p> <p>A physician's order for Resident #C, dated 12/3/13, indicated to increase Novolog to 20 units with lunch and 16 units in p.m.</p> <p>Review of the MAR for Resident #C, for the month of December, 2013, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 12/2/13, 12/3/13, 12/4/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/23/13, 12/24/13, 12/25/13, 12/26/13, 12/27/13, 12/28/13, 12/30/13, and 12/31/13.</p> <p>- There was no documentation Novolog 16 units at 11 a. m. was given on: 12/2/13 prior to the change in dosage. There was no documentation Novolog 20 units with lunch was given on: 12/6/13, 12/9/13,</p>						

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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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	<p>12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/23/13, 12/24/13, 12/25/13, 12/27/13, and 12/20/13 after the change in dosage.</p> <p>- There was no documentation Novolog 16 units in p.m. was given on 12/17/13 and 12/23/13.</p> <p>There was no documentation Lantus 44 units q evening was given on: 12/2/13, 12/6/13, 12/20/13, 12/22/13, 12/28/13, and 12/29/13.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p> <p>The MAR for the month of January, 2014, indicated Resident #C received: Novolog 26 units q morning, Novolog 20 units with lunch, Novolog 16 units q evening, and Lantus 44 units q bedtime. The MAR also indicated she remained on the same sliding scale for Novolog.</p> <p>Review of the MAR for Resident #C, for the month of January, 2014, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 1/3/14, 1/10/14, and 1/17/14.</p>			

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 05/29/2014
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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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	<p>- There was no documentation Novolog 20 units with lunch was given on: 1/3/14, 1/6/14, 1/10/14, and 1/17/14.</p> <p>- There was no documentation Novolog 16 units q evening was given on: 1/2/14, 1/3/14, 1/6/14, 1/8/14, 1/9/14, 1/13/14, 1/15/14, 1/16/14, 1/17/14, 1/20/14, 1/21/14, 1/23/14, 1/24/14, 1/27/14, 1/28/14, 1/29/14, 1/30/14, and 1/31/14.</p> <p>- There was no documentation Novolog Lantus 44 units q bedtime was given on: 1/2/14, 1/3/14, 1/8/14, 1/9/14, 1/10/14, 1/13/14, 1/15/14, 1/16/14, 1/17/14, 1/20/14, 1/21/14, 1/23/14, 1/24/14, 1/27/14, 1/28/14, 1/29/14, 1/30/14, and 1/31/14.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p> <p>Review of the MAR for Resident #C, for the month of February, 2014, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 2/18/14.</p> <p>- There was no documentation Novolog 20 units with lunch was given on:</p>			

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 05/29/2014
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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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	<p>2/28/14.</p> <ul style="list-style-type: none"> <li>- There was no documentation Lantus 44 units q bedtime was given on: 2/28/14.</li> <li>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</li> </ul> <p>Review of the MAR for Resident #C, for the month of March, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- There was no documentation Novolog 26 units q morning was given on: 3/8/14, 3/16/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/30/14, and 3/31/14.</li> <li>- There was no documentation Novolog 20 units with lunch was given on: 3/9/14, 3/26/14, 3/27/14, 3/28/14, 3/30/14, and 3/31/14.</li> <li>- There was no documentation Novolog 16 units q evening was given on: 3/28/14 and 3/31/14.</li> <li>- There was no documentation Lantus 44 units q bedtime was given on: 3/28/14, and 3/31/14.</li> <li>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</li> </ul>			

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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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	<p>4. A Review of Resident #B's clinical record indicated her diagnoses included but were not limited to hypertension (high blood pressure), CVA (stroke), hemiplegia, COPD (chronic obstructive pulmonary disease), neuropathy, seizure disorder, arthritis, left below the knee amputation, lymphedema, muscular weakness, infantile cerebral palsy. The Resident Assessment/Service Form dated 4/30/14 indicated, "...Resident was alert and oriented and had no difficulty remembering and using information." The assessment further indicated she, "...does not require directions or reminding from others."</p> <p>Review of Resident #B's nurses notes included the following:</p> <p>-On 5/25/14 at 9:00 a.m., "...Res. (resident) requesting medications. Writer gave meds to Res. Res. stated, "These are the wrong meds (medications)." Writer looked at med cup. They were not res's meds. Writer started to pull res's meds and another had fallen. Writer was tending to other res. when Res came into nurse's station and stated, "I need my meds and I need them now." Writer was still tending to other res. Res. got angry and stormed off..."</p> <p>-On 5/25/14 at 2 p.m., "...QMA</p>						

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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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	<p>(Qualified Medication Aide) tried to find res. all day to give her meds. Res. LOA (Leave of Absences)...."</p> <p>-On 5/25/14 at 5 p.m., " Res given 5 p.m. meds. Res stated, "You are missing pills." Writer stated to res. that time frame for meds was over. State regulations did not warrant writer to give res. pills that were overdue. Res. got mad at writer and stated, "I am going to report you." Don notified.</p> <p>On 5/28/14 at 12:13 p.m. the Facility Manager provided a written statement from LPN #1 about missed medications for Resident # B. The review of LPN #1's written statement dated 5/27/14 indicated the following, "...I gave res. a med cup with pills in it which I thought was hers....Upon further investigation, they were indeed not hers. Res. handed the med cup back to me not taking any of the meds....I was about to give res her pills when another res. came into med room with injuries from a fall. I did not give Res her pills and she got mad at me....Res. left before I could give her pills... Res was LOA all afternoon at church....Res came back at dinner for meds. Res stated, "You are missing pills. Where are my morning pills?" ....I told res that since they were scheduled from 6-2 p.m. it was past the state window to be</p>			

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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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	<p>given...."</p> <p>A review of the Resident B's MARS (Medication Administration Record Sheet) on 5/28/14 at 1:45 p.m., indicated on 5/25/14 the initials of the nurse was circled for the following medications:</p> <p>Certa vite (multivitamin) 1 tab(tablet) every day.</p> <p>Ferrous Sulf (Iron Supplement) 325 mg (milligrams, a measurement) 1 tab BID (2 times a day).</p> <p>Oyster Shell/D (Calcium with Vitamin D supplement) 500 mg/200 IU (international units, a measurement) 1 tab BID.</p> <p>Carbamazepine XR (for seizure disorder) 400 mg 1 tab po BID.</p> <p>Losartan HCT (for high blood pressure) 50-12.5 mg 1 tab po daily.</p> <p>Mobic (for pain and inflammation) 15 mg 1 tab po every day.</p> <p>Pot. Chloride ER (potassium chloride, a supplement) 20 mEq (milliequivalent, a measurement) 1 tab po BID.</p> <p>Furosemide (for edema) 40 mg 1 tab po every day.</p> <p>Advair Deskus (an inhaler for respiratory conditions) 250.50 1 puff BID for COPD.</p> <p>Plavix (an anticoagulant) 75 mg 1 tab po every day.</p> <p>Zocor (for high cholesterol) 20 mg 1 tab po every day.</p>			

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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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	<p>Gabapentin (for neuropathy pain) 600 mg 2 tabs TID.</p> <p>The Nurse's Medication Notes on MARS dated 5/25/14 indicated, "...6-2. Res. refused meds x 3. Res upset about not getting meds on time. Res. LOA for rest of 1st shift..."</p> <p>A review of the May, 2014 MARS dated 5/25/14 with LPN #1 and during an interview with LPN #1 on 5/28/14 at 1:50 p.m., she indicated she was the nurse who had given Resident #B the wrong medication cup. She indicated the resident did not take the wrong medications, and indicated she started to get medications ready for resident when another resident came in with an injury from a fall. Resident #B demanded her medications and the nurse told her she would have to wait until she was done taking care of the other resident who had fallen. She indicated the resident left without taking her morning medications on 5/25/14.</p> <p>An interview with Resident #B on 5/28/14 at 2:15 p.m., indicated on Sunday morning, 5/25/14 she received the wrong medication cup of pills from LPN #1. She indicated she knows her medications and also indicated her name was not on the medication cup. She indicated she</p>			

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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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	<p>could not read the name on the medication cup but knew it was not her name. She indicated she did not take any of the medications and gave it back to the nurse. She indicated if she didn't watch closely she would have received the wrong medications. She indicated another resident came into the nurse's station after they had fallen. She indicated the nurse told her she would have to wait. The resident indicated she needed her pills but could not wait any longer because her ride to church was waiting for her, so she left. She further indicated the nurse tried to give her the wrong amount of pills when she came back from church.</p> <p>A review of the Facility Policy provided by Facility Manager on 5/29/14 at 12:05 p.m., titled, Medication Policy and Procedures Manual for Assisted Living/Residential dated 1997, indicated, "...Adhering to medication regimen prescribed by your physician is important for your medications to work properly...."</p> <p>A current undated facility policy "Medication Storage in the Facility", provided by the Facility Manager on 5/29/14 at 12:05 p.m., indicated "...Medications are administered in accordance with written orders of the physician or other authorized</p>			

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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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R000243	<p>prescriber...Emergency pharmacy services are available on a 24-hour basis from the contract pharmacy provider...."</p> <p>This State Tag relates to Complaint IN00149926.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.</p> <p>Based on interview and record review, the facility failed to maintain accurate and complete documentation of the time of the administration of medication for one resident (Resident H), and of the administration of insulin (Resident #C). The facility further failed to document the reason medications were not given to a third resident (Resident #B).</p> <p>Findings include:</p> <p>1. On 5/29/14 at 9:35 A.M., NP (nurse practitioner) #1, NP #2 and LPN #10 were interviewed. LPN #10 indicated unless the medication was ordered at</p>	R000243	<p>Facility will notify resident, POA/responsible party with verbal communication to current physician as soon as an indication for process of medication/insulin regimen is disrupted. All communication will be documented appropriately under nurse's notes within each resident's charts. The process will be implemented by initial nursing staff being aware of this occurrence. Review of this process will begin weekly for the next 8 weeks and then monthly for 4 months to verify all residents have appropriate medications or have a plan in place to help facilitate financial means to receive medications. This process started on 5/30/14. Documentation in-services</p>	06/25/2014

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 05/29/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>specific times (i.e. 5 A.M.) the medications were scheduled to be given within the time frames as applicable. For example a bid (twice a day) medication would be given during the 6 A.M. -2 P.M. and 2 P.M. -10 P.M. time frames. LPN #10 indicated when the nurse initials a time frame, the medication was given at some point during that time frame. Documentation was lacking as to the specific time the medication was given.</p> <p>On 5/29/14 at 9:50 A.M., the DON was interviewed. She indicated if the physician order doesn't indicate a specific time, ie every 8 hours, the medication is put on the 6-2 and/or 2-10 time frames. She indicated for the 6-2 medications, they are pulled at breakfast and for the 2-10 medications, they are pulled with the evening meal, approximately 5 P.M.</p> <p>On 5/29/14 at 9:50 A.M., LPN #11 was interviewed. She indicated she gave Resident H her medications around noon on 5/29/14, when the resident returned to the facility. These medications were observed to be put in the medication cup by LPN #11 on 5/27/14 at 8:25 A.M. At the time, documentation of the resident's medications were reviewed for 5/27/14. All the medications had been initialed as given for this date for the 8 hour time</p>		<p>scheduled for 6/25/14. DON will again educate what should be done for proper documentation. DON will also review the notification process to the physician when the resident's medication regimen has been disrupted. DON will</p>	

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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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	<p>frame of 6--2. Documentation was lacking of the specific time the medications had been administered to the resident.</p> <p>On 5/29/14 at 12:05 P.M., the ADON (Assistant Director of Nursing) provided a current copy of the policy and procedure for "Medication Storage in the facility." This policy was dated December 2009. This policy included, but was not limited to, the following: "...Medication administration is documented on the resident's MAR (medication administration record) at the time the resident takes the medication by the person...assisting with the administration of the medication...The information on the MAR includes:...Date and time of medication administration...Administration times will be documented in the resident's medication administration record. A medication administration schedule will be determined for all scheduled (routine) medications. Administration times will be documented in the resident's medication administration record...Medications are to be given within one hour of the scheduled administration time, except before or after meals orders, which are administered precisely as ordered..."</p>			

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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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	<p>On 5/29/14 at 2:05 P.M., the DON (Director of Nursing) was interviewed. She indicated the physician and NP (nurse practitioner) sign the physician orders so they know the times the medications are given. She indicated for example, the times of BID (twice a day) are noted on the physician orders as "6-2" and "2-10." The DON indicated it is acceptable practice for the nurses and/or QMAs (qualified medication assistants) to initial the MAR (medication administration record) to indicate the resident was given the medication within the 8 hour time frame of 6 A.M. - 2 P.M. and/or 2 P.M. - 10 P.M. She also indicated it was acceptable for the nurses and/or QMAs to documented in the MAR as the medications are poured into the medication cups even though the specific time the resident received the medication was not documented on the MAR.</p> <p>On 5/29/14 at 2:20 P.M., the DON was interviewed and she indicated, "There was no way they (the nurses and/or QMAs) could document the specific time for all of the meds (medications) they give to the Residents."</p> <p>On 5/29/14 at 4:02 P.M., QMA (Qualified Medication Assistant) #5 was interviewed. She indicated she had a resident who received Metamucil. At</p>			

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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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	<p>this time, a copy was received of the resident's MAR (medication administration record). The MAR included but was not limited to the following: "SM Fiber Pow (powder) 28.3%...twice daily." The administration times for the medication were documented on the MAR as 6-2 and 2-10. The other medications on the MAR also had the administration times of 6 a.m.-2 p.m. and 2 p.m. - 10 p.m. Documentation was lacking to indicate the medication was scheduled at a time to be given 2 hours before or 2 hours after other medications. 2. Review of the clinical record for Resident #C on 5/29/14 at 9:41 a.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, hypertension, and coronary atherosclerosis.</p> <p>The Medication Administration Record (MAR), dated for the month of November, 2013, indicated Resident #C received: Novolog 26 units q (every) morning, Novolog 16 units q day at 11a.m., Novolog 14 units with dinner, and Lantus 44 units q evening. The MAR also indicated Novolog per sliding scale of: blood sugar of 100 -150 give 2 units, blood sugar 151 - 200 give 4 units, blood sugar of 201 - 250 give 6 units, blood sugar of 251 - 300 give 8 units, and</p>			

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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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	<p>blood sugar &gt;300 give 10 units.</p> <p>Review of the Medication Administration Record (MAR) for Resident #C, for the month of November, 2013, indicated the following:</p> <ul style="list-style-type: none"> <li>- There was no documentation Novolog 26 units q morning was given on: 11/1/13, 11/4/13, 11/5/13, 11/9/13, 11/10/13, 11/15/13, 11/16/13, 11/17/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, 11/24/13, 11/25/13, 11/26/13, 11/27/13, 11/29/13, and 11/30/13.</li> <li>- There was no documentation Novolog 16 units at 11a.m. was given on: 11/1/13, 11/4/13, 11/5/13, 11/9/13, 11/10/13, 11/15/13, 11/21/13, 11/22/13, 11/23/13, 11/25/13, 11/26/13, 11/27/13, and 11/29/13.</li> <li>- There was no documentation Novolog 14 units q with dinner was given on: 11/10/13, 11/11/13, 11/24/13, and 11/30/13.</li> <li>- There was no documentation Lantus 44 units q evening was given on: 11/10/13, 11/24/13, and 11/26/13.</li> <li>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</li> </ul>			

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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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	<p>A physician's order for Resident #C, dated 12/3/13, indicated to increase Novolog to 20 units with lunch and 16 units in p.m.</p> <p>Review of the MAR for Resident #C, for the month of December, 2013, indicated the following:</p> <ul style="list-style-type: none"> <li>- There was no documentation Novolog 26 units q morning was given on: 12/2/13, 12/3/13, 12/4/13, 12/6/13, 12/7/13, 12/8/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/15/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/23/13, 12/24/13, 12/25/13, 12/26/13, 12/27/13, 12/28/13, 12/30/13, and 12/31/13.</li> <li>- There was no documentation Novolog 16 units at 11a.m. was given on: 12/2/13 prior to the change in dosage. There was no documentation Novolog 20 units with lunch was given on: 12/6/13, 12/9/13, 12/10/13, 12/11/13, 12/12/13, 12/13/13, 12/16/13, 12/17/13, 12/18/13, 12/19/13, 12/20/13, 12/23/13, 12/24/13, 12/25/13, 12/27/13, and 12/20/13 after the change in dosage.</li> <li>- There was no documentation Novolog 16 units in p.m. was given on 12/17/13 and 12/23/13.</li> </ul>			

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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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	<p>There was no documentation Lantus 44 units q evening was given on: 12/2/13, 12/6/13, 12/20/13, 12/22/13, 12/28/13, and 12/29/13.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p> <p>The MAR for the month of January, 2014, indicated Resident #C received: Novolog 26 units q morning, Novolog 20 units with lunch, Novolog 16 units q evening, and Lantus 44 units q bedtime. The MAR also indicated she remained on the same sliding scale for Novolog.</p> <p>Review of the MAR for Resident #C, for the month of January, 2014, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 1/3/14, 1/10/14, and 1/17/14.</p> <p>- There was no documentation Novolog 20 units with lunch was given on: 1/3/14, 1/6/14, 1/10/14, and 1/17/14.</p> <p>- There was no documentation Novolog 16 units q evening was given on: 1/2/14, 1/3/14, 1/6/14, 1/8/14, 1/9/14, 1/13/14, 1/15/14, 1/16/14, 1/17/14, 1/20/14,</p>			

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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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	<p>1/21/14, 1/23/14, 1/24/14, 1/27/14, 1/28/14, 1/29/14, 1/30/14, and 1/31/14.</p> <p>- There was no documentation Novolog Lantus 44 units q bedtime was given on: 1/2/14, 1/3/14, 1/8/14, 1/9/14, 1/10/14, 1/13/14, 1/15/14, 1/16/14, 1/17/14, 1/20/14, 1/21/14, 1/23/14, 1/24/14, 1/27/14, 1/28/14, 1/29/14, 1/30/14, and 1/31/14.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p> <p>Review of the MAR for Resident #C, for the month of February, 2014, indicated the following:</p> <p>- There was no documentation Novolog 26 units q morning was given on: 2/18/14.</p> <p>- There was no documentation Novolog 20 units with lunch was given on: 2/28/14.</p> <p>- There was no documentation Lantus 44 units q bedtime was given on: 2/28/14.</p> <p>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</p>			

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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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	<p>Review of the MAR for Resident #C, for the month of March, 2014, indicated the following:</p> <ul style="list-style-type: none"> <li>- There was no documentation Novolog 26 units q morning was given on: 3/8/14, 3/16/14, 3/26/14, 3/27/14, 3/28/14, 3/29/14, 3/30/14, and 3/31/14.</li> <li>- There was no documentation Novolog 20 units with lunch was given on: 3/9/14, 3/26/14, 3/27/14, 3/28/14, 3/30/14, and 3/31/14.</li> <li>- There was no documentation Novolog 16 units q evening was given on: 3/28/14 and 3/31/14.</li> <li>- There was no documentation Lantus 44 units q bedtime was given on: 3/28/14, and 3/31/14.</li> <li>- There was no documentation on the back side of the MAR to indicate why the insulin was not given as ordered.</li> </ul> <p>3. A Review of Resident #B's clinical record indicated her diagnoses included but were not limited to hypertension (high blood pressure), CVA (stroke), hemiplegia, COPD (chronic obstructive pulmonary disease), neuropathy, seizure disorder, arthritis, left below the knee amputation, lymphedema, muscular weakness, infantile cerebral palsy. The</p>			

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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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	<p><b>Resident Assessment/Service Form dated 4/30/14 indicated, "...Resident was alert and oriented and had no difficulty remembering and using information." The assessment further indicated she, "...does not require directions or reminding from others."</b></p> <p>A review of the Resident B's MARS (Medication Administration Record Sheet) on 5/28/14 at 1:45 p.m., indicated on 5/18/14 and 5/19/14 the initials of the nurse were circled for the following medications:</p> <p>Certa vite (multivitamin) 1 tab(tablet) every day.                      Ferrous Sulf (Iron Supplement) 325 mg (milligrams, a measurement) 1 tab BID (2 times a day).                      Oyster Shell/D (Calcium with Vitamin D supplement) 500 mg/200 IU (international units, a measurement) 1 tab BID.                      Carbamazepine XR (for seizure disorder) 400 mg 1 tab po BID.                      Losartan HCT (for high blood pressure) 50-12.5 mg 1 tab po daily.                      Mobic (for pain and inflammation) 15 mg 1 tab po every day.                      Pot. Chloride ER (potassium chloride, a supplement) 20 mEq (milliequivalent, a measurement) 1 tab po BID.                      Furosemide (for edema) 40 mg 1 tab po</p>			

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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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	<p>every day.</p> <p>Advair Deskus (an inhaler for respiratory conditions) 250.50 1 puff BID for COPD.</p> <p>Plavix (an anticoagulant) 75 mg 1 tab po every day.</p> <p>Zocor (for high cholesterol) 20 mg 1 tab po every day.</p> <p>Gabapentin (for neuropathy pain) 600 mg 2 tabs TID.</p> <p>There was no documentation in The Nurse's Medication Notes on MARS to indicated why the medications were not given.</p> <p>Reviewed the May, 2014 MARS dated with LPN #1 and during the interview with her on 5/28/14 at 1:50 p.m., she indicated the nurse's initials are circled on the MARS when the medication was not given. She further indicated an explanation is documented on the back side of the MARS why the medication was not given.</p> <p>During an interview with the ADON on on 2/29/14 at 9:35 a.m. indicated the circled nurses initials indicated the medication was not given. She further indicate the reason why the medication was not given should be documented on the back of the MARS page or in the nurses notes. She could not provide the documentation to why Resident #B's</p>						

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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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R000272	<p>meds were not given on 5/19/14 and 5/20/14.</p> <p>A current undated facility policy "Medication Storage in the Facility", provided by the Facility Manager on 5/29/14 at 12:05 p.m., indicated "...Medication administration is documented on the resident's MAR at the time the medication is given by the person administering the medication, including an explanation if the medication was not taken... The resident's MAR is initialed by the person administering the medication in the space provided under the date and on the line for that specific medication. Initials on the MAR are verified with a full signature in the space provided...If a dose of a regularly scheduled medication is refused by the resident, circle the time in the correct space on the MAR, write Ref (refused), and initial...."</p> <p>This State Tag relates to Complaint IN00149926.</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure milk was served at the proper</p>	R000272	Dining servers will ensure that milk is kept on ice to maintain proper temperature by 6/13/14. CNA's on the memory units will ensure that they store properly	06/25/2014

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 05/29/2014
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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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	<p>temperature, potentially affecting 128 of the 128 residents who received meals prepared by the facility.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal in the facility dining room on 5/27/14, the following was observed:</p> <p>- At 11:30 a.m., Server #2 was observed pushing an open two-tiered cart from one table to another in the dining room delivering beverages of choice to the residents. The open two-tiered cart contained carafes of coffee, clear plastic pitchers of assorted juices and iced tea, and a gallon of white milk. The gallon of milk had not been placed on ice to ensure the milk was served at the recommended temperature.</p> <p>2. During an observation of the lunch meal in the facility dining room on 5/28/14, the following was observed:</p> <p>- At 11:20 a.m., a cart with a well filled with ice was pushed from the kitchen into the dining room. Clear plastic pitchers of assorted juices, iced tea, and a gallon of white milk were placed on two open two-tiered carts from the cart containing ice in the well. Server #2 and Server #3 were observed to push the open</p>		<p>store the milk in between serving resident's. Staff will be in-serviced on 6/25/14 on properly labeling and covering food items in resident refrigerators. CNA's on the memory units are checking the resident refrigerator daily. Management will monitor this weekly for the next 8 weeks and then monthly for the next 4 months.</p>	

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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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	<p>two-tiered carts from one table to another in the dining room delivering beverages of choice to the residents. The gallons of milk had not been placed on ice to ensure the milk was served at the recommended temperature.</p> <p>- At 11:45 a.m., the gallons of milk were placed into the cart well filled with ice, 25 minutes after the start of the beverage service.</p> <p>The Dietary Manager was interviewed on 5/29/14 at 9:05 a.m. During the interview she indicated the temperature of the milk was taken in the facility kitchen immediately before the gallons of milk were placed in the well containing ice on the cart which was pushed into the dining room. She further indicated the gallons of milk were placed on the open tiered cart for service to the residents, but had not been placed in ice to keep the milk at the appropriate temperature.<sup>3</sup></p> <p>During an observation of the lunch meal in the 10th Floor Memory Care Unit dining room on 5/27/14 from 11:28 a.m. through 12:10 p.m., the following was observed:</p> <p>-At 11:45 a.m., CNA #5 brought a half full gallon of milk into the dining room from the unit's refrigerator and poured the milk into cups and served the milk to the</p>			

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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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	<p>5 residents who requested milk. CNA # 5 did not check the temperature of the milk before serving it to the Residents. CNA #5 left the milk out on the counter top.</p> <p>-At 11:50 a.m., observed CNA #5 cover the remaining chocolate brownies with paper towel and take to the refrigerator. The CNA did not label the brownies with a date before putting them into the refrigerator.</p> <p>-During an interview at 11:52 a.m., CNA #5 indicated she had gotten the milk from the unit's refrigerator. She indicated they keep milk, juices and left overs in the refrigerator for the Residents to have later.</p> <p>-During an interview with CNA #5 at 12:07 p.m., she indicated they do not take temperatures of the any food served on the Memory Units.</p> <p>-At 12:10 p.m., the milk, lemonade and peach drink still remained out on the counter top, not on ice.</p> <p>A current undated facility policy "Food Temperatures", provided by the Dietary Manager on 5/29/14 at 10:28 a.m., indicated "...Cold foods should be maintained at a maximum of 41 degrees</p>						

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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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R000273	<p>F (Fahrenheit)...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to protect resident's food and beverages from potential contamination, failed to wash hands appropriately for the recommended amount of time and after touching contaminated surfaces, failed to wash hands before donning a pair of disposable gloves, and failed to properly store resident food in the refrigerator on the Memory Care Units. The facility further failed to act upon elevated refrigerator temperatures on the Memory Care Unit. This deficient practice had the potential to affect 128 of the 128 residents who received meals prepared by the facility.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 5/27/14 in the dining room, the following was observed:</p> <p>- At 11:37 a.m., Server #4 was observed</p>	R000273	<p>To ensure proper protocol, an all staff in-service will be conducted on 6/25/14. The topics discussed will be proper hand washing technique, when and how to change disposable gloves, and the importance of covering all food when transporting/handling food and beverages. Each staff member will receive a handout and sign verifying they understand the safe food handling standards. For the next 6 months it will be the responsibility of the dietary manager to complete periodic checks of meal services for all 3 meals and provide documentation to administrator when completed. As of 5/27/14, the thermometers were places centrally in all refrigerators with medication and on the memory care units. Temperature is checked daily and recorded on the log. DON will check log weekly.</p>	06/25/2014

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 05/29/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to carry three lunch plates of food to residents seated at the same dining room table. She was observed to carry one plate in her left hand, one plate in her right hand, and one plate on her right forearm. The rim of the plate carried on her right forearm was observed to touch her uniform top.</p> <p>- At 11:41 a.m., Server #4 was observed to carry three lunch plates of food to residents seated at the same dining room table. She was observed to carry one plate in her left hand, one plate in her right hand, and one plate on her right forearm. The rim of the plate carried on her right forearm was observed to touch her uniform top.</p> <p>2. During an observation of the lunch meal on 5/28/14 in the main dining room, the following was observed:</p> <p>- At 11:38 a.m., Server #2 was observed pushing an open two-tiered cart through the dining room pouring glasses of beverages for the residents. He was observed to touch two resident's on the back of their clothing and directly return to the beverage cart and proceed to fill glasses of beverages for other residents. He was not observed to wash his hands after touching the resident's clothing.</p>			

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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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	<p>The Dietary Manager was interviewed on 5/29/14 at 9:05 a.m. During the interview she indicated staff were to handle plates for the residents to prevent contamination. She also indicated staff were to wash their hands for 20 seconds prior to meal service. She further indicated staff were to re-wash their hands if their hands become contaminated. 3. During an observation of the lunch meal in the 10th Floor Memory Care Unit dining room on 5/27/14 from 11:28 a.m. through 12:10 p.m., the following was observed:</p> <p>- At 11:35 a.m., Certified Nursing Assistant (CNA) #5, was observed to wash her hands for 10 seconds, then donned disposable gloves and began to serve beverages to the 10 Residents seated in the dining room.</p> <p>-At 11:37 a.m., CNA #5 stopped serving beverages to Residents to assist a visitor onto the locked elevator. The CNA reached into her pocket for the elevator key with her gloved hand. The CNA returned to the dining room, removed the disposable gloves and donned new gloves without washing her hands and resumed serving beverages to the Residents.</p> <p>-At 11:40 a.m., CNA #5 removed disposable gloves and donned new</p>						

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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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	<p>disposable gloves without washing her hands and began serving lunch meal plates. CNA #5 touched the top rim of the all 10 plates as she carried the plate to the table to serve the resident.</p> <p>-At 11:45 a.m., CNA #5 left the dining room and returned with a half full gallon of milk. CNA #5 donned new disposable gloves without washing her hands and served milk to the Residents.</p> <p>-At 11:50 a.m., CNA #5 donned new disposable gloves without washing her hands and served Residents chocolate cake on small plates. The CNA touched the top rim of the dessert plates as she served the Residents.</p> <p>-At 12:07 p.m., during an interview with CNA #5 she indicated she should wash her hands for 20 seconds and after ever 5th plate passed. She did not indicate she should wash her hands after removing gloves.4. During the initial tour of the facility on 5-27-2014 from 10:08 a.m. to 10:50 a.m., the following was observed on floors 9 and 10:</p> <p>- a small refrigerator on each floor was identified by the DON for resident use. The refrigerators contained 2 plastic cups of food without being covered, a pitcher of yellow liquid without a label identifying or dating the drink, 2 bottles</p>						

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of salad dressing which were undated when opened and not labeled with a resident name.</p> <p>On 5-27-2014 at 11:32 a.m., the following was observed in the 9th floor Memory Care unit refrigerator:</p> <ul style="list-style-type: none"> <li>- Refrigerator temperature was 52 degrees Fahrenheit. The temperature log indicated the temperature for 5-27-2014 was 48 degrees Fahrenheit. The thermometer was in the door of the refrigerator. (When the thermometer was moved to the inside shelf, at 11:58 a.m. the temperature was 38 degrees Fahrenheit.)</li> <li>- Unlabeled with resident names and undated contents of the refrigerator included a 16 ounce bottle of Ranch dressing, a 16 ounce bottle of Roasted Red Pepper Dressing, an opened 16 ounce bottle of soda with 1/2 left, a plastic cup of uncovered and undated dessert, a green bottle of clear liquid without a name or date, a sack with containers inside unlabeled or dated and a taco bell sack without a name or date on it.</li> </ul> <p>On 5-27-2014 at 12:00 p.m., the following was observed in the 10th floor Memory Care unit refrigerator:</p> <ul style="list-style-type: none"> <li>- an opened 32 ounce jar of spaghetti sauce without a name or date on it</li> </ul>			

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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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	<p>- 5 plates of brownies loosely covered with brown paper towels without being labeled with names or dated.</p> <p>-an uncovered pitcher with clear liquid inside.</p> <p>An interview with CNA #13 and CNA #14 on 5-28-2014 at 11:14 a.m., indicated the black refrigerators on the 9th floor nurse's station and on the 10th floor resident lounge were for the residents use.</p> <p>A review of the temperature log for the 9th floor refrigerator was reviewed on 5-28-2014 at 11:14 a.m. and indicated the following the temperatures recorded in degrees Fahrenheit:</p> <p>5-8-2014 48 5-9-2014 48 5-10-2014 55 5-11-2014 41 5-12-2014 50 5-13-2014 50 5-14-2014 50 5-15-2014 50 5-16-2014 50 5-17-2014 50 5-18-2014 50 5-19-2014 50 5-20-2014 50 5-21-2014 48 5-22-2014 47 5-23-2014 50</p>			

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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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5-24-2014 46 5-25-2014 50 5-26-2014 48 5-27-2014 48	<p>An interview CNA #13 on 5-29-2014 at 9:08 a.m., indicated the 3rd shift staff checks the refrigerator temperature and CNA #13 was not aware of the refrigerator temperature recordings were not in the safe range for food storage. CNA #13 indicated she would have reported any refrigerator problems to the DON. The CNA #13 indicated if the refrigerator temperatures were above the the safe range for food storage, the contents of the refrigerator would need to be discarded.</p> <p>An interview during the environmental tour on 5-29-2014 from 9:35 a.m. to 10:35 a.m., the Facility Manager and the Maintenance Manager indicated they had not received a report of the 9th floor refrigerator temperatures being elevated. Further interview with the Facility Manager, indicated the food stored in the refrigerators on the 9th and 10th floors should be labeled, dated and covered securely.</p> <p>A copy of the "Bacteria Control Chart" dated 3-22-2005 from the ISDH (Indiana State Department of Health) Food</p>			

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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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	<p>Protection Programs was obtained from CNA #13, and indicated "...refrigerators kept in this range to reduce food spoilage by bacteria 32 degrees Fahrenheit to 41 degrees Fahrenheit..."</p> <p>An undated policy "Storage of refrigerated and Dry Foods", provided by the Dietary Manager on 5-29-2014 at 10:28 a.m., indicated "...food being returned to storage after cooking or preparation must be covered...all containers must be labeled with the contents and date food item was placed in storage...."</p> <p>5. During the lunch meal service on 5-27-2014 in the 9th floor Memory Care unit dining room, the following observations were made:</p> <ul style="list-style-type: none"> <li>- 11:36 a.m. CNA #15 washed hands for 8 seconds and began serving residents their drinks.</li> <li>- 11:38 a.m. CNA #15 assisted a resident to her seat by using her hands to touch the resident's arms and guiding her to her seat. Without washing her hands, CNA #15 continued to serve residents their drinks.</li> <li>- 11:39 a.m. CNA #15 used a key to call the elevator and returned across the hall to the dining room and without washing her hands began to serve 6 residents their plates.</li> </ul>			

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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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	<p>- 11:40 a.m. CNA #15 washed her hands for 14 seconds and served an additional 5 residents their plates.</p> <p>- 11:47 a.m. CNA #15 moved a chair and without washing her hands served another resident her plate.</p> <p>- 11:50 a.m. CNA #15 washed her hands with soap for 7 seconds and then passed out an additional plate to a resident and served 6 residents an ice cream sandwich.</p> <p>During the lunch meal service on 5-28-2014 in the 9th floor Memory Care unit dining room, the following observations were made:</p> <p>- 11:31 a.m. CNA #14 washed hands for 10 seconds and left dining room to alert residents it was time for lunch.</p> <p>- 11:25 a.m. CNA #14 returned to the dining room and without washing her hands, poured a cup of coffee for a resident.</p> <p>- 11:36 a.m. CNA #14 began to serve residents their plates without washing her hands first. CNA #14 touched the rims of the plates with her thumb and served 12 residents. An additional 2 plates with CNA #14 touching the rims with her thumb were placed on the table without a resident being present.</p> <p>- 11:37 a.m. CNA #14 passed plastic coffee cups to the residents while touching the rims of the cups with her fingers.</p>						

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 05/29/2014	
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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R000301	<p>- 11:40 a.m. CNA #14 carried a styrofoam coffee cup while touching the rim of the cup with her fingers for a resident.</p> <p>- 11:44 a.m. CNA #14 carried 2 plates of pie while touching the rims of the plates with her thumb.</p> <p>- 11:45 a.m. CNA #14 carried 3 plates of pie with 1 plate touching the front of her uniform and returned to get an additional 3 plates of pie and served residents after 1 plate was carried against her uniform.</p> <p>- 11:51 a.m. CNA #14 obtained a snack for a resident without washing her hands and after she had cleared away dirty dishes.</p> <p>-</p> <p>A current undated facility policy "Standard Precautions", provided by the Dietary Manager on 5/29/14 at 10:28 a.m., indicated "...Hands must be washed between any task which has the possibility of transferring bacteria from resident to resident..."</p> <p>A current undated facility policy "Standard Precautions", provided by the Dietary Manager on 5/29/14 at 10:28 a.m., indicated "...For routine washing, wash the hands for 15-30 seconds...."</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following:</p>						

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 05/29/2014	
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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	<p>(A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, interview and record review, the facility failed to ensure prescription medication bottles were appropriately labeled to include, but not limited to, the date the multi use vial was opened and/or include the resident's name and/or physician name for 2 of 4 medication carts observed.</p> <p>Findings include:</p> <p>On 5/27/14 at 1:20 P.M., the 3rd medication cart was observed with LPN #11. In the top drawer of the cart, were 10 bottles of Flonase nose spray, of which 4 bottles were not documented when they were opened. A bottle of Latanoprost ophthalmic eye drops with the name of a resident, was observed to have the resident name and room number of the bottle but was lacking the physician name. A bottle of Centrum (multivitamins) was in the second drawer</p>	R000301	Nursing is to properly label all OTC medication with the proper information including name, physician sname, prescription number, name and strength of the drug, directions of use,date of issue, and expiration date by 6/25/14. Also, all nasal sprays and eyedrops will have listed the date opened. Each cart is being audited by the assigned nursing staff member and will check off on related task sheet by 6/25/14 and ongoing each week. They will ensure the above are being done accurately as well as maintaining a clean and organized cart. All loose pills will be properly discarded in the sharps container.	06/25/2014			

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 05/29/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>from the top. The bottle had no name, no physician name. The number 9 A was written on the top of the lid. It was written in pen and was difficult to read. A bottle of Vitamin D2 2000 IU had what appeared to be at one time information written on the bottle in marker but no information was legible at this time. LPN #11 indicated "it kind of came off." LPN #11 indicated these bottles should have labels on them with the physician name and resident name but these two bottles "just got missed." Both bottles of medications were observed to have been opened. The bottom right drawer of the cart was observed to have 4 opened bottles of Milk of Magnesia, with no documentation when they were opened. Two of two opened bottles of Mylanta were also not documented when they had been opened.</p> <p>Throughout the drawers in the cart housing the medication punch cards (cards with medication pills encapsulated in bubbles) there were various loose pills observed in the bottom of the drawers. There were 4 loose pills observed in the bottom drawer. LPN #11 was interviewed at the time and indicated the carts are so full of medication cards that "the pills just pop out." Also observed in the drawers of the cart, were dried spills of various color, accumulation of white</p>			

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>dusty matter in the corners of the drawers and also bit and pieces of paper.</p> <p>On 5/27/14 at 1:30 P.M., the medication cart #1 was observed with QMA (qualified medication assistant) #1. The bottom drawer of the cart was observed to have dried spills of various colors and bits of paper. In the middle left drawer were observed loose pills in the bottom of the drawer, two round white pills and an oblong orange pill. Also observed was a bottle of "extra strength pain reliever" which had a room number (1409) on the bottle but was missing the physician name. Also observed was a bottle of vitamin D3, which was also missing the physician name. In this drawer, was also observed 1 white loose tablet and 2 green oblong loose tablets.</p> <p>On 5/29/14 at 12:05 P.M., the ADON (Assistant Director of Nursing) provided a current copy of the policy and procedure for "Medication Storage in the facility." This policy was dated December 2009. This policy included, but was not limited to, the following: "Medication Labeling: ...All prescription and non-prescription containers...must be clearly labeled with the resident's name and room number...Each prescription medication label includes: patient name...physician/prescriber</p>			

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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
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	name...Non-prescription (over the counter) medications dispensed pursuant to a physician/prescriber order are labeled in accordance with the requirements for a prescription label...Medications in multiple dose vials...must have a label indicating the date the vial or container was first opened or used..."			