

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2016
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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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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 25, 26 and 27, 2016</p> <p>Facility number: 012288 Provider number: 012288 AIM number: N/A</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Medicaid: 95 Private: 30 Total: 125</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed on May 31, 2016 by 17934.</p>	R 0000		
R 0090 Bldg. 00	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by 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; (B) poisonings; (C) fires; or (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 (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>			

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	<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 report an unusual occurrence to the Indiana State Department of Health (ISDH), as a Resident received a burn when smoking a cigarette while the oxygen was in use. This unusual occurrence involved 1 Resident (Resident #68) for 1 of 1 reportable incident reviewed.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #68 on 5/26/16 at 11:00 a.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus Type II, congestive heart failure, hypertension, lung cancer and chronic obstructive pulmonary disease.</p> <p>Review of the Nurses Notes for Resident #68 on 5/26/16 at 11:25 a.m., indicated the following, "...Resident was outside smoking in parking lot with O2 (oxygen) on...tank started to smoke...O2 tubing melted onto lap...small area burned skin et (and) Blackened with smoke...other resident seen [sic] W/C (wheelchair) on fire and moved Resident to safety and put fire out ...MD (Physician) and Family</p>	R 0090	<p>Lamplight Inn of Fort Wayne kindly requests paper compliance for the 2016 Annual Survey On 6/29/16, an all staff in-service will be conducted on Unusual Circumstances to be reported to ISDH. A QI Monitoring Tool called ISDH Reporting will be utilized every week x4, monthly x5 for at least 6 months. Data will be collected daily from the 24 hour nursing report by the DON/Designee and submitted to the QI Committee. If the threshold of 95% is not met, an action plan will be developed. Non-Compliance with facility procedure may result in disciplinary action up to and including termination</p>	06/29/2016

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	<p>notified...." Initials of nurse.</p> <p>An interview with the DON (Director of Nursing) on 5/26/16 at 2:35 p.m., indicated the burn incident happened when Resident #68, who had not been smoking cigarettes, decided to light up a cigarette and she received a burn on her lap. The DON indicated the burn incident was reported to her Medicaid Waiver Case Manager and she further indicated it was the only report required.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 5/26/16 at 2:40 p.m., indicated the burn incident for Resident #68 was reported to the Medicaid Waiver Case Manager and provided a copy of the report.</p> <p>Review of the Report document for Resident #68 provided by the ADON on 5/26/16 at 3:00 p.m., indicated the following, "...Indiana Division of Aging, Incident Initial Report...Last Name...First Name: Resident #68...Describe the injury, condition or circumstance of the Incident and the activities taking place immediately prior to incident: Resident was outside smoking in the parking lot with her O2 tank and the tubing started smoking and melted on her lap small area on her thigh and refused to go to the ER (Emergency Room)....Plan to Resolve</p>			

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	<p>(Immediate and Long Term: NP (Nurse Practitioner) ordered Silvadene cream and cover with telfa pad daily. Will continue to monitor.... Report Generated Date and Time: 10/26/15 11:47:39 AM...."</p> <p>An interview with the ADON on 5/27/16 at 10:15 a.m., indicated Resident #68 had quit smoking cigarettes and was using a Vape Pen (a type of vaporized electronic cigarette). The ADON indicated a Vape Pen could be used while the O2 was being used because it did not have a flame. She also indicated Resident #68 was out of the Vape Pen cartridges and got a cigarette from another resident. Resident #68 lit up the cigarette which resulted in the burn to her thigh.</p> <p>An interview with the Executive Director (ED) on 5/27/16 at 11:00 a.m., indicated the incident involving Resident #68 was an unusual occurrence. She also indicated the incident was not reported to ISDH. She indicated she had interviewed Resident #68 and the Resident indicated there was not an open flame or a fire and indicated the burn was quarter size and healed quickly. The ED indicated she did not investigate the incident any further than talking with Resident #68 and indicated she did not interview the Resident witness. She further indicated</p>			

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	<p>the DON had reported the incident to the Medicaid Waiver Case Manager.</p> <p>Review of the NP progress note for Resident # 68, dated 10/27/15, and provided by the ADON on 5/27/16 at 12:00 p.m., indicated, "...Acute Visit...Nursing request for burn to R (right) upper thigh obtained from melted O2 tubing. Res was outside smoking with O2 on. 1.3 x 0.7 (centimeters, measurement) wound R upper thigh wound bed pink....Diagnosis: 1) Burn...2) Chronic Pain...3) COPD...4) tobacco dependence...Plan: apply Silvadene and telfa daily....No desire to quit at this time...has decreased (arrow down) # (number) of cigarettes per day...."</p> <p>Review of the current non-dated facility policy provided by the Executive Director on 5/27/16 at 8:45 a.m., titled, Incidents/Accidents, indicated, "...Whenever an occurrence or event leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member on the grounds of priority Life Care, an Incident/Accident Report must be completed....Notify the Manager as soon as possible if there was actual injury to the resident, visitor or staff member....When in doubt, complete the form....If there is any injury resulting in need for medical treatment, the</p>			

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R 0153 Bldg. 00	<p>family/responsible person must be notified...." The Facility Policy did not include to report incidents of unusual occurrences/injuries to the ISDH within 24 hours of becoming aware of the unusual occurrence as stated in the ISDH Residential Regulations, "...00900...(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...."</p> <p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on observation, interview and record review, the facility failed to ensure portable oxygen tanks were stored in a safe and secure manner for 9 of 10 residents with portable oxygen tanks stored in their rooms.</p>	R 0153	Lamplight Inn of Fort Wayne kindly requests paper compliance for the 2016 Annual SurveyBy 6/29/16 all oxygen tanks will be secured in oxygen racks. On	06/29/2016

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	<p>(Resident #56, #96, #134, #130, #85, #84, #77, #68, #10)</p> <p>Findings include:</p> <p>On 5/25/16 at 10:45 a.m., the following observations were made in resident rooms:</p> <p>Residents # 84, #130 and #77 were observed to have one metal, torpedo shaped portable oxygen tank, standing unsecured on the floor in their rooms.</p> <p>Residents #85 and #10 were observed to have 2 unsecured, portable oxygen tanks in their rooms.</p> <p>Resident #68 was observed to have 3 unsecured, portable, metal oxygen tanks in the room. There was also a rack with 12 portable oxygen tanks securely stored.</p> <p>On 5/26/16 at 10:00 a.m., a tour of Resident rooms was conducted with the Maintenance Supervisor and indicated the following:</p> <p>Resident #56 was observed to have 2 portable metal, oxygen tanks sitting unsecured on the floor.</p> <p>Residents #96 and #134 were observed to have 3 portable, metal oxygen tanks</p>		<p>6/29/16, an all staff in-service will be conducted on Oxygen Safety and Storage. On 6/29/16 all residents requiring Oxygen therapy will be educated on Oxygen Storage and safety by a Respiratory Therapist. A QI monitoring tool called Oxygen Safety will be utilized weekly X 4 weeks, monthly X 6 months. Data will be collected from each apartment containing oxygen tanks by the Maintenance Director or his designee and submitted to the QI committee. If the threshold of 95% is not met, an action plan will be developed. Non-Compliance with facility procedure may result in disciplinary action up to and including termination.</p>				

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	<p>sitting unsecured on the floor. Resident #134 was also observed to have a rack of 11 metal oxygen tanks sitting in the room. Along the wall, which connected two rooms, one of the free standing oxygen tanks was sitting at a slight angle. The Maintenance Supervisor immediately moved the oxygen tank to a secure area.</p> <p>All of the above rooms had either carpet or linoleum covering the floor surface.</p> <p>On 5/26/16 at 10:17 a.m., the ADON (Assistant Director of Nursing) indicated whoever delivers the oxygen will provide racks for the oxygen tanks today.</p> <p>On 5/26/16 at 10:25 a.m., the Administrator was interviewed. She indicated the oxygen was usually delivered once a week. She indicated if the resident's door was locked, the Nursing Staff would be notified and they would let the oxygen delivery company into the resident's room.</p> <p>On 5/26/16 at 2:00 p.m., the ADON provided a current copy of the "Oxygen Equipment: Portable Cylinder, (name of company). She indicated when the oxygen supply company initially delivered the oxygen to the residents, the company had the residents sign this form. The form included, but was not limited</p>			

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	<p>to, the following: "If your oxygen is being supplied from a cylinder or tank, be sure to have it secured in an upright position so that it cannot be knocked over. A stand has been provided for this purpose. If you keep extra cylinders on hand, be sure that they are stored lying down if they are not in a stand or cart..."</p> <p>On 5/25/16 at 10:10 a.m., the DON (Director of Nursing) provided a resident roster which indicated the interviewable residents. Of the resident rooms observed with the unsecured, freestanding oxygen tanks, only resident #134 and #130 were identified as interviewable (alert, oriented and reliable) by the facility.</p> <p>On 5/26/16 at 2:10 p.m., CNA (Certified Nursing Assistant) #2 was interviewed. She indicated to her knowledge it was okay if the metal oxygen tanks were left unsecured, out of a rack on the resident's floor. She indicated the residents on this floor "don't have a rack to put them in."</p> <p>On 5/26/16 at 2:20 p.m., CNA #3 was interviewed. She indicated the metal oxygen tanks should always be in a rack and not left free standing on the floor.</p> <p>On 5/27/16 at 9:52 a.m., CNA #1 was interviewed. She indicated she was not</p>			

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	<p>sure if it was alright for the metal oxygen tanks to be free standing out of a rack in the residents' rooms. She indicated if she had to guess, she would think the oxygen tanks should be kept in a rack.</p> <p>On 5/27/16 at 9:55 a.m., a confidential interview was conducted. The resident indicated that yesterday the "oxygen man" informed them that the portable metal tanks should always be kept in a rack and not free standing.</p> <p>On 5/27/16 at 10:15 a.m., the Administrator was interviewed. She indicated the facility does not have a policy and procedure for oxygen storage. She indicated when residents moved in to the facility, the oxygen company had the resident sign a document which informed them of oxygen safety. The Administrator indicated the direct care staff should be responsible for the oxygen care for residents. She indicated they contacted the oxygen companies yesterday to provide the appropriate number of racks so all the tanks can be safely and securely stored, but they have not seen them yet. She indicated at one time, the oxygen company did inservice the staff on oxygen tank care.</p>			

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R 0356 Bldg. 00	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. <p>Based on interview and record review, the facility failed to maintain a complete emergency information file containing a photograph of each resident, potentially affecting 67 of 125 residents who resided in the facility.</p> <p>Findings include:</p> <p>The facility emergency information file was reviewed on 5-26-2016 at 9:04 a.m. During the review, photographs of 67</p>	R 0356	Lamplight Inn of Fort Wayne kindly requests paper compliance for the 2016 Annual SurveyAll photographs were placed in the Emergency Information File by 5/30/16. A company policy was put into place on 6/1 in regards to taking new residents photograph. All residents will have their photograph taken upon admission. A copy of the photograph will be placed with the emergency information file. An	06/01/2016
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	<p>residents were missing of the 125 residents currently residing in the facility.</p> <p>An interview with the Receptionist on 5-26-2016 at 9:30 a.m., indicated she was to keep the emergency file updated as new residents came to the facility. The Receptionist indicated the Executive Director would get the resident's picture for the emergency file.</p> <p>The Executive Director was interviewed on 5-26-2016 at 3:16 p.m. During the interview, she indicated photographs of residents should be in the emergency file. She indicated she was not aware that the pictures were not with each resident's emergency information as she had 3 copies of each resident's picture at admission for the clinical record, the Medication Administration Record and the emergency file.</p> <p>A current, undated policy, "Emergency Information" was provided by the Executive Director on 5-27-2016 at 11:40 a.m. The policy indicated "...a Resident Information Record will be completed for each person moving to the residence...The record will be updated annually or as needed...." The facility policy did not include resident photographs (for identification of the resident)to be in the emergency file.</p>		<p>inservice was provided on 6/1 to all concierge staff. A QI monitoring tool called Emergency File Audit will be utilized every week x4 weeks. Monthly x5 for at least 6 months. Data will be collected by ED/Designee and submitted to the QI Committee. If the threshold of 95% is not met, an action plan will be developed. Non Compliance with facility procedure may result in disciplinary action, up to and including termination.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Further interview with the Executive Director, indicated the policy needed to be updated.				