

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 12/22/2014
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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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00158196 completed on 10-31-2014.</p> <p>Complaint IN00158196 - Not corrected.</p> <p>Survey date: December 22, 2014</p> <p>Facility number: 012288 Provider number: 012288 AIM number: N/A</p> <p>Survey team: Virginia Terveer, RN, TC Julie Call, RN</p> <p>Census bed type: Residential: 135 NCC: 10 Total: 145</p> <p>Census payor type: Medicaid: 95 Other: 50 Total: 145</p> <p>Sample: 3</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p>	R000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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R000241	<p>Quality review completed on December 23, 2014 by Randy Fry RN.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were administered correctly for 1 of 3 resident records reviewed. (Resident F) Furthermore, the facility failed to ensure the Plan of Correction dated 12-17-2014 was adequately implemented for prevention of medication errors. This deficiency had the potential to affect 135 of 145 residents who required medication administration from the facility nursing staff.</p> <p>Findings include:</p> <p>An observation on 12-22-2014 at 2:40 p.m., indicated Resident F resided on the Dementia unit.</p>	R000241	<p>On 1/21/15 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.</p>	01/21/2015

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	<p>A record review for Resident F indicated the resident was admitted on 6-11-2012 and had diagnoses including but not limited to diabetes, dementia and hypertension.</p> <p>A review of the nurse's notes dated 12-19-2014 for Resident F indicated the following: "8:00 p.m. Resident given 2 Nov (Novolin) 70/30 28 units in pm MD family and ADON (Assistant Director of Nursing) notified will continue to monitor for adverse reactions...."</p> <p>A review of physician orders dated 12-19-2014 (untimed) indicated "...BS (blood sugar) check q (every) hr (hour) till 1 AM if over 200 q 2 hr till 8 AM hold AM till call (physician) after 8 AM...."</p> <p>A review of the Medication Incident Report Form provided by the DON on 12-22-2014 at 12:30 p.m., indicated the following: "...Date of Report: 12-19-2014 Resident Name: Resident F Date Error Occurred: 12-19-2014 Time Noted 6:30 PM Medication: Nov (Novolin) 70/30 Dose: 28 units Route: SQ (subcutaneously) Time: 6:15</p>			

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	<p>Describe the error and how it occurred: LPN #1 took the pm dinner meds (medications) that needed past [sic] and...Nov 70/30 with me...did his shot and pass meds on all floors other nurse came up and gave shot she did sign it out...."</p> <p>An interview with the DON (Director of Nursing) on 12-22-2014 at 12:33 p.m., indicated LPN #1 who gave the Novolin 70/30 insulin to Resident F on 12-19-2014 at 6:15 p.m., reported he did not check the MAR (Medication Administration Record) prior to giving the insulin for Resident F. The DON indicated the MAR was already initialed by another nurse who had already given Resident F the evening dose of Novolin 70/30 28 units, so the resident received two times the insulin dose ordered by the physician.</p> <p>An interview with Ombudsman #2 on 12-22-2014 at 1:50 p.m., indicated she was visiting the facility today to follow up with resident concerns which included Resident F's family concern regarding medications being given incorrectly.</p> <p>An interview with a family member of Resident F on 12-22-2014 at 2:40 p.m., indicated the family member had ongoing concerns with medications being given</p>			

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	<p>incorrectly to her loved one.</p> <p>A review of the "Summary Report of Meeting" dated 12-17-2014 and provided by the DON on 12-22-2014 at 12:50 p.m., indicated subjects covered during the meeting included "Compliance Program, Location of Fire Safety Devices, Incidents/Accidents Policy, Medication/Incident Report Form and Year end quiz...."</p> <p>A review of the Nursing Meeting 11-26-14 agenda provided by the DON on 12-22-2014 at 2:05 p.m. indicated "proper procedure following a med error" and "Med times and how they are to be administered" were covered during the meeting.</p> <p>A review of the sign in sheets provided by the DON on 12-22-2014 at 2:15 p.m. for the November 26, 2014 nurse meeting and the December 17, 2014 staff meeting indicated 9 of 22 staff who pass medications had not attended the in-service for the proper way to administer medication. The facility did not follow the Plan of Correction dated 12-17-2014 which indicated "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...." There was no further documentation</p>			

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	<p>provided by the facility as to when the remaining 9 nursing staff would be attending an inservice on the proper way to administer medication. LPN #1 attended the November 26, 2014 nurse meeting.</p> <p>This deficiency was cited on October 31, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				