

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 05/13/2015
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NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802
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R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 11, 12 and 13, 2015</p> <p>Facility number: 012288 Provider number: 012288 AIM number: N/A</p> <p>Census Bed Type: Residential: 123 Total: 123</p> <p>Census payor type: Medicaid: 88 Private: 35 Total: 123</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R 000		
R 144 Bldg. 00	<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>A. Based on observation and interview, the facility failed to ensure the exterior walls of the west and east end stairwells</p>	R 144	The facility will ensure that the exterior of the building is free of all water leakage by July 30, 2015. Ongoing to make sure this	07/30/2015

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>of the facility were maintained in a structurally sound and intact manner to prevent erosion due to water leakage, for two of two stairwells in the facility.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure medication carts were kept clean and free of loose medications and pill debris and grit for 3 of 4 medication carts (Medication Cart #1, #2 and #4) and 1 of 3 medication overflow carts. (Medication Overflow Cart #4)</p> <p>Findings include:</p> <p>A. On 5/11/15 at 10 a.m., the facility provided a current census sheet which indicated the current resident census was 123. It also indicated the following areas where residents reside: first, second and fourth floors had no residents residing on them; third floor had 13 residents; fifth floor had 16 residents; sixth floor had 14 residents; seventh floor had 17 residents; eighth floor had 13 residents; ninth floor had 14 residents and was a locked dementia unit; tenth floor, also a locked dementia unit had 12 residents; 12 residents on the eleventh floor, 15 resident's on the twelfth floor, there was no thirteenth floor and the top floor, the fourteenth floor, had 11 residents.</p>		<p>plan stays in place, the maintenance director will complete weekly rounds of the interior and exterior and report any deficiencies to the Executive Director immediately. By June 5, 2015, all nurses and QMA's will be in serviced on the department of health's standards for sanitation. All clinical staff that is assigned to dispense medications from the medication cart will clean and monitor them. On Mondays, 1st shift is responsible for checking for loose pills and to clean them. On Wednesdays, 2nd shift will check for loose pills and to clean them. Fridays, 3rd shift will check for loose pills and clean them. This will be monitored ongoing by the use of a task binder that is to be signed by each nurse checking the carts. The nursing management will complete audits of the task binder weekly. The quote for repairs was uploaded 6/8/15</p>		

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	<p>On 5/13/15 at 1 p.m., the facility was toured with the Maintenance Supervisor and the Housekeeping Supervisor. At the time, the Maintenance Supervisor was interviewed. He indicated the 4th floor was not occupied by any residents currently but had just been renovated to be utilized as an additional "locked, secure, dementia unit." They indicated the building had been built in 1968 and was formerly a (name of hotel). They also indicated no resident's resided in the basement, first and second floors of the facility. At the time, a room on the 14th floor, in the northwest corner of the building was toured. They indicated the room was not currently occupied. The room was observed to have buckled, displaced wallpaper, which had peeled away from the wall in the corners of the room, exposing the drywall beneath at least 1/2 way down the length of the wall from the ceiling. The Maintenance Supervisor indicated the wallpaper was buckled due to the moisture coming to the interior of the building from the exterior.</p> <p>On 5/13/15 at 1:15 p.m., the west exterior stairwell of the facility was observed with the Maintenance and Housekeeping Supervisors. The following was observed on each floor in the west end exterior stairway wall and between the</p>			

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	<p>stairway floor levels to various extents: rope caulking was hanging out from between cement joints in the wall or missing; areas of the cement wall were observed to have random areas of peeled paint exposing the cement beneath; and areas at the top of the exterior walls and along the joints were observed to have peeling paint along a drip pattern which followed the joint and the paint and cement was flaking off in spots. In various areas of the exterior walls, the water damage and erosion to the interior of the walls extended the vertical length of the wall and in some areas extended at least 1/2 of the distance of the horizontal wall and vertical wall. The Maintenance Supervisor indicated on the exterior of the building, there was a recessed area or ledge between the floors. He indicated when it "rains real hard and there is a lot of wind like there was this past Monday, the water pools on the ledge on the outside of the building between floors, seeps in a crack and works its way inside." He indicated this was what was causing the displacement of the rope caulking, the peeling paint and/or the erosion of the cement walls. He indicated when he found these areas of corrosion; he scraped, caulked and repainted them. He indicated when he repaired the problems in this way, it would only be a fix until the next hard,</p>			

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	windy rain and then the same thing would happen. He indicated to repair this correctly; it should be repaired from the outside of the building to prevent the water from entering the interior of the building. At this time, between the 8th and 7th floors, was observed a triangular piece of cement, which was dangling from the wall by a piece of rope caulking. The triangular piece of cement was located near the bottom of the wall. The Maintenance Supervisor indicated due to the hard wind and rain this past Monday, the pressure had built up in the wall and knocked the chunk of cement off the wall. Between the 2nd and 3rd floors positioned over the stairwell was the following: an area near the top of the ceiling which was 2 feet wide and 1 foot deep was cement which had separated from the wall with a distance of 3 inches between the free, loose edge of cement and the wall. The Maintenance Supervisor indicated he was unaware of this area being in this condition. The Maintenance Supervisor indicated every floor on the west end of the building stair well had some extent of water damage. He indicated this damage concerned him. At this time the east end stair well was observed. The same type of cracks in the cement with peeling paint and disrupted rope caulking with erosion and corrosion in the joint between cement areas was			

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	<p>observed but not to the extent of the damage observed in the west end stairwell. At the time the Maintenance Supervisor indicated the east end stairwell also had water damage but not to the extent of the west end stairwell.</p> <p>On 5/13/15 at 1:45 p.m., the Maintenance Supervisor indicated he does not have a preventative maintenance plan for the exterior walls of the stairwells. He indicated he "just fixes it as it comes." He also indicated if residents would need to be evacuated from the building and not be able to utilize the elevators, for example during a fire, the residents would need to be evacuated from their rooms using the east and west end stairwells.</p> <p>B. 1. During an observation of the medication carts with LPN (Licensed Practical Nurse) #1 on 5-12-2015 at 9:35 a.m., the following was observed: One and a half loose pills and a sticky residue was found in the bottom drawer of Medication Cart #1.</p> <p>The bottom right drawer of Medication Cart #1 had a sticky residue on the bottom of the drawer.</p> <p>Medication Overflow Cart #4 had 7 loose pills scattered on the bottom of the 2nd drawer, and a gritty residue in the bottom and along the back edge of the 2nd drawer.</p>			

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	<p>B. 2. During an observation of Medication Cart #4 with LPN #3 on 5-12-2015 at 10:10 a.m., the following was observed:</p> <p>A partial loose white pill was found on the bottom of the left side of drawer 2. The bottom of the third drawer had pill grit debris along the back edge of the drawer.</p> <p>The bottom right third drawer had pill grit debris along the back edge of the drawer.</p> <p>B. 3. During an observation of Medication Cart #2 with QMA (Qualified Medication Aide) #8 on 5-12-2015 at 3:47 p.m., the following was observed:</p> <p>The bottom of the third drawer had pill grit debris along the back edge of the drawer.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:20 p.m., indicated the facility had daily task sheets for nursing staff for cleaning the medication carts.</p> <p>On 5-3-2015 at 3:35 p.m., the ADON provided the facility current Daily Task Sheet for May 2015 for Cart 1, Cart 2, Cart 3 and Cart 4 which included the following: "...Tasks to be done EVERY SHIFT,</p>			

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R 148 Bldg. 00	<p>EVERYDAY, EVERYBODY [sic]...Sunday...2p-10p clean med cart with Sani wipes, discard loose pills...Tuesday...2p-10p clean med cart with Sani wipes, discard loose pills...Thursday...6a-2p clean med cart with Sani wipes, discard loose pills...."</p> <p>An undated, current policy "Medication Storage in the Assisted Living Facility" was provided by the ADON on 5-13-2015 at 3:55 p.m. The policy indicated "...medication storage areas are kept clean...."</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 upkeep of the facility. (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. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>A. Based on observation, interview and</p>	R 148	By June 5, 2015, all staff will be	06/05/2015			

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	<p>record review, the facility failed to ensure staff were able to verbalize and enact emergency procedures which included, but were not limited to procedures for tornado warnings (one observation of an actual tornado warning), fire safety and evacuation procedures for 3 of 5 staff interviewed. The facility further failed to ensure staff were knowledgeable of procedures to engage the emergency gas shut off valve for two gas dryers for 1 of 1 supervisory staff and 2 of 2 housekeeping/laundry staff interviewed regarding the emergency fire procedures.</p> <p>B. Based on observation and interview, the facility failed to ensure potentially hazardous personal care products and hand sanitizer were maintained in a safe and secure manner on 1 of 2 locked, dementia units in the facility.</p> <p>Findings include:</p> <p>A. During an interview with Resident #8, who resided on the 11th floor of the facility, on 5-11-2015 at 1:23 p.m., a tornado warning announcement over the loud speaker in the hallway was heard. The announcement indicated for residents to stay in their rooms and staff will come to let you know what to do. Near the end of the interview at 1:55 p.m., another announcement was made that the tornado</p>		<p>trained on the Tornado Watch/Warning policy as well as the location of the gas shut off valves. The policies have also been placed near the service elevator entrance on each floor so staff can review them regularly. Tornado drills will be conducted bi-annually and logged in the maintenance records. The Executive Director will oversee the drills take place. These policies will also be covered at the new hire orientation that new employees are required to attend. Also, all resident rooms will have the name of the resident located on the exterior of the entrance. Also, while the maintenance department conducts monthly fire drills each month, they will educate and remind staff of fire emergency procedures including evacuation. On going, the Maintenance Director will the monitor the Fire Drill Log book to ensure this plan remains in place.</p>				

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	<p>warning was downgraded to a tornado watch. During the interview, staff was not observed to provide any safety instructions to Resident #8. This resident room had floor to ceiling windows across the northern wall of the room with no curtains.</p> <p>On 5/13/15 at 11 a.m., the Housekeeping supervisor and the Maintenance supervisor were observed in the basement laundry room. At the time, the housekeeping supervisor was interviewed. She indicated she was unaware of the location of the emergency shut off valves for the two large gas dryers in her department. At the time, the maintenance supervisor indicated the location of the emergency gas shut off valves was behind the gas dryers on a pipe located near the ceiling. The Maintenance supervisor indicated the height of the emergency shut off valves was 6 feet from the ground. The emergency shut off valve did not have any identifying mark and/or verbiage to indicate the purpose of the valve.</p> <p>On 5/13/15 at 12:50 p.m., Housekeeping staff #1 was interviewed. She indicated she sometimes does laundry at the facility. She indicated she thinks the facility has electric dryers. At 12:51 p.m., Housekeeping staff #2 was</p>			

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	<p>interviewed. She indicated she thinks the facility has electric dryers.</p> <p>On 5/13/15 at 1 p.m., the facility was toured with the Maintenance and Housekeeping Supervisor. They indicated the top floor of the building was the 14th floor but the floor below was designated as the "twelfth floor." They indicated there was no "thirteenth" floor in the facility. They also indicated the 10th and 9th floors were a "locked, secure, dementia unit," and the 4th floor was not occupied by any residents currently but had just been renovated to be utilized as an additional "locked, secure, dementia unit." They indicated the building had been built in 1968 and was formerly a (name of hotel). They also indicated no residents resided in the basement, first and second floors of the facility.</p> <p>The facility census form dated 5/11/15 indicated the current resident census was 123. Observation and review of clinical records indicated more than four residents residing on upper floors in the building were morbidly obese and would be extremely difficult to evacuate down the facility stairwells in a fire emergency. A significant number of residents in the facility had medical disabilities requiring wheelchair mobility and/or staff</p>			

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	<p>assistance with transfers and mobility making them very difficult to evacuate down the stairwells as the elevators were not available during a fire emergency.</p> <p>On 5/13/15 at 2:18 p.m., QMA #33 was interviewed regarding fire safety procedures. She indicated she remembered "PASS" and "RACE" but was unable to identify the accompanying procedure for both acronyms. When questioned what she would do in the event of a fire, she responded "You make me so nervous, I can't think." She was unable to provide fire safety procedure information.</p> <p>On 5/13/15 at 3:20 p.m., CNA #20 was interviewed. She indicated when a tornado warning is enacted; the staff were to ensure all the residents are out of their rooms and in the halls, away from the windows. She indicated also, that the drapes in all the resident's rooms should be pulled closed during a tornado warning.</p> <p>On 5/13/15 at 3:40 p.m., the Maintenance Supervisor was interviewed. He indicated on 5/10/15, when the tornado warning sounded in the building, staff were to ensure the drapes in all the resident's rooms were closed. He also indicated the time frame in which all the</p>			

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	<p>residents would be assisted into the hall on each floor from the time the tornado warning was announced in the building, would be 30 minutes. At this time, he was made aware during the Tornado Warning announced in the building on 5/10/15 at 1:23 p.m., it was observed on the 11th floor, no staff came into a resident's room to alert the resident of the drill and to ensure the drapes in the room were closed from the time the warning was enacted until 1:55 p.m., when the warning was announced as downgraded to a tornado watch. The Maintenance Supervisor indicated the staff had a "push to talk mic (microphone)" (earpiece with a microphone attached, which staff wears on their person and can communicate to other staff throughout the building). He indicated when staff talks on the push to talk mic, anyone with a microphone can hear all conversations on it.</p> <p>On 5/13/15 at 3:45 p.m., the Maintenance Supervisor indicated he had already in-serviced the laundry staff regarding to how to turn off the emergency gas valve for the two gas dryers in the basement. He indicated the two gas dryers and the two boilers were the only mechanical devices which were natural gas in the facility.</p> <p>On 5/13/15 at 4 p.m., CNA #21 was</p>			

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	<p>interviewed. She indicated on the evening shift there were 2 - 3 CNAs staffing 8 floors and the locked dementia units, on the 9th and 10th floors, each had a CNA who remained on that floor for each shift, for a total of 4-5 CNAs in the building. She indicated in the event of a fire and the need to evacuate residents, this would be done by assisting residents in each of the stairwells on the east and/or west end of the building. She indicated residents who were non-ambulatory, would be placed on a blanket on the floor and assisted down the steps in this manner. She indicated it would take less than 20 minutes for the CNAs to check the whole building to ensure resident safety when a fire drill was activated.</p> <p>On 5/13/15 at 4:10 p.m., CNA #22 was interviewed. She indicated if there was a fire, she would evacuate the resident to a lower level than the floor with the fire, but she was unsure exactly which floor to evacuate residents to.</p> <p>On 5/13/15 at 4:15 p.m., the DON was interviewed. She indicated if there was a fire on the 14th floor of the facility she would evacuate residents to one floor below the fire.</p> <p>On 5/13/15 at 4:40 p.m., the</p>			

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	<p>Administrator provided current copies of the facility policy and procedure for "Tornado/Strong Winds." The procedure for "Tornado Warning" included, but was not limited to, the following: "During a declared Tornado Warning: Move the resident into the central hallways away from the windows and account for the presence of all residents. The hallway by the elevators...Shut the doors to the resident rooms when the residents are moved and place a pillow or blanket outside their rooms by the door...close window drapes, shades...to prevent injury from flying glass..."</p> <p>On 5/13/15 at 5 p.m., QMA #32 provided a copy of the "Fire Drill Evaluation Checklist" obtained from the Maintenance Supervisor. This form had documented and highlighted "Tornado Drill." On 5/13/15 at 5:06 p.m., the Maintenance Supervisor was interviewed. He indicated the above form with the highlighted words "Tornado Drill" was documentation of the "Tornado Drill" he had recently conducted on 4/8/15. The form included, but was not limited to, the following information: "Did team members rescue endangered residents...check doors for heat; was the manual pull station activated properly...Fire Department notified appropriately...did team members bring</p>			

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	<p>fire extinguishers...know how to use extinguishers..." The Drill received a total score of 100, which indicated the drill "meets standards." Documentation was lacking on the "Tornado Drill" form of appropriate components of compliance which were documented in the policy and procedure provided by the facility.</p> <p>On 5/13/15 at 5:07 p.m., the Maintenance Supervisor was interviewed and the undated Fire Safety policy and procedure was reviewed. The policy and procedure included, but was not limited to, the following: "...when a fire is reported on your floor everyone is required to evacuate through a set of fire doors on your floor or via the stairs downward at least two floors to a safe area or to the outside..." He indicated the most recent fire drill had been completed within the last quarter. The Maintenance Supervisor indicated the following: when a fire alarm sounds throughout the facility, the floor on which the fire is located and the floors above and below the floor with the fire receive an announcement to evacuate. He further indicated documentation was lacking in the current policy and procedure regarding resident evacuation.</p> <p>B. 1 On 5/12/15 at 11:05 a.m., the 9th floor was observed. The first room east</p>			

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	<p>in the hallway from the nurses ' station was observed. This room was entered through an unlocked door. In the room was observed a hair washing basin with a table top surface over it. On either side of the basin were drawers. In the unlocked top drawer was observed the following: a can of (brand name) shaving cream; (brand name) two containers of stick deodorant; a uncapped safety razor; (brand name) 17 ounce of aerosol hairspray; after shower deodorant body powder; 13.5 ounce of liquid "2 in 1 Shampoo." All of the above personal care products were observed to have the labeling on them of "keep out of reach of children."</p> <p>There were 13 confused and disoriented residents residing on this locked dementia unit.</p> <p>On 5/13/15 at 8:45 a.m., the DON was made aware of the personal care products unsecured on the 9th floor dementia unit. She indicated these items should not have been unsecured. She indicated the door to this room should have been locked.</p> <p>B. 2. An observation of Medication Cart #3, which was located on the 9th floor memory care unit on 5-13-2015 at 10:02 a.m., indicated a 4 ounce bottle of Gel Rite hand sanitizer was in the side</p>			

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R 151 Bldg. 00	<p>compartment of the unattended medication cart. The label on the Gel Rite bottle indicated "...keep out of reach of children..."</p> <p>Several residents were seated in the vicinity of the medication cart.</p> <p>B. 3. An observation of the unattended Medication Cart #3, which was located on the 9th floor memory care unit on 5-13-2015 at 11:30 a.m., indicated the 4 ounce bottle of Gel Rite hand sanitizer remained in the side compartment of the medication cart with several residents seated nearby in the dining area of the unit.</p> <p>410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review the facility failed to ensure 5 of 10 pets housed in the facility had their required immunizations potentially affecting all of the residents and pets residing in the facility.</p>	R 151	By June 26, 2015 and ongoing, all 9 of the facility pets will be current with their annual exams and vaccinations. Moving forward, all pet records and the pet policy must be signed before an animal will be considered to be a part of the community. Staff was in serviced on 5/27/15 to	06/26/2015

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	<p>Findings include:</p> <p>On 5/13/15 at 9:50 a.m., the Social Service Director provided 10 health records for the residents' pets residing in the facility. The residents' pet health records indicated the following:</p> <p>A pet's health record dated 6/10/2013 for a feline (cat) indicated the cat had an examination and a Feline Distemper/Up. Resp. (Upper Respiratory) Booster on 06/10/13. The pet's health record also indicated the Feline Distemper/Up. Resp. Booster was due on 06/10/14 and Rabies Feline 3 year vaccine was due on 02/17/15.</p> <p>A pet's health record dated 09/26/12 for a feline indicated the cat had an examination, a Leukemia/Feline Booster, FVRCP Booster and a Rabies Small Animal Vacc (vaccine) on 9/26/12. The pet's health record indicated the Rabies Vacc - 1 year, FVRCP Booster and Leukemia/Feline booster were overdue on 09/26/13.</p> <p>A pet's health record dated 11/04/13 for a feline indicated the cat had an annual examination, and was given a Feline Rabies Vaccination-1 year and a feline Fel-O-Vax-CaliciVax on 11/4/13. The pet's health record indicated the next</p>		<p>report any new pets found in the community to ensure proper documentation was received. The ED will review all resident agreements within 48 hours of admission. While conducting the quarterly assessment, the nurse will also inquire about the pet's health. There will also be a notice in the resident's clinical chart or file to alert the practitioner of the pet and when their annual vaccinations are exams are due.</p>				

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	<p>vaccines and examination were due on 11/4/14.</p> <p>A non-dated pet's health record for a feline indicated a Rabies Vaccination-1 year was due on 3/11/14 and a Dist/Calici/Rhino-TR Booster was due on 3/11/14.</p> <p>A pet's health record dated 03/01/14 for a canine (dog) indicated Vaccination (7 in 1), Bordetella and DHPP vaccinations were given on 3/1/14.</p> <p>An interview on 5/13/15 at 2:30 p.m., with the Director of Social Services indicated the pets' health records were current and indicated the pets were past due for the required vaccinations. The Social Service Director also indicated the pet's records were kept in the business office and it should have been a team effort to make sure the pets in the facility had their current vaccines.</p> <p>An interview on 5/13/15 at 4:40 p.m., with the Executive Director indicated the pet records were current when the pets first entered the facility. The Executive Director further indicated the pet records needed to be reviewed when the resident's service plans were reviewed; the pet's vaccinations and records would then be current.</p>			

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R 243 Bldg. 00	<p>On 5/11/15 at 2:05 p.m., the Executive Director provided the facility's current, non-dated policy, titled, Pet Policy, which indicated, "...All pets brought on the Community's premises must be registered and the registration must be updated annually...Inoculations...Dogs must be vaccinated in accordance with the appropriate State and local laws. This includes, but is not limited to, canine distemper, infectious hepatitis-lepto series, parvo virus and rabies, with booster shots as needed....Cats must be vaccinated in accordance with the appropriate State and local laws. This includes, but is not limited to, feline enteritis and rabies, with booster shots as needed...."</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</p>			

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	<p>administering the drug or treatment.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation of PRN (as needed) narcotic pain medication for 2 of 2 residents reviewed for PRN narcotic pain medications. (Resident #8 and #4)</p> <p>Findings include:</p> <p>1. A review of Resident #8's record began on 5-11-2015 at 2:30 p.m. The physician orders for May 2015 indicated diagnoses included but were not limited to diabetes, hypertension and interstitial cystitis (bladder inflammation).</p> <p>Physician orders for March 2015 provided by the DON (Director of Nursing) on 5-13-2015 at 8:15 a.m., indicated an order for Percocet, a brand name for oxycod/APAP, 10/325 mg (milligrams) 1 tab po (by mouth) q (every) 4 hours PRN.</p> <p>A review of the March 2015 narcotic sign out sheets indicated the facility maintained 2 separate narcotic count sheets, a Controlled Drug Use Record provided by the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:10 p.m. and a (facility) Individual Narcotic Record provided by the DON on 5-13-2015 at 2:20 p.m. from 3-14-2015</p>	R 243	By June 12, 2015, the revised PRN flowsheets will be implemented for all PRN medications. All nurses and QMA's will be shown how to properly document such medications at a mandatory inservice conducted by the DON on June 2nd. For the next 3 months and ongoing, the Director of Nursing and/or Assistant director of Nursing will audit the PRN Flowsheets to ensure proper documentation has taken place and the record is maintained to make sure this plan stays in place.	06/12/2015			

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	<p>1200 (12:00 p.m.) through 3-22-2015 at 4 p.m.</p> <p>The Percocet 10/325 mg (milligrams) Individual Narcotic Record and the Controlled Drug Use Records for Resident #8 for March 2015 indicated the following dates/times did not have corresponding administration documentation on the PRN Medication Flow Sheet (provided by the Administrator on 5-13-2015 at 1:15 p.m.) and the Medication Record (provided by the DON on 5-13-2015 at 8:15 a.m.) by the nurse or QMA (Qualified Medication Aide):</p> <p>3-3-15 7 a.m., 11 a.m. and 3 p.m. 3-5-15 12 a.m., 3:30 a.m., 11 a.m. 3-6-15 11:30 a.m. and 5:30 p.m. 3-7-15 8:30 a.m., 12:30 p.m. and 4 p.m. 3-8-15 10:30 a.m., 2:30 a.m. and 4 p.m. 3-9-15 11:30 a.m., 3:30 p.m. and 7:30 p.m. 3-10-15 12 a.m. and an illegible time 3-11-15 1 a.m., 8 a.m., and 4 p.m. 3-12-15 9 a.m. and 4 p.m. 3-13-15 12 a.m., 10 a.m. and 4 p.m. 3-14-15 12:30 a.m., 8 a.m. times 2 (given by 2 different nurses), 12 p.m. times 2 (given by 2 different nurses) 3-15-15 12 a.m., 1 a.m., 4 a.m., 8:30 a.m., 4 p.m. and 8 p.m. times 2 (signed out by 2 different nurses) 3-16-15 2 a.m., 8 a.m., 8:30 a.m., 1</p>			

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	<p>p.m., 4 p.m., 6 p.m., 8 p.m. 3-17-15 12 a.m. (given by 2 different nurses-one documented and the other did not document), 8 a.m., 4 p.m., 8 p.m. times 2 (signed out by 2 different nurses) 3-18-15 8 a.m., 9 a.m., 12 p.m., 4 p.m., 8 p.m. times 2 (signed out by 2 different nurses) 3-19-15 1 a.m., 4 a.m., 10 a.m., 4 p.m. times 2 (signed out by 2 different nurses) and 8 p.m. times 2 (signed out by 2 different nurses) 3-20-15 12 a.m., illegible time, 1 p.m., 4 p.m. 3-21-15 12 a.m., 10 a.m., 2 p.m., 4 p.m. 3-22-15 8 a.m., 12 p.m., 4 p.m. time 2 (signed out by 2 different nurses) 3-23-15 12:45 p.m., 4:30 p.m. 3-24-15 8 a.m., 12 p.m., 4 p.m. 3-25-15 8 a.m., 12 p.m., 4 p.m. 3-26-15 8 a.m., 12 p.m., 4 p.m. 3-27-15 12 a.m., 7 a.m., 4 p.m. 3-28-15 12 a.m., 8 a.m., 12 p.m. 3-29-15 3 a.m., 11 a.m., 4 p.m. 3-30-15 12 a.m., 7:30 a.m., 12 p.m., 5 p.m. 3-31-15 12 a.m., 8 a.m., 12 p.m., 4 p.m.</p> <p>Physician orders for April and May 2015, provided by the DON on 5-13-2015 at 8:15 a.m., indicated oxycod/APAP (Endocet, a narcotic pain medication)10 mg/325 mg was ordered "1 tablet by mouth every 4 hours as needed."</p>			

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	<p>The Controlled Drug Use Records for Resident #8 for April and May 2015 and provided by the Administrator on 5-13-2015 at 1 p.m., indicated the following dates/times did not have corresponding administration documentation on the PRN Medication Flow Sheet (provided by the Administrator on 5-13-2015 at 1:15 p.m.) and the Medication Record for April and May 2015 (provided by the DON on 5-13-2015 at 8:15 a.m.) by the nurse or QMA:</p> <p>4-1-15 8 a.m., 12 p.m. 4-2-15 8 a.m., 12 p.m. 4-3-15 8 a.m., 12 p.m., 8 p.m. 4-4-15 8 a.m., 12 p.m. 4-5-15 8 a.m., 12 p.m. 4-6-15 12 a.m., 7 a.m., 5 p.m., 9 p.m. 4-7-15 8 a.m., 12 p.m., 4 p.m. 4-8-15 8 a.m., 12 p.m., 4 p.m. 4-9-15 8 a.m., 12 p.m., 4 p.m. 4-10-15 7 a.m., 11 a.m., 4 p.m., 8 p.m. 4-11-15 12 p.m., 4 p.m., 8 p.m. 4-12-15 7 a.m., 11 a.m., 8 p.m. 4-13-15 12 a.m., 7 a.m., 3 p.m., 8 p.m. 4-14-15 12 a.m. 8 a.m., 12 p.m., 8 p.m. 4-15-15 7 a.m., 11 a.m., 3 p.m. 4-16-15 7 a.m., 11 a.m., 3 p.m. 4-17-15 7 a.m., 11 a.m., 3 p.m., 7 p.m. 4-18-15 2 p.m. 4-19-15 12 a.m., 8 a.m., 12 p.m., 4 p.m. 4-20-15 6:45 a.m., 11 a.m., 3 p.m., 8</p>			

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	<p>p.m.</p> <p>4-21-15 12 a.m., 7 a.m., 12 p.m., 3 p.m.</p> <p>4-22-15 12 a.m., 8 a.m.</p> <p>4-23-15 12 a.m., 8 a.m., 12 p.m., 3 p.m.</p> <p>4-24-15 1600 (4 p.m.), 2000 (8 p.m.)</p> <p>4-25-15 7 a.m., 11 a.m., 3 p.m.</p> <p>4-26-15 0800 (8 a.m.), 1200 (12 p.m.), 4 p.m., 10 p.m.</p> <p>4-27-15 0800 (8 a.m.), 1200 (12 p.m.), 1600 (4 p.m.)</p> <p>4-28-15 7 a.m., 11 a.m., 4 p.m.</p> <p>4-29-15 7 a.m., 11 a.m., 3 p.m.</p> <p>4-30-15 12 a.m., 7 a.m., 11 a.m., 4 p.m.</p> <p>5-1-15 0800 (8 a.m.), 1340 (1:40 p.m.), 2000 (8 p.m.)</p> <p>5-2-15 7 a.m., 11 a.m., 4 p.m., 10 p.m.</p> <p>5-3-15 12 a.m., 8 a.m., 12 p.m., 4 p.m.</p> <p>5-4-15 12 p.m., 1600 (4 p.m.)</p> <p>5-5-15 4:45 a.m., 8 a.m., 12 p.m., 4 p.m.</p> <p>5-6-15 2 a.m., 8 a.m., 4 p.m.</p> <p>5-7-15 1 a.m., 8 a.m., 12 p.m., 3 p.m.</p> <p>5-8-15 3 a.m., 8 a.m., 3 p.m.</p> <p>5-9-15 5 a.m., 2:30 p.m., 8 p.m.</p> <p>5-10-15 8:30 a.m.</p> <p>5-11-15 2 a.m., 8 a.m., 1 p.m., 8 p.m.</p> <p>5-12-15 7 a.m., 12 p.m., 3 p.m.</p> <p>An interview with QMA #5 on 5-13-2015 at 2:20 p.m., indicated for a resident who requested a PRN narcotic pain medication, the QMA would follow this procedure: Check for the order.</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>Contact the nurse for an approval. Label a medication cup with the resident's first initial, last name and room number. Get the narcotic medication from the locked narcotic box in the medication cart. Sign out the narcotic on the controlled drug use record or narcotic count sheet. Chart the narcotic information on the PRN Medication Flow Sheet and sign her initials followed by a slash and flag it for the nurse to sign. Further interview with QMA #8 indicated the date, time, Medication name, reason and initials were to be charted on the PRN Medication Flow Sheet and the Medication Record should be initialed.</p> <p>An interview with the DON on 5-12-2015 at 3:10 p.m., indicated the PRN narcotic pain medications were signed out on the individual narcotic records for the resident and the nurse was to chart the medication administration on the PRN Medication Flow sheet or the Medication Record. Further interview with the DON on 5-13-2015 at 3:15 p.m., indicated the PRN narcotic pain medication should be documented on the PRN Medication Flow Sheet for each time the PRN medication was given. A policy on medication administration was requested.</p>			

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	<p>A documentation policy for medication administration was not provided by the facility.</p> <p>2. Review of the clinical record for Resident #4 on 5/11/15 at 1:50 p.m., indicated the following: diagnoses included, but were not limited to, chronic lower back pain and history of cellulitis (inflammation of the cells of the skin).</p> <p>Physician orders for Resident #4 indicated Oxycodone 20 mg (milligrams) every 8 hours routine (changed from 10 mg every 8 hours on 3/11/15) and Oxycodone 10-20 mg every 6 hours PRN (as needed) for pain.</p> <p>Review of the PRN Medication Flow Sheet, and the Controlled Drug Use Record for Resident #4, for the month of April 2015, indicated the following:</p> <p>On 4/1/15, the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill, indicating she received the Oxycodone PRN as ordered. There was no PRN Medication Flow Sheet available for review.</p> <p>On 4/18/15 at 8:00 p.m. and 4/19/15 at 12:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill, indicating she</p>			

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	<p>received the Oxycodone PRN as ordered. There was no PRN Medication Flow Sheet available for review.</p> <p>Review of the PRN Medication Flow Sheet, and the Controlled Drug Use Record for Resident #4, for the month of May 2015, indicated the following:</p> <p>On 5/9/15 at 4:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill at 4:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>On 5/9/15 at 8:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill at 8:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>On 5/10/15, the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill at 4:00 a.m., at 4:00 p.m., and at 8:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>The ADON was interviewed on 5/13/15 at 10:05 a.m. During the interview she indicated all PRN narcotics given were to</p>			

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R 300 Bldg. 00	<p>be recorded on the PRN Medication Flow Sheet.</p> <p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.</p> <p>Based on observation, interview and record review, the facility failed to ensure open dates were recorded on multi-use vials of insulin/insulin pens for 5 of 49 vials of opened insulin and 2 of 5 insulin pens which were stored out on a counter in the medication storage room.</p> <p>Findings include:</p> <p>An observation of the opened insulin vials and insulin pens in the medication room on 5-12-2015 at 10:30 a.m., indicated the following did not have open dates written on them:</p> <p>A vial of Novolog with a prescription date of 5-6-2015 A vial of Humalog with a prescription date of 4-3-2015 A vial of Humulin N with a prescription date of 4-18-2015 A vial of Humalog with a prescription date of 4-30-2015</p>	R 300	<p>By 6/5/15, all nurses will be in serviced on the importance of labeling insulin when opened. Grandview Pharmacy will provide "date opened" stickers that may be utilized. The director of nursing or assistant director of nursing will inspect all open vials and pens containing insulin weekly for the next 3 months. Ongoing, the nursing management will periodically check all insulins to ensure they have been dated will make sure this plan stays in place.</p>	06/05/2015

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	<p>A vial of Humulin 70/30 with a prescription date of 2-16-2015</p> <p>A Lantus Solostar insulin pen without a prescription date</p> <p>A Levemir Flex Touch pen without a prescription date</p> <p>An interview with the ADON (Assistant Director of Nursing) on 5-12-2015 at 10:57 a.m., indicated the above insulin vials and pens did not have open dates written on them.</p> <p>An interview with LPN #1 and the ADON on 5-12-2015 at 11:00 a.m., indicated the Levemir pen was pulled last week on Thursday, 5-7-2015, as well as the Novolog vial and the Humulin N vial. Further interview with the LPN #1 indicated she was not aware of when the 2 Humalog vials and the Humulin 70/30 vials were opened. LPN #1 indicated the insulin vials/pens should be dated as soon as the vials/pen were opened.</p> <p>An interview with the ADON on 5-13-2015 at 3:20 p.m., indicated there are daily task sheets for nursing staff to ensure open dates were on opened insulin vials/pen.</p> <p>A Daily Task Sheet for each of the medication carts was provided by the ADON on 5-13-2015 at 3:35 p.m. and</p>			

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	<p>indicated the following: "...Cart 1 and Cart 4...Tasks to be done EVERY SHIFT, EVERYDAY, EVERYBODY... Tuesday 6a - 2p check insulins for expirations, open dates...Friday 2p - 10p check insulins for expirations, open dates...</p> <p>An interview with the Administrator on 5-13-2015 at 4:42 p.m., indicated the facility did not have a policy for recording open dates on the opened insulin vials/pens.</p> <p>The Nursing 2014 Drug Handbook indicated the following information on insulin storage at room temperature: "...opened vials...of Novolog are stable at room temperature for 28 days..." For Levemir Flex Touch Pen "...after initial use, a cartridge...may be used for up to 42 days if kept at room temperature..." For Lantus "...advise patient on proper drug storage...discard...opened...cartridge system after 28 days whether refrigerated or not..."</p> <p>A website, pi.lilly.com/us/humalog-kwikpen-um.pdf obtained 5-14-2015 at 1:27 p.m., for Humalog Prescribing Information - Eli Lilly and Company indicated the</p>			

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R 301 Bldg. 00	<p>following: "...in use Humalog vials...should be stored at room temperature...and must be used within 28 days or be discarded, even if they still contain Humalog..."</p> <p>A website, www.pi.lilly.com/us/HUMULIN-7030-IFU.pdf obtained 5-14-2015 at 1:30 p.m., for Humulin 70/30 -Instructions for use Humulin 70/30 indicated the following: "...after Humulin 70/30 vials have been opened...store...at room temperature for up to 31 days...throw away all opened vials after 31 days of use, even if there is still insulin left in the vial..."</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (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</p>			

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	<p>permitted. Based on observation, interview and record review, the facility failed to ensure prescription medications/ointments/creams were labeled with a pharmacy label in 2 of 4 medication carts (Medication Carts #3 and #4), 1 of 3 overflow medication carts (Overflow Medication Cart #4) and 1 of 1 treatment cart.</p> <p>1. An observation of the treatment cart with LPN #1 (Licensed Practical Nurse) on 5-12-2015 at 9:35 a.m., indicated the following were found: A tube of Lidocaine 2.5 and Prilocaine cream (a physician prescribed numbing cream) 30 grams which was mostly used and did not have a pharmacy label affixed to the tube. A partially used tube of Santyl (physician prescribed wound care treatment) 30 grams did not have a pharmacy label affixed to the tube.</p> <p>An interview with LPN #1 on 5-12-2015 at 9:55 a.m., indicated the treatments should have had labels.</p> <p>2. An observation of the Medication Overflow cart #4 on 5-12-2015 at 10:00 a.m., indicated 9 packets of Renvela 2.4 grams (a physician prescribed medication for dialysis patients) were in the top</p>	R 301	Nursing is to properly label all prescription medications with the residents name, physician's name, prescription number, expiration date (if not on the manufacture label), date issued (if indicated) Name and strength of drug (if not on the manufacture's label), Directions for use, Pharmacy name and address where filled. Each Medication Cart will be audited by the assigned nursing staff member and will check off on related task sheet by 6/12/15. On going, nursing management will conduct audits to ensure proper labeling to make sure this plan stays in place. All nursing staff attended an in-service on 6/2/15 and nursing management provided examples of the proper way to label all medications.	06/12/2015			

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	<p>drawer of the cart without a prescription label affixed. An interview with LPN #1 indicated she was unsure why the packets were in the drawer.</p> <p>3. An observation of Medication Cart #4 with LPN #3 on 5-12-2015 at 10:10 a.m., indicated 23 individual blister packs of Ferrex 150 mg (milligrams) caplets (a physician prescribed mineral iron) were in a compartment in the top drawer of the medication cart loose and unlabeled. There was not a prescription label to identify the resident name, ordering physician or the directions for use. An interview with LPN #3 indicated she did not know which resident the Ferrex medication belonged to.</p> <p>4. An observation of Medication Cart #3, located on the 9th floor memory unit with QMA #4 (Qualified Medication Aide) on 5-13-2015 at 10:40 a.m., indicated the following: In the top drawer, an opened bottle of Dorzolamide HCl-Timolol Maleate Ophthalmic solution (for glaucoma) with a resident name written on the bottle, did not have a prescription label to identify the ordering physician, the directions for use, the date of issue or the pharmacy who filled the prescription. An opened date was not written on the bottle. In the top drawer, an Advair Diskus</p>			

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	<p>inhaler was in a compartment without a prescription label to identify the resident, the ordering physician, the directions for use, the date of the prescription, the opened date or the pharmacy who filled the prescription.</p> <p>An interview with QMA #4 indicated she did not know which resident the Advair Diskus belonged. Further interview with the QMA indicated the medications should have had prescription labels.</p> <p>An interview with the DON (Director of Nursing) on 5-13-2015 at 3:15 p.m., indicated the treatments, Advair Diskus inhaler and Niferex should have had prescription labels on them and been stored in a plastic bag.</p> <p>A current undated policy, "Medication Storage in the Assisted Living Facility" and provided by the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:55 p.m., indicated "...Medications are stored safely, securely and properly...and in accordance with federal and state laws and regulations...."</p> <p>An interview with the Administrator on 5-13-2015 at 4:42 p.m., indicated the facility had no further policies or information on labeling of prescription medications.</p>			

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R 302 Bldg. 00	<p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on observation, interview and record review, the facility failed to ensure OTC (Over the Counter) medications/ointments/treatments/creams were labeled with the resident and physician name in 2 of 4 medication carts (Medication Cart #3 and 4), 2 of 3 medication overflow carts (Medication Overflow cart #2 and #4) and 1 of 1 treatment cart.</p> <p>Findings include:</p> <p>1. During an observation of the treatment cart with LPN (Licensed Practical Nurse) #1 on 5-12-2015 at 9:35 a.m., the following were observed without labels to identify the resident or the prescribing physician: An opened and partially used 1.5 ounce tube of Medi-Honey, An opened and partially used 8.5 ounce bottle of Aloe Gel,</p>	R 302	<p>Nursing is to properly label all OTC medications with the residents name, physician's name, expiration date (if not on the manufacture label), Name and strength of drug (if not on the manufacture's label), Each Medication Cart will be audited by the assigned nursing staff member and will check off on related task sheet by 6/5/15. On going, nursing management will conduct audits to ensure proper labeling to make sure this plan stays in place. All nursing staff attended an in-service on 6/2/15 and nursing management provided examples of the proper way to label all medications.</p>	06/05/2015

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	<p>An opened and partially used 4 ounce bottle of Medline Remedy Nutrashield, A 5 ounce spray bottle of Nix (a spray for lice),</p> <p>An opened and partially used 8 ounce bottle of Scrub Care Providone Iodine Topical Solution, and</p> <p>An opened and partially used 2 ounce tube of Vitamin A & D ointment</p> <p>An interview with LPN #1 on 5-12-2015 at 9:55 a.m., indicated the ointments/topicals and treatments should have had labels on them. The LPN indicated "these items have to have labels when the products come in and if there is not a label, we are supposed to put labels on them."</p> <p>2. An observation of Medication Overflow Cart #2 with LPN #1 on 5-12-2015 at 9:56 a.m., indicated a bottle of Occuvite Adult 50 tabs was in the 2nd drawer without a label to identify the name of the resident or the prescribing physician.</p> <p>An interview with LPN #1 on 5-12-2015 at 9:58 a.m., indicated the Occuvite was not labeled "right."</p> <p>3. An observation of the Medication Overflow Cart #4 with LPN #1 on 5-12-2015 at 10:00 a.m., indicated the</p>			

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	<p>following were not labeled with a resident or physician name: 2 Boxes of Mucus [sic] Relief DM with 10 tabs in each box, One 12 ounce bottle of Milk of Magnesia, A box of laxative suppositories, and An opened bottle of Tylenol 500 mg (milligram) Extra Strength 24 capsule</p> <p>An interview with LPN #1 on 5-12-2015 at 10:07 a.m., indicated "these were supposed to be labeled when they came in."</p> <p>4. An observation of Medication Cart #4 with LPN #3 on 5-12-2015 at 10:10 a.m., indicated the following were not labeled with a resident or physician name: An opened bottle of Persersivision 120 soft gel caps and A container of Gas Relief 60 tabs</p> <p>5. An observation of Medication Cart #3 located on the 9th floor with QMA (Qualified Medication Aide) #4 on 5-13-2015 at 10:40 a.m., indicated the following OTC medications were not labeled with a resident or physician name: A bottle of CoQ10 and A bottle of Vitamin D3 1000 IU (International Units) 300 tabs</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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R 304	<p>An interview with QMA #4 on 5-13-2015 at 10:50 a.m., indicated the OTC medication bottles should have a label with the resident's name, physician's name, date, dose and the resident's room number.</p> <p>An interview with the DON (Director of Nursing) on 5-13-2015 at 3:15 p.m., indicated the OTC medications/treatments should be labeled with the Resident and Physician name.</p> <p>A current undated policy, "Medication Storage in the Assisted Living Facility" and provided by the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:55 p.m., indicated "...Medications are stored safely, securely and properly...and in accordance with federal and state laws and regulations...."</p> <p>An interview with the Administrator on 5-13-2015 at 4:42 p.m., indicated the facility had no further policies or information on labeling of OTC medications.</p>						
	410 IAC 16.2-5-6(e)						

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Bldg. 00	<p>Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to ensure prescription and over the counter (OTC) medications were maintained in a locked, secure manner for 2 of 2 medication storage areas/medication rooms in the facility. This had the potential to affect 13 confused and disoriented residents residing on the 9th floor dementia unit.</p> <p>Findings include:</p> <p>1. On 5/12/15 at 11:20 a.m., the 9th floor dining room on the locked, secured dementia unit was observed on the north side of the hall. Directly across the dining room on the south side of the hall, was a row of cabinets on the wall, with the bottom of the cabinets 4 1/2 feet from the floor. The cabinets were able to be accessed directly from the hall as there was no observed barrier to prevent entrance to this area. The cabinets were observed to have a keyed locking mechanism on the inner bottom corner of each cabinet door. A cabinet door, which appeared to be closed and was</p>	R 304	<p>On 5/27/15, all of the locks on the Memory Care units were checked and or replaced where indicated. Staff was made aware that they are to never leave medications unsecured in a defective cabinet or storage area. They are to secure all medications and notify maintenance immediately. Ongoing, the maintenance department and Memory Care Director will conduct weekly rounds to ensure all locked doors and cabinets are working properly to make sure this plan stays in place.</p>	05/27/2015			

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	<p>positioned flush with the adjoining cabinet door, was easily opened without the use of a key. When opened, this cabinet was observed to have a label on the shelf of "overflow" medications. At the time, the QMA (Qualified Medication Assistant) on the floor had left this area to pass medications on the 10th floor, so at this time, the area was unsupervised by facility QMA and/or professional nursing staff. The CNA (certified nursing assistant) on the unit was across the hall in the dining area, passing out drinks to residents. The CNA was not aware the medication cabinet was unlocked and did not remain in constant visual field of the cabinets. At 11:35 a.m., QMA #31 returned to the floor and was made aware the cabinet door, which contained the "overflow" medications was not locked. At 11:40 a.m. the top shelf of the cabinet was observed with QMA #31 with the following medications observed: antifatulent pills, 2 bottles of Aspirin 81 mg (milligrams), Lomotil, Aspirin 325 mg, Lidoderm patches, Flector patches and simethicone 80 mg pills. The middle shelf was observed to have the following medications: 3 bottles of Milk of Magnesia, 2 bottles of Robafen syrup, 2 boxes of Albuterol individually packages treatment doses; 3 boxes of Spiriva, Enoxaparin Injectable, Advair, Timolol eye drops, Potassium Chloride Extended</p>			

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	<p>release 10 MEQ (milliequivalents) in a non safety capped medication bottle; 3 bottles of Cranberry Concentrate 4200 mg, 750 capsules of Stool Softner, 3 bottles of Vitamin B12, multivitamins, 2 bottles of fish oil, Vitamin B1 pills, calcium 600mg +D 500mg and Vitamin D2 pills. The bottom shelf was observed to have the following: Zofran, Dulcolax, Tessalon, Pepcid, Renvelta, Prednisone, Carvediol, Potassium Chloride, Tessalon, Voltarex, Benadryl, Refresh eye drops, Timolol, Ipratropium nasal spray, Namenda, Divalproex, Vitamin D3, Lisinopril, Risperdal (antipsychotic), Lasix, Aspirin, Benzona, Fish oil, Metoprolol, Urecholine, Bumex, Celexa, Vitamin D, Prostate Capsules, Colace, Oxybutrin, Tegretol, Fiber, Fosamax, Gaviscon, Mucinex, Vitamin B12, Vitamin D3 x 2 bottles, Flonase and Artificial Tears. After the medication cabinet was observed, QMA #31 was observed to insert a key into the keyhole when the cabinet door was closed.</p> <p>On 5/13/15 at 8:45 a.m., the DON was made aware of the unsecured medications in the 9th floor cabinets for the overflow medications. She indicated these medication should be locked at all times.</p> <p>On 5/13/15 at 8:55 a.m., the wall cabinets, which were located on the 9th</p>			

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	<p>floor were observed. The cabinet door, which was observed on 5/12/13 at 11:20 a.m. was again opened by pulling on the knob without the use of a key. The interior of the cabinet was observed to have the "overflow medications, prescription and over the counter (OTC) medications as observed in this location on 5/12/15 at 11:20 a.m. At this time, QMA #30 was interviewed regarding the unlocked, unsecured medications in the cabinet. She indicated at this time, "They are working on the door today."</p> <p>On 5/13/15 at 4 p.m., the Maintenance Man was interviewed. He indicated prior to 5/12/15, he did not have any maintenance request to repair the non functioning lock on the cabinet door on the 9th floor. 2. 5/13/15 at 4:30 p.m., an unidentified resident was observed to open the medication room door located on the 2nd floor near the main dining room. The unidentified resident indicated there was no one in the medication room. It was observed the second floor medication room was unlocked and there were no staff in the the medication room. It was also observed the area outside the medication room there were several residents waiting to go to the dining room. In the unlocked medication room, 3 over flow medication carts and 1 treatment cart were unlocked.</p>			

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R 349 Bldg. 00	<p>The medication carts contained prescription and over the counter medication and the treatment cart contained treatment creams and ointments. 49 opened vials of insulin and a large container of PDI (bleach wipes) were observed out on the countertop in the medication room.</p> <p>An interview with the Executive Director on 5/13/15 at 4:33 p.m., indicated she was unaware the medication room, the medication carts, treatment cart and insulin was unsecured and unattended. She further indicated the medication room should be locked when unattended.</p> <p>A current undated policy, "Medication Storage in the Assisted Living Facility" and provided by the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:55 p.m., indicated "...Medications storage areas, rooms, and carts are kept locked. Only authorized personnel are allowed access to the medication storage area...."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as</p>			

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	<p>follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate resident clinical records for 2 of 2 residents (Resident #8 and Resident #4) reviewed for pain medication potentially affecting 121 of 123 residents whose medication was administered by the facility.</p> <p>Findings include:</p> <p>1. A review of Resident #8's record began on 5-11-2015 at 2:30 p.m. The physician orders for May 2015 indicated diagnoses included but were not limited to diabetes, hypertension and interstitial cystitis (bladder inflammation).</p> <p>Physician orders for March 2015 provided by the DON (Director of Nursing) on 5-13-2015 at 8:15 a.m., indicated an order for Percocet, a brand name for oxycod/APAP, 10/325 mg (milligrams) 1 tab po (by mouth) q (every) 4 hours PRN.</p> <p>A review of the March 2015 narcotic sign out sheets indicated the facility maintained 2 separate narcotic count sheets, a Controlled Drug Use Record</p>	R 349	This seems to be the same citation as 0243. I have entered how we will ensure proper documentation in our response to 0243.	06/05/2015

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	<p>provided by the ADON (Assistant Director of Nursing) on 5-13-2015 at 3:10 p.m. and a (facility) Individual Narcotic Record provided by the DON on 5-13-2015 at 2:20 p.m. from 3-14-2015 1200 (12:00 p.m.) through 3-22-2015 at 4 p.m.</p> <p>The Percocet 10/325 mg (milligrams) Individual Narcotic Record and the Controlled Drug Use Records for Resident #8 for March 2015 indicated the following dates/times did not have corresponding administration documentation on the PRN Medication Flow Sheet (provided by the Administrator on 5-13-2015 at 1:15 p.m.) and the Medication Record (provided by the DON on 5-13-2015 at 8:15 a.m.) by the nurse or QMA (Qualified Medication Aide):</p> <p>3-3-15 7 a.m., 11 a.m. and 3 p.m. 3-5-15 12 a.m., 3:30 a.m., 11 a.m. 3-6-15 11:30 a.m. and 5:30 p.m. 3-7-15 8:30 a.m., 12:30 p.m. and 4 p.m. 3-8-15 10:30 a.m., 2:30 a.m. and 4 p.m. 3-9-15 11:30 a.m., 3:30 p.m. and 7:30 p.m. 3-10-15 12 a.m. and an illegible time 3-11-15 1 a.m., 8 a.m., and 4 p.m. 3-12-15 9 a.m. and 4 p.m. 3-13-15 12 a.m., 10 a.m. and 4 p.m. 3-14-15 12:30 a.m., 8 a.m. times 2 (given by 2 different nurses), 12 p.m.</p>			

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	<p>times 2 (given by 2 different nurses) 3-15-15 12 a.m., 1 a.m., 4 a.m., 8:30 a.m., 4 p.m. and 8 p.m. times 2 (signed out by 2 different nurses) 3-16-15 2 a.m., 8 a.m., 8:30 a.m., 1 p.m., 4 p.m., 6 p.m., 8 p.m. 3-17-15 12 a.m. (given by 2 different nurses-one documented and the other did not document), 8 a.m., 4 p.m., 8 p.m. times 2 (signed out by 2 different nurses) 3-18-15 8 a.m., 9 a.m., 12 p.m., 4 p.m., 8 p.m. times 2 (signed out by 2 different nurses) 3-19-15 1 a.m., 4 a.m., 10 a.m., 4 p.m. times 2 (signed out by 2 different nurses) and 8 p.m. times 2 (signed out by 2 different nurses) 3-20-15 12 a.m., illegible time, 1 p.m., 4 p.m. 3-21-15 12 a.m., 10 a.m., 2 p.m., 4 p.m. 3-22-15 8 a.m., 12 p.m., 4 p.m. time 2 (signed out by 2 different nurses) 3-23-15 12:45 p.m., 4:30 p.m. 3-24-15 8 a.m., 12 p.m., 4 p.m. 3-25-15 8 a.m., 12 p.m., 4 p.m. 3-26-15 8 a.m., 12 p.m., 4 p.m. 3-27-15 12 a.m., 7 a.m., 4 p.m. 3-28-15 12 a.m., 8 a.m., 12 p.m. 3-29-15 3 a.m., 11 a.m., 4 p.m. 3-30-15 12 a.m., 7:30 a.m., 12 p.m., 5 p.m. 3-31-15 12 a.m., 8 a.m., 12 p.m., 4 p.m.</p> <p>Physician orders for April and May 2015,</p>			

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	<p>provided by the DON on 5-13-2015 at 8:15 a.m., indicated oxycod/APAP (Endocet, a narcotic pain medication)10 mg/325 mg was ordered "1 tablet by mouth every 4 hours as needed."</p> <p>The Controlled Drug Use Records for Resident #8 for April and May 2015 provided by the Administrator on 5-13-2015 at 1 p.m., indicated the following dates/times did not have corresponding administration documentation on the PRN Medication Flow Sheet (provided by the Administrator on 5-13-2015 at 1:15 p.m.) and the Medication Record for April and May 2015 (provided by the DON on 5-13-2015 at 8:15 a.m.) by the nurse or QMA:</p> <p>4-1-15 8 a.m., 12 p.m. 4-2-15 8 a.m., 12 p.m. 4-3-15 8 a.m., 12 p.m., 8 p.m. 4-4-15 8 a.m., 12 p.m. 4-5-15 8 a.m., 12 p.m. 4-6-15 12 a.m., 7 a.m., 5 p.m., 9 p.m. 4-7-15 8 a.m., 12 p.m., 4 p.m. 4-8-15 8 a.m., 12 p.m., 4 p.m. 4-9-15 8 a.m., 12 p.m., 4 p.m. 4-10-15 7 a.m.,11 a.m., 4 p.m., 8 p.m. 4-11-15 12 p.m., 4 p.m., 8 p.m. 4-12-15 7 a.m., 11 a.m., 8 p.m. 4-13-15 12 a.m., 7 a.m., 3 p.m., 8 p.m. 4-14-15 12 a.m. 8 a.m., 12 p.m., 8 p.m. 4-15-15 7 a.m., 11 a.m., 3 p.m.</p>			

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	<p>4-16-15 7 a.m., 11 a.m., 3 p.m. 4-17-15 7 a.m., 11 a.m., 3 p.m., 7 p.m. 4-18-15 2 p.m. 4-19-15 12 a.m., 8 a.m., 12 p.m., 4 p.m. 4-20-15 6:45 a.m., 11 a.m., 3 p.m., 8 p.m. 4-21-15 12 a.m., 7 a.m., 12 p.m., 3 p.m. 4-22-15 12 a.m., 8 a.m. 4-23-15 12 a.m., 8 a.m., 12 p.m., 3 p.m. 4-24-15 1600 (4 p.m.), 2000 (8 p.m.) 4-25-15 7 a.m., 11 a.m., 3 p.m. 4-26-15 0800 (8 a.m.), 1200 (12 p.m.), 4 p.m., 10 p.m. 4-27-15 0800 (8 a.m.), 1200 (12 p.m.), 1600 (4 p.m.) 4-28-15 7 a.m., 11 a.m., 4 p.m. 4-29-15 7 a.m., 11 a.m., 3 p.m. 4-30-15 12 a.m., 7 a.m., 11 a.m., 4 p.m. 5-1-15 0800 (8 a.m.), 1340 (1:40 p.m.), 2000 (8 p.m.) 5-2-15 7 a.m., 11 a.m., 4 p.m., 10 p.m. 5-3-15 12 a.m., 8 a.m., 12 p.m., 4 p.m. 5-4-15 12 p.m., 1600 (4 p.m.) 5-5-15 4:45 a.m., 8 a.m., 12 p.m., 4 p.m. 5-6-15 2 a.m., 8 a.m., 4 p.m. 5-7-15 1 a.m., 8 a.m., 12 p.m., 3 p.m. 5-8-15 3 a.m., 8 a.m., 3 p.m. 5-9-15 5 a.m., 2:30 p.m., 8 p.m. 5-10-15 8:30 a.m. 5-11-15 2 a.m., 8 a.m., 1 p.m., 8 p.m. 5-12-15 7 a.m., 12 p.m., 3 p.m.</p> <p>An interview with QMA #5 on</p>			

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	<p>5-13-2015 at 2:20 p.m., indicated for a resident who requested a PRN narcotic pain medication, the QMA would follow this procedure:</p> <p>Check for the order.</p> <p>Contact the nurse for an approval.</p> <p>Label a medication cup with the resident's first initial, last name and room number.</p> <p>Get the narcotic medication from the locked narcotic box in the medication cart.</p> <p>Sign out the narcotic on the controlled drug use record or narcotic count sheet.</p> <p>Chart the narcotic information on the PRN Medication Flow Sheet and sign her initials followed by a slash and flag it for the nurse to sign.</p> <p>Further interview with QMA #8 indicated the date, time, Medication name, reason and initials were to be charted on the PRN Medication Flow Sheet and the Medication Record should be initialed.</p> <p>An interview with the DON on 5-12-2015 at 3:10 p.m., indicated the PRN narcotic pain medications were signed out on the individual narcotic records for the resident and the nurse was to chart the medication administration on the PRN Medication Flow sheet or the Medication Record. Further interview with the DON on 5-13-2015 at 3:15 p.m., indicated the PRN narcotic pain</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>medication should be documented on the PRN Medication Flow Sheet for each time the PRN medication was given. A policy on medication administration was requested.</p> <p>A documentation policy for medication administration was not provided by the facility.</p> <p>2. Review of the clinical record for Resident #4 on 5/11/15 at 1:50 p.m., indicated the following: diagnoses included, but were not limited to, chronic lower back pain and history of cellulitis (inflammation of the cells of the skin).</p> <p>Physician orders for Resident #4 indicated Oxycodone 20 mg (milligrams) every 8 hours routine (changed from 10 mg every 8 hours on 3/11/15) and Oxycodone 10-20 mg every 6 hours PRN (as needed) for pain.</p> <p>Review of the Medication Administration Record (MAR), the PRN Medication Flow Sheet, and the Controlled Drug Use Record for Resident #4, for the month of March 2015, indicated the following discrepancies:</p> <p>On 3/5/15 at 5:00 a.m., the PRN Medication Flow Sheet indicated Oxycodone 10 mg was given for general pain. There was no corresponding date</p>			

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	<p>and time on the Controlled Drug Use Record indicating the medication was signed out by staff and given.</p> <p>On 3/8/15 at 8:30 a.m., the PRN Medication Flow Sheet indicated Oxycodone 10 mg was given for general pain. There was no corresponding date and time on the Controlled Drug Use Record indicating the medication was signed out by staff and given.</p> <p>On 3/29/15, the MAR indicated Oxycodone 10 mg PRN was given. There was no documentation on the PRN Medication Flow Sheet or corresponding date and time on the Controlled Drug Use Record indicating the medication was signed out by staff and given.</p> <p>Review of the PRN Medication Flow Sheet, and the Controlled Drug Use Record for Resident #4, for the month of April 2015, indicated the following discrepancies:</p> <p>On 4/1/15, the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill, indicating she received Oxycodone PRN as ordered. The Controlled Drug Use Record indicated the number of pills left decreased from 20 to 18, instead of 19. There was no PRN Medication Flow</p>						

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	<p>Sheet available for review.</p> <p>On 4/18/15 at 8:00 p.m. and 4/19/15 at 12:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill, indicating she received the Oxycodone PRN as ordered. The Controlled Drug Use Record indicated the number of pills left decreased from 31 to 29, instead of 30. There was no PRN Medication Flow Sheet available for review.</p> <p>Review of the PRN Medication Flow Sheet, and the Controlled Drug Use Record for Resident #4, for the month of May 2015, indicated the following discrepancies:</p> <p>On 5/9/15 at 4:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill at 4:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>On 5/9/15 at 8:00 p.m., the Controlled Drug Use Record for Resident #4, indicated she received 1 Oxycodone pill at 8:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>On 5/10/15, the Controlled Drug Use</p>			

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	<p>Record for Resident #4, indicated she received 1 Oxycodone pill at 4:00 a.m., at 4:00 p.m., and at 8:00 p.m., indicating she received the Oxycodone PRN as ordered. The PRN Medication Flow Sheet was blank.</p> <p>The ADON was interviewed on 5/13/15 at 10:05 a.m. During the interview she indicated all PRN narcotics given were to be recorded on the PRN Medication Flow Sheet.</p>						