

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 10/31/2014
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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 the investigation of complaint IN00158196.</p> <p>Complaint IN00158196-Substantiated with findings.</p> <p>Survey Dates: October 30 & 31, 2014</p> <p>Facility number: 012288 Provider number: N/A AIM number: N/A</p> <p>Survey team: Angela Strass, RN Christine Fodrea, RN</p> <p>Census bed type: Residential: 134 Total: 134</p> <p>Census payor type: Medicaid: 91 Other: 43 Total: 134</p> <p>Sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on November 3, 2014 by Randy Fry</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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R000036	<p>RN.</p> <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, interview, and record review, the facility failed to notify a resident's family of a medication error in a timely manner for 1 resident (B) in a sample of 4 resident records reviewed. Finding includes: Observation of Resident B on 10/30/14 at 10:30 a.m. indicated</p>	R000036	Facility will notify resident, POA/responsible party, and physician via verbal communication as soon as a medication error occurs. on 10/31/14 an additional Medication Cart became utilized. This increased staff for 1st and 2nd shift. Beginning 11/6/2014, nursing staff is to contact supervisors immediately after notifying all the appropriate parties. The DON will conduct	11/06/2014

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	<p>she resided on the Dementia Unit.</p> <p>Review of the clinical record for resident (B) indicated she was admitted to the facility on 1/3/14 with Diagnoses including but not limited to Dementia, Hypertension and Depression.</p> <p>Review of nursing notes for resident (B) indicated the following: 10/11/14 at 10:00 a.m. – "Resident given wrong medication on first shift. Resident was given medication of another resident by QMA (qualified medication aide) . Resident acting normal after given medication. Nurse Practitioner notified new order monitor blood pressure every hour for 8 hours. Check blood sugar. Hold all first shift medications due to interaction. ADON Assistant Director of Nursing) notified. Blood sugar 147, blood pressure 155/77 pulse 48. Resident will be monitored throughout the day."</p> <p>10/11/14 at 6:00 p.m. – "Resident's POA (Power of Attorney) Daughter notified residents vitals within normal limits all this shift."</p> <p>Interview with the Director of</p>		weekly audits of nursing notes and Incident reports for the next 6 months to ensure the plan is in place.	

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R000241	<p>Nursing on 10/31/14 at 9:15 a.m. indicated the nurse on duty 10/11/14 during first shift notified the nurse practitioner when the incident happened but did not notify the resident's family until 6:00 p.m. on 10/31/14.</p> <p>On 10/31/14 at 10: 40 a.m. review of the facility Policy for Incidents/Accidents provided by the Director of Nursing and dated 9/1/10 indicated the following:</p> <p>"Whenever an occurrence or event leads to unintentional consequences and an unfortunate happening to a resident, visitor or staff member on the grounds of Lamplight Communities, an Incident/Accident Report must be completed.</p> <p>If a resident has experienced the incident, they should be involved in the decision as to whether or not the family/responsible person is notified."</p> <p>This state tag is related to complaint IN00158196</p>			

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	<p>Health Services - Offense</p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered to the right person for 1 resident (B) in a sample of 4 resident records reviewed.</p> <p>Finding includes:</p> <p>Observation of Resident B on 10/30/14 at 10:30 a.m. indicated she resided on the Dementia Unit.</p> <p>Review of the clinical record for resident (B) indicated she was admitted to the facility on 1/3/14 with Diagnoses including but not limited to Dementia, Hypertension and Depression.</p> <p>Review of nursing notes for resident (B) indicated the following: 10/11/14 at 10:00 a.m. - "Resident given wrong medication on first shift. Resident was given medication of another resident by QMA (qualified medication aide) .</p>	R000241	On 11/27/14 and 12/17/14 A mandatory Nursing staff meeting will be held to in-service the proper way to administer medication. On an ongoing basis, disciplinary action will be taken for any medication error caused by staff. For the next 6 months, the ADON will distribute a nursing skill check off for all new nursing employees to ensure this safety plan is in place.	11/26/2014

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	<p>Resident acting normal after given medication. Nurse Practitioner notified new order monitor blood pressure every hour for 8 hours. Check blood sugar. Hold all first shift medications due to interaction. ADON Assistant Director of Nursing) notified. Blood sugar 147, blood pressure 155/77 pulse 48. Resident will be monitored throughout the day."</p> <p>On 10/31/14 at 9:15 a.m. interview with the Director of Nursing and review of a Medication Incident Report Form" dated 10/11/14 indicated a QMA (Qualified Medication Aide) had given resident (B) the wrong medication. Further interview indicated the Nurse Practitioner had been notified of the wrong medication administration to the resident and ordered the facility to monitor the resident's blood pressure ever hour for 8 hours, check the resident's blood sugar and hold all first shift medications.</p> <p>On 10/31/14 at 1:30 p.m. review of the "Medication Incident Report Form" dated 10/11/14 indicated the resident had received Atenolol (blood pressure medication) 37.5 milligrams, Potassium chloride</p>			

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	(potassium supplement) 20 milliequivalent's, Glipizide Extended Release (used to control blood sugar) 5 milligrams, and Furosemide (a water reducing medication) 60 milligrams in error. This state tag is related to complaint IN00158196				