

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 11/03/2014
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NAME OF PROVIDER OR SUPPLIER  LAMPLIGHT INN AT THE LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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R000000	<p>This visit was for the Investigation of Complaints IN00157180, IN00157186, IN00157462 and IN158164.</p> <p>Complaint IN00157180 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00157462 -- Substantiated. State residential deficiencies related to the allegations are cited at R045, R064, R241, R296 and R349.</p> <p>Complaint IN00157816 -- Substantiated. State residential deficiencies related to the allegations are cited at R064, R157, R241, R296, R297 and R349.</p> <p>Complaint IN00158164 -- Substantiated. State residential deficiency related to the allegations is cited at R144.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: October 28, 29, 30 and 31, 2014 and November 3, 2014</p> <p>Facility number: 012497 Provider number: 012497 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p>	R000000	<p>This Plan of Correction (POC) is prepared and executed because it is required by the provisions of State and Federal Law, and not because Lamplight Inn at the Leland agrees with the allegations contained there-in.</p> <p>Please let this POC response serve as the facility's Credible Allegation of Compliance.</p>	
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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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R000045	<p>Census bed type: Residential: 82 Total: 82</p> <p>Census Payor type: Other: 82 Total: 82</p> <p>Sample: 6</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on November 6, 2014 by Cheryl Fielden, RN.</p> <p>410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman</p>			
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	<p>program (for involuntary relocations or discharges only).</p> <p>(v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.</p> <p>(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.</p> <p>(vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).</p> <p>(B) Record the reasons in the resident ' s clinical record.</p> <p>(C) Include in the notice the items described in subdivision (9).</p> <p>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.</p> <p>(8) Notice may be made as soon as practicable before transfer or discharge when:</p> <p>(A) the safety of individuals in the facility would be endangered;</p> <p>(B) the health of individuals in the facility would be endangered;</p> <p>(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;</p> <p>(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or</p> <p>(E) a resident has not resided in the facility for thirty (30) days.</p> <p>(9) For health facilities, the written notice specified in subdivision (7) must include the following:</p> <p>(A) The reason for transfer or discharge.</p> <p>(B) The effective date of transfer or</p>			

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	<p>discharge.</p> <p>(C) The location to which the resident is transferred or discharged.</p> <p>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. "</p> <p>(E) The name of the director and the address, telephone number, and hours of operation of the division.</p> <p>(F) A hearing request form prescribed by the department.</p> <p>(G) The name, address, and telephone number of the state and local long term care ombudsman.</p> <p>(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.</p> <p>Based on interview and record review, the facility failed to provide to 1 of 1 residents reviewed for discharge, prior to a discharge to another facility for</p>	R000045	A. Resident B was not discharged from facility until 11/3/14, when resident notified us she would not be returning from her rehab stay. Resident's family moved furniture	12/23/2014			

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	<p>rehabilitation services, the state form for transfer and/or discharge This deficient practice could adversely affect the resident's right for appeal of a transfer/discharge. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 10-31-14 at 11:05 a.m. Her diagnoses included, but were not limited to, chronic essential tremors, anxiety, depression, heart disease, lung disease, neuropathy and diabetes.</p> <p>In review of the nursing notes, dated 10-9-14 and signed by the Director of Nursing (DON), indicated the resident had received new orders from her physician for a soft diet and to be supervised during eating. The notes indicated the DON discussed this with the physician and with Resident #B. It indicated, "Resident stated she would be more comfortable in rehab setting." It indicated the resident provided the names of 3 different facilities she would prefer to be transferred to for rehab services. It indicated the resident was approved for admission at the third facility of her choice. Nursing notes, dated 10-12-14 and signed by the DON, indicated the attending physician had requested the resident for stat (immediate) tests to be</p>		<p>out on 11/2/14 and notified front desk. At resident B request, facility was arranging a temporary rehab stay at a local ECF of resident's choosing, for her swallowing issues. While waiting for Area 9 approval, facility received another order from physician to transfer resident B to hospital for STAT testing. Resident's return to facility was expected prior to transfer to ECF rehab. While at the hospital, the ECF received Area 9 approval for the temporary rehab and transferred resident directly from hospital to ECF. The proper Patient Transfer Form (attached) was used for the transfer to the hospital.</p> <p>Policy was followed properly with final discharge being 11/3/14. The Discharged Residents list given state surveyors upon entry had the incorrect discharge date for resident B (an error by our Bus. Off.). The medical record and facility census report clearly reflect resident was on facility bed hold with return expected, until notified by resident/family that resident would not be returning.</p> <p>B. At risk would be any resident being discharged from facility. A review of the records for residents discharged in the past six months was completed by the DON and no residents were adversely affected by this citing.</p> <p>C. All licensed staff has been in-serviced 11/20/14, on proper completion of transfer forms, both</p>				

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	<p>conducted at the local hospital. It indicated the facility which had accepted the resident for transfer had contacted the facility and requested a physician's order for the transfer. It indicated Resident #B's attending physician was unavailable and an emergency admission order was obtained from the facility's Medical Director. It indicated the resident was informed of this and was aware she would transfer directly from the hospital upon completion of her testing to the skilled nursing facility.</p> <p>In an interview with the DON on 10-31-14 at 1:10 p.m., she indicated Resident #B was not discharged from the facility as she still has her belongings in her room. She indicated the resident was currently in rehab therapy at an area skilled nursing facility.</p> <p>In an interview with the Administrator on 10-31-14 at 1:10 p.m., he indicated he had placed Resident #B on the discharge list as a means to ensure the census numbers for the corporate numbers to be correct. He indicated he would need to verify the actual discharge dates.</p> <p>A listing of residents who had transferred or discharged from the facility in the last 6 months was provided by the Administrator on 10-28-14 at 3:00 p.m.</p>		<p>temporary transfer and for discharge transfer. A separate transfer form will be sent with each resident being transferred, as well as included in their packet. This will assure each resident has received their individual copy. A Transfer Tracking Sheet has been added to be completed for each transfer and to provide the tool to better monitor the process. All licensed staff will have been in-serviced on these changes 12/23/14.</p> <p>D. DON or designee will review all Involuntary/Voluntary Discharge Transfers for proper documentation and completion, monthly for six months and report findings to the administrator quarterly. Compliance will be achieved with three months of continual compliance.</p> <p>E. Date of Comp. – 12/23/14</p>	

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	<p>It indicated Resident #B had discharged to an area skilled nursing facility on 10-9-14.</p> <p>In an interview with the DON on 11-3-14 at 11:45 a.m., she indicated she did not fill out the state form for transfer or discharge for Resident #B. She indicated she did not have the time to complete the form. She indicated, "I don't consider her a discharge because she was only going to [name of skilled nursing facility] for a short term rehab. Yes, I'd been working on getting her some rehab for several days because of her swallowing problem."</p> <p>The state form for transfer or discharge includes information on transfer and discharge rights, reason for the transfer/discharge, effective date of the transfer/discharge, location in which the resident is being transferred/discharged to, contact information for the area Ombudsman and appeal rights regarding the transfer/discharge.</p> <p>This Residential tag relates to Complaint IN00157462.</p> <p>2.5-1(2)(r)(6)(A) 2.5-1(2)(r)(6)(A)(i) 2.5-1(2)(r)(6)(A)(ii) 2.5-1(2)(r)(6)(A)(iii)</p>			

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R000064	<p>2.5-1(2)(r)(6)(A)(iv) 2.5-1(2)(r)(6)(A)(v) 2.5-1(2)(r)(6)(C) 2.5-1(2)(r)(9)(D)</p> <p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure misappropriation of property, related to resident's medications, does not occur for 1 of 5 residents during 1 of 3 Medication Pass Observations with 1 of 3 licensed nurses. (Resident #E and LPN #1)</p> <p>Findings include:</p> <p>During a Medication Pass Observation on 10-29-14 at 5:35 a.m., with LPN #1 for Resident #E, he indicated the resident did not have the physician-ordered omeprazole available. He was then observed to obtain an unopened card of 28 pills of omeprazole 20 milligrams,</p>	R000064	<p>A. LPN was doing medication pass with state surveyor and was observed as if he was going to borrow a medication from one resident to use for another. The surveyor interrupted and explained that was not permitted. Medication did not get administered nor was it ever taken out of pharmacy packaging. The LPN in question was suspended, pending facility investigation and later resigned. Resident E was not affected by this occurrence. The resident was administered only the medications belonging to them. The 'borrowed' meds were never removed from the packaging. B. At risk would be all residents for whom the facility dispenses</p>	12/08/2014

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	<p>belonging to another resident, from a locked storage area. LPN #1 was observed to prepare to remove the medication from the card and was halted immediately prior to removal of the medication from the card by the observer.</p> <p>He indicated, "We sometimes borrow from other resident's medications from one patient to another patient until their meds come in. I've been a nurse [since early 2014]. I didn't know you couldn't do that. I worked at [name of an area facility] and we sometimes did that. I knew you couldn't do that [borrowing of medications] with narcotics."</p> <p>In an interview with the Director of Nursing (DON) on 10-29-14 at 7:05 a.m., she indicated, "I can't believe he [LPN #1] wouldn't know you can't borrow somebody's pills. He's a new nurse and should know better."</p> <p>In an interview with the DON on 10-30-14 at 3:00 p.m., she indicated LPN #1 had been suspended, pending the results of the facility's investigation.</p> <p>Resident #E's clinical record was reviewed on 10-30-14 at 1:55 p.m. The Medication Administration Record for October, 2014 indicated the resident's supply of omeprazole, Topamax and</p>		<p>medication. All current resident MARs were reviewed by DON or her designee, and no other residents were adversely affected by this citing. C. All licensed staff have been in-serviced 11/20/14, for proper medication administration techniques. Orientation for LPN and Medication Pass Review are attached. All new licensed staff will be trained for proper medication administration techniques. There will be four random medication passes completed with D.O.N. or designee a week. This will involve the medication pass check off list. There are no set times as this is random. The start date for this will be 12-8-14 and will be ongoing for six months. At which time, passes will be reviewed and determined if still needed. There will be sheets filled out for audit of the MARS once a week beginning the week of 12-8-14 and this will continue to be ongoing so there will not be a stop date. MARs will be filled out correctly and will be so going forward. D. DON or designee, will perform above random medication check-off reviews with all licensed staff for 6 months, and report compliance to administrator quarterly. Compliance will be achieved with 30 days of consecutive proper MARs documentation. E. Date of Comp. – 12/8/14</p>				

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	<p>Certavite were not given as the supply was "out" and had been reordered on 10-29-14 at 6:00 a.m. A nursing note, dated 10-29-14, indicated the same. It also indicated the resident had displayed no "ill effects" and the attending physician was notified of this by fax.</p> <p>In an interview with a Pharmacy Technician from the non-contracted pharmacy on 10-30-14 at 2:45 p.m., she indicated she was currently checking each resident's supply of physician-ordered medications to ensure each resident had the correct number of medications. She indicated this was being done at the request of the facility. She indicated, "I guess there were some problems with borrowing of meds," [from one resident to another resident by facility staff.]</p> <p>In interview with the DON on 10-30-14 at 4:45 p.m., on 10-31-14 at 2:10 p.m., and on 11-3-14 at 8:50 a.m., she indicated the facility does not have written policies on medication assistance and/or administration. On 10-31-14 at 2:10 p.m., she indicated inservices are conducted on an "as needed" basis regarding medication administration.</p> <p>This Residential tag relates to Complaint IN00157462 and IN00157816.</p>			

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R000090	<p>2.5-1(2)(hh)</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (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. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the</p>			

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	<p>premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed to ensure an unusual occurrence of misappropriation was reported to the Indiana State Health Department within 24 hours. (Resident #E)</p> <p>Findings include:</p> <p>During a Medication Pass Observation on 10-29-14 at 5:35 a.m. with LPN #1 for Resident #E, he indicated the resident did not have the physician-ordered omeprazole available. He was then observed to obtain an unopened card of 28 pills of omeprazole 20 milligrams, belonging to another resident, from a locked storage area. LPN #1 was observed to prepare to remove the</p>	R000090	A. LPN was doing medication pass with state surveyor on 10/29/14 and was observed as if he was going to borrow a medication from one resident to use for another. The surveyor interrupted and explained that was not permitted. The medication did not get administered nor was it ever even removed from its packaging. Resident E was not adversely affected as only the proper medication was administered and the 'borrowed' medication was never removed from its packaging. On 10/31/14, surveyor inquired if a report to state had been completed for this event. Facility indicated it had not since the state surveyor was present, resident E had received only the appropriate medication and the 'borrowed' medication had never been removed from its packaging. The resident did not	12/08/2014

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	<p>medication from the card and was halted immediately prior to removal of the medication from the card by the observer.</p> <p>He indicated, "We sometimes borrow from other resident's medications from one patient to another patient until their meds come in. I've been a nurse [since early 2014]. I didn't know you couldn't do that. I worked at [name of an area facility] and we sometimes did that. I knew you couldn't do that [borrowing of medications] with narcotics."</p> <p>In an interview with the Director of Nursing (DON) on 10-29-14 at 7:05 a.m., she indicated, "I can't believe he [LPN #1] wouldn't know you can't borrow somebody's pills. He's a new nurse and should know better."</p> <p>In an interview with the DON on 10-30-14 at 3:00 p.m., she indicated LPN #1 had been suspended, pending the results of the facility's investigation.</p> <p>Resident #E's clinical record was reviewed on 10-30-14 at 1:55 p.m. The Medication Administration Record for October, 2014 indicated the resident's supply of omeprazole, Topamax and Certavite were not given as the supply was "out" and had been reordered on 10-29-14 at 6:00 a.m. A nursing note,</p>		<p>experience an unusual occurrence. State surveyor explained even though she was present, this type of event did require a report. The facility's DON then submitted its report.</p> <p>B. At risk would be all residents for whom the facility dispenses medication. All current resident MARs were reviewed by DON or her designee, and no other residents were adversely affected by this citing.</p> <p>C. Non-contracted pharmacy is setting up their own EDK in facility to ensure the facility has access at all times to the most commonly used medications. Non-contract pharmacy is performing cycle fill one day early to ensure adequate coverage.</p> <p>All licensed staff have been in-serviced 11/20/14 on what constitutes an unusual occurrence, the need for proper and timely reporting and given a State Regulation hand book as part of the re-training.</p> <p>D. DON will review with administrator potential unusual occurrences as they happen to determine if they require reporting to state. This monitoring will continue ongoing.</p> <p>E. Date of Comp. – 12/8/14</p>				

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	<p>dated 10-29-14, indicated the same. It also indicated the resident had displayed no "ill effects" and the attending physician was notified of this by fax.</p> <p>In an interview with a Pharmacy Technician from the non-contracted pharmacy on 10-30-14 at 2:45 p.m., she indicated she was currently checking each resident's supply of physician-ordered medications to ensure each resident had the correct number of medications. She indicated this was being done at the request of the facility. She indicated, "I guess there were some problems with borrowing of meds," [from one resident to another resident by facility staff.]</p> <p>In interview with the DON on 10-30-14 at 4:45 p.m., on 10-31-14 at 2:10 p.m. and on 11-3-14 at 8:50 a.m., she indicated the facility does not have written policies on medication assistance and/or administration. On 10-31-14 at 2:10 p.m., she indicated inservices are conducted on an "as needed" basis regarding medication administration.</p> <p>On 11-3-14 at 1:00 p.m., the DON provided a copy of an email subject page which denoted the facility had emailed the unusual occurrence report regarding LPN #1 and Resident #E to the Indiana</p>			

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R000144	<p>State Department of Health's Incident Division on 11-2-14 at 8:27 a.m.</p> <p>2.5-1(3)(g)(1)</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure a clean and comfortable environment as related to elevator foyers on 5 of 8 floors had scuffed up and/or torn wallpaper, a ceiling tile of one hallway had obvious water damage, the basement area had large amounts of visible clutter and significant water damage to a conference room area ceiling and the laundry areas on 3 floors had multiple laundry aides sitting out and unattended.</p> <p>Findings include:</p> <p>During an initial tour with the Director of Nursing on 10-28-14 between 9:30 a.m., and 10:15 a.m., and an environmental tour on 10-30-14 at 9:50 a.m., with the Administrator and Maintenance Director, the following concerns were observed:</p>	R000144	<p>A. Sixth floor foyer electrical outlet cover has been replaced. Hallway ceiling tile near room 715 has been replaced. Hole and ceiling tile in lower level conference room has been repaired and replaced. The resident's personal laundry supplies have been removed from the laundry mat areas on floors 3-7. Residents have been instructed that all personal laundry supplies must be stored in their apartments. Policy will be included with New Resident Handbook and reviewed at time of admission. Former exercise room has been closed and is no longer a common area. Appropriate signage is in place for 'STORAGE' and 'EMPLOYEES ONLY'. This area will serve to store donated furniture and other item requiring storage. Elevator foyers on floors 3-7 are a 'work in progress', as the floor tiles &amp; cove base are being replaced to match the newly installed flooring in</p>	12/23/2014

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	<p>-The elevator foyer area for floors 3, 4, 5, 6 and 7 had wallpaper that was loose, scuffed up and/or torn which gave the foyers an unkempt appearance.</p> <p>-On the third floor's elevator foyer, an area that appeared to be a damaged area of the wall, approximately 3 inches off of the floor and had an opening of approximately 12 inches long.</p> <p>-On the sixth floor, the elevator foyer had 1 of 2 electrical outlets without a cover.</p> <p>-The doorway from the elevator foyer to the hallways on floors 3, 4, 5, 6 and 7 were scuffed up and in need of paint.</p> <p>-In the hallway, near Room 715, a ceiling tile with a large brown stain was present. The Maintenance Director indicated he had been waiting for this area to dry before changing the ceiling tile from a previous moisture issue.</p> <p>-In the public areas of the basement, a large amount of clutter was visible. This clutter included unused or donated furniture, exercise equipment and various odds and ends.</p> <p>-In a conference room in the basement, an entire ceiling tile had a hole in it and was dark in color, compared to the other white tiles. Obvious water stains were on the wall beneath this area. A wastebasket was sitting underneath this area with approximately six inches of water in it. The Maintenance Director indicated the wastebasket is supposed to be emptied</p>		<p>the hallways. Temporary cove base will be installed to cover the ragged wallpaper &amp; hole in wall 3" above flooring.</p> <p>B. No residents were adversely affected by this citing.</p> <p>C. Cited items and areas will be added to facility's Monthly Preventative Maintenance Inspection.</p> <p>D. Maintenance Director will provide copies of the Monthly Preventative Maintenance Inspection to the administrator quarterly, for 6 months. Compliance will be achieved with 30 days of timely repair/completion to issues cited in monthly reports.</p> <p>E. Date of Comp. – 12/23/14</p>	

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R000157	<p>out at least weekly, but was unable to determine when this had last occurred.</p> <p>-The laundry areas on floors 3, 5 and 6 had unattended laundry aides present. Floor 3 had 1 bottle of detergent and 4 containers of various laundry aides. Floor 5 had 2 bottles of detergent, 1 bottle of bleach, 1 bottle of fabric softener and 1 other laundry aide. Floor 6 had 5 bottles of detergent, 1 bottle of bleach and 1 other laundry aide.</p> <p>This Residential tag relates to Complaint # IN00158164.</p> <p>2.5-1(5)(a)</p> <p>410 IAC 16.2-5-1.5(n) Sanitation and Safety Standards - Deficiency n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure medications for 1 of 5 resident's medications were not touched by a staff members bare hands during a Medication Pass Observation. This deficient practice could potentially contaminate this resident's medications and possibly</p>	R000157	<p>A. The basin of water was immediately removed. Sinks are available to staff and residents next to nursing station in bathrooms. Sink available for staff next to DON office. The LPN in question was suspended for citing above and later resigned.</p> <p>B. At risk are any residents visiting the nursing station. Basin was</p>	11/26/2014

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	<p>expose the staff member to detrimental medication reactions.(Resident #E and LPN #1)</p> <p>B. Based on observation and interview, the facility failed to ensure the nursing station, where many residents received their medications, has a sink available. The nurse's station also was observed to have an open plastic basin in which residents and staff would dispose of water from drinking cups into this basin. This deficient practice could potentially adversely affect any residents and staff who receive care or work in this area.</p> <p>Findings include:</p> <p>A. During a Medication Pass Observation on 10-29-14 at 5:35 a.m., with LPN #1 for Resident #E, he was observed to use hand sanitizer prior to beginning preparing medications for Resident #E. LPN#1 was observed to obtain 10.5 pills and/or capsules and place them into a medication cup. When queried as to how many medications he had in the medication cup, he was observed to tilt the cup onto its side and allow some of the medications to touch his bare left hand while he counted the medications.</p> <p>When LPN #1 was queried if the medications had touched his hand, he</p>		<p>available in nursing station for less than 12 hours. No residents were adversely affected by this citing.</p> <p>C. Staff will be retrained on washing hands and by completing a medication pass check off list with DON or assigned designee, at least one per shift (M-F) each week times 6 months. New hires will have to complete two medication check offs while in training and then fall into rotation. After 6 months a random one will be completed on each shift per month.</p> <p>All licensed staff have been in-serviced 11/20/14 for retraining schedule.</p> <p>D. DON will review Hand Washing policy annually for needed updates and report compliance to administrator annually, ongoing.</p> <p>E. Date of Comp. – 11/26/14</p>	

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	<p>indicated, "When I was counting the pills, they barely touched my hand. It could be a problem if my hand was dirty."</p> <p>B. During the Initial Tour of the facility with the Director of Nursing (DON) on 10-28-14 between 9:30 a.m., and 10:15 a.m., there was no sink observed in the nursing station, located on the second floor. A plastic basin was observed to be located inside the entrance to the nursing station, sitting on a small table. The plastic basin was observed to have approximately one inch of clear fluid present in it.</p> <p>The DON indicated sinks were located next door in the public restroom area. The DON indicated the plastic basin was for staff and/or residents to pour any unused water from drinking cups into the basin. She indicated this prevented water from going into the trash can.</p> <p>On 10-28-14 at 11:35 a.m., LPN #3 was observed to dispose of water into the basin.</p> <p>On 10-30-14 at 9:50 a.m., a tour of the facility was conducted with the Administrator and Maintenance Director. At the nursing station, the Administrator was observed to remove the plastic basin from the area. The plastic basin was</p>			

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R000241	<p>observed to have approximately 1/2 inch of clear fluid in it. The Administrator indicated, "That cannot be left there. I don't know who said that was okay." He indicated the facility will try to resolve the lack of sink availability for the nursing station.</p> <p>On 11-3-14 at 8:50 a.m., the DON provided a copy of a policy she had provided for requested information on Universal Precautions. This policy was entitled, "Handwashing," and was indicated to be the current policy in effect. This policy was undated. The policy indicated the process to wash one's hands, but did not indicate when or under what circumstances handwashing should take place in regard to resident care.</p> <p>This Residential tag relates to Complaint IN00157816.</p> <p>2.5-1(5)(n)</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</p>			

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	<p>licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were administered as ordered and routinely documented regarding administration of the medication for 5 of 5 residents reviewed for medication administration. (Residents #B, #C, #D, #E and #F)</p> <p>1. Resident #B's clinical record was reviewed on 10-31-14 at 11:05 a.m. Her diagnoses included, but were not limited to, chronic essential tremors, anxiety, depression, heart disease, lung disease, neuropathy and diabetes. Review of her service plan, dated 9-9-14, indicated she was alert and oriented, was able to generally make safe decisions and had some memory problems. It indicated the facility administered her medications to her. It indicated she moved into the facility on 8-30-14.</p> <p>Review of Resident #B's Medication Administration Records (MAR) for August, 2014 indicated an inability to locate the medication administration records for 8-30-14 and 8-31-14. In interview with the Director of Nursing (DON) on 11-3-14 at 11:45 a.m., she indicated she could not locate this information.</p>	R000241	<p>A. Staff is being retrained on the importance of initialing MARs and checking/re-ordering medications at the appropriate times. Nurses will be instructed to complete proper documentation including verification of personal information and dates. Pharmacy contacted to not pre-date bulk MARs in printing. All licensed staff is being counseled on the incompleteness of documentation. MARs Audit Form and Write-Up on Medication attached.</p> <p>B. All current resident MARs were reviewed by DON or her designee, and no other residents were adversely affected by this citing.</p> <p>C. DON or designee will perform written audit checks randomly, at least one per shift (M-F) for 6 months.</p> <p>D. DON will report compliance to administrator quarterly for 6 months. Compliance will be achieved with 30 days of consecutive proper MARs documentation.</p> <p>E. Date of Comp. – 12/8/14</p>	12/08/2014			

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	<p>In review of the MAR for what should have been identified as September, 2014 and October, 2014, it indicated some of the MAR were dated for those two months, but some were also identified as for March, 2014. Some of these MAR had intermittent dates documented as medications having been documented as administered, but many had several dates for most medications left blank. A physician order, dated 9-10-14, indicated the resident was able to self-administer her medications. On the MAR, dated for September, 2014 and March, 2014, were hand-written documentation of "self-administers" with various dates in which this was initiated. These dates varied from 9-10-14 to 9-26-14. The October, 2014 MAR indicated the resident self administered her medications.</p> <p>In review of her September 1 to 30, 2014 MAR, it indicated several medications which had the administrator's initials circled. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. Please note in the medications listed below, unless specifically indicated, circled entries did</p>			

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	<p>not specify why the medication was not administered. Several medications had blank entries with no indication as to why the administration date and time were blank. Those were as follows:</p> <ul style="list-style-type: none"> <li>-Spironolactone 50 mg (milligrams) daily at bedtime by mouth. Circled initials were documented on 9-6-14 and 9-7-14 for "6P-9P." (sic) Blank administration blocks were noted on 9-1-14, 9-2-14, 9-3-14, and 9-11-14 through 9-16-14 at "6P-9P." (sic) A handwritten note from the 9-18-14 administration block indicated "self administers."</li> <li>-Venlafaxine 75 mg daily by mouth. Blank administration blocks were noted on 9-1-14, 9-3-14, and 9-11-14 through 9-16-14 at "6A-9A." A handwritten note from the 9-18-14 administration block indicated "self administers."</li> <li>-Zanaflex 4 mg three times daily by mouth. Circled initials were documented on 9-10-14 for "6A-9A," on for "11A-1P," on 9-9-14 and 9-10-14 for "6P-9P." Blank administration blocks were noted on 9-1-14, 9-2-14, 9-3-14, and 9-11-14 through 9-16-14 for all three doses due on those dates. Additional blank administration blocks were noted on 9-4-14 and 9-5-14 for the dose due for "6P-9P." A handwritten note from the 9-18-14 administration block indicated "self administers."</li> <li>-Renal Caps 1 mg daily at 12 noon by</li> </ul>			

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	<p>mouth. Blank administration blocks were noted on 9-1-14, 9-3-14, 9-4-14, 9-7-14 and 9-11-14 through 9-14-14. A note on the back of the MAR indicated on 9-14-14 at 8:00 A.M. this medication was not administered and the pharmacy was aware of the need.</p> <p>A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Doxycycline Hyclate 50 mg each evening by mouth. Blank administration blocks were noted on 9-1-14,9-4-14, 9-5-14, and 9-11-14 through 9-14 for "3P-5P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Cymbalta 30 mg daily at bedtime by mouth. Blank administration blocks were noted on 9-1-14,9-2-14, 9-3-14, 9-5-14, and 9-11-14 through 9-14 for "6P-9P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Nexium 40 mg twice daily, before breakfast and before supper, by mouth. Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, 9-6-14, and 9-8-14 through 9-14 for "5A." Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, 9-7-14 and 9-10-14 through 9-14-14 for "3P-5P." A handwritten note from the 9-14-14 administration block indicated</p>			

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	<p>"self administers."</p> <p>-Fluoxetine 40 mg daily by mouth. Blank administration blocks were noted on 9-1-14 through 9-5-14 and 9-11-14 through 9-14-14 at "6A-9A." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Advair Diskus 500/50 mg one puff twice daily by mouth. Blank administration blocks were noted on 9-1-14, 9-3-14 and 9-11-14 through 9-14-14 at "6A-9A." Blank administration blocks were noted on 9-1-14 through 9-5-14, 9-8-14, and 9-11-14 through 9-14-14 at "6P-9P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>- Lasix 40 mg, 2 tablets, (total of 80 mg) twice daily by mouth at 5:00 a.m. and 12 noon. Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, and 9-9-14 through 9-14-14 at "5A." Blank administration blocks were noted on 9-1-14, 9-4-14, 9-6-14, 9-7-14 and 9-11-14 through 9-14-14 at "12N."</p> <p>A MAR, dated 9-3-14 to 9-30-14, indicated a new order on 9-3-14 for Lyrica 100 mg three times daily by mouth. Circled initials were documented on 9-6-14 for "6A-9A," and for "11A-1P." Blank administration blocks were noted on 9-8-14 and 9-9-14 for the</p>			

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NAME OF PROVIDER OR SUPPLIER  LAMPLIGHT INN AT THE LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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	<p>"6A-9A" dose; on 9-4-14 and 9-8-14 for the "11A-1P" dose; on 9-4-14, 9-5-14, 9-7-14 for the "6P-9P" dose. A handwritten note from the 9-11-14 administration block indicated "self administers."</p> <p>A MAR, dated 9-10-14 to 9-30-14, indicated the following: -Advair Diskus 500 mcg/50mcg (microgram) inhale one puff by inhalation twice daily. Blank administration blocks were noted on 9-17-14, 9-19-14 and 9-20-14 for the "6A-9A" dose; on 9-11-14, 9-12-14, 9-15-14, 9-17-14, 9-24-14 and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers." -Aldactone 50 mg twice daily by mouth. Blank administration blocks were noted on 9-17-14 for the "6A-9A" dose; on 9-17-14, and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers." -Atorvastatin 10 mg daily by mouth. Circled initials were documented on 9-11-14 and 9-18-14 through 9-24-14. Blank administration blocks were noted on 9-17-14 and 9-25-14. A handwritten note on the 9-26-14 block indicated, "self administers." -Cymbalta 60 mg, 2 capsules, (total of 120 mg) daily by mouth. Circled initials</p>			

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	<p>were documented on 9-12-14, 9-16-14 and 9-18-14 for the "6A-9P" dose. Blank administration blocks were noted on 9-17-14, 9-20-14 and 9-21-14. On the back of the MAR, a notation on 9-12-14 and 9-14-14 at 7:45 A.M. indicated this medication was not given and "the pharmacy was notified of the need." This medication was documented as administered on the front of the MAR for 9-14-14; on 9-12-14 the medication had encircled initials. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Doxycycline Monohydrate 50 mg twice daily by mouth. Circled initials were documented on 9-18-14 for the "6A-9A" dose. Blank administration blocks were noted on 9-12-14, 9-17-14, 9-19-14, 9-20-14 and 9-21-14 for the "6A-9A" dose; on 9-15-14 and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Fluticasone 50 mcg 2 sprays in each nostril daily. Circled initials were documented on 9-14-14, 9-15-14, 9-16-14 and 9-18-14 dose for "6A-9A" dose. Blank administration blocks were noted on 9-12-14, 9-13-14, 9-17-14, 9-19-14, 9-20-14 and 9-21-14 for the "6A-9A" dose. A notation on 9-14-14 at 8:00 A.M. indicated the medication was not given and the pharmacy was aware of</p>			

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	<p>the need for the medication. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>A MAR, dated 3-28-14 to 3-31-14 was documented for Resident #B. Resident #B was not admitted to the facility until August, 2014. Medication administration was documented from the 10th through the 26th, with a handwritten notation on the 26th which indicated, "self administers." This MAR indicated the following:</p> <ul style="list-style-type: none"> <li>-Ropinirole 2 mg one tablet. No frequency or administration route indicated. Time slots were marked for twice daily. Blank administration blocks were noted on 3-17-14 for the "6A-9A" dose and on 3-25-14 for the "6P-9P" dose.</li> <li>-Venlafaxine ER 75 mg one cap with food. No frequency or administration route indicated. Time slot was marked for once daily. Circled initials were documented on 3-22-14 for the "6A-9A" dose. Blank dose administration blocks were noted on 3-15-14, 3-17-14, 3-19-14, 3-20-14 for the "6A-9A" dose.</li> <li>-Zanaflex 4 mg three times daily by mouth. Blank administration blocks were noted on 3-17-14 and 3-20-14 for the "6A-9A" dose; on 3-18-14 and 3-25-14 for the "11A-1P" dose; on 3-25-14 for the "6P-9P" dose.</li> </ul>			

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	<p>2. In review of Resident #C's clinical record on 10-30-14 at 2:35 p.m., it indicated her diagnoses included, but were not limited to, Parkinson's disease, high blood pressure, CVA (cerebrovascular accident or stroke), Parkinson's disease and COPD (chronic obstructive pulmonary disease). Her service plan, dated 10-12-14, indicated she was alert and oriented to person, place and time, but required some cueing related to memory issues. It indicated the facility administered her medications to her.</p> <p>In review of her September, 2014 MAR, it indicated multiple medications which had the administrator's initials circled. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. Several medications had blank entries with no indication as to why the administration date and time were blank. Those were as follows: -Advair Diskus 500/50: inhale one puff by mouth twice daily. Circled initials were documented on 9-3-14 and 9-28-14 for "6A-9A" and 9-28 and 9-29-14 for "5P-9P." A blank administration block was noted on 9-12-14 at "5P-9P."</p>			

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	<p>-Aspirin 81 mg (milligrams) one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A."</p> <p>-Atenolol 25 mg one tablet twice daily by mouth. Circled initials were documented as follows on 9-3-14 for "6A-9A."</p> <p>-Calcium Carb 500 mg plus Vitamin D one tablet twice daily by mouth. Circled initials were documented on 9-3-14, 9-20-14 and 9-21-14 for "6A-9A."</p> <p>-Sinemet 25/100 mg one tablet four times daily by mouth. Circled initials were documented on 9-3-14 at "6A-8A" and "11A-1P" on 9-20-14.</p> <p>-Aricept 5 mg two tablets (10 mg total) daily by mouth. Circled initials were documented on 9-7-14, 9-23-14 and 9-24-14 for "5P-9P." A blank administration block was noted on 9-5-14 at "5P-9P."</p> <p>-Lasix 20 mg one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A."</p> <p>-Neurontin 100 mg three tablets (total of 300 mg) twice daily by mouth. A blank administration block was noted on 9-5-14 at "5P-9P."</p> <p>-Lexapro 20 mg one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A."</p> <p>-Prilosec 20 mg one tablet daily by mouth. Circled initials were documented</p>			

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	<p>on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A." -Potassium Chloride Micro 20 mg, extended release, one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A." -Trihexyphen 2 mg three times daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A."</p> <p>An entry on the backside of the MAR, dated 9-24-14 by LPN #2, indicated, "Waiting for del [delivery]. This entry did not indicate what medications were not present or for what time. The MAR did not indicate any circled or blank entries for 9-24-14.</p> <p>3. Resident #D's clinical record was reviewed on 10-31-14 at 9:45 a.m. Her diagnoses included, but were not limited to, stroke, bipolar disorder, anxiety, depression and diabetes. Her most recent service plan, dated 10-8-14, indicated she was alert and oriented to person, place and time, had poor decision-making skills and had poor memory. It indicated the facility administered her medications to her.</p> <p>In review of Resident #D's Medication</p>			

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	<p>Administration Records (MAR) for September, 2014, several medications were indicated to have encircled initials or blank administration blocks. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. The following listed medications were noted to have the following issues without explanations documented:</p> <ul style="list-style-type: none"> <li>-Ativan 0.5 mg (milligrams) twice daily by mouth. Blank administration blocks for 3 of 60 doses.</li> <li>-Metformin 500 mg daily by mouth. Encircled initials for 2 of 30 doses and blank administration blocks for 1 of 30 doses.</li> <li>-Omeprazole 20 mg daily by mouth. Encircled initials for 1 of 30 doses.</li> <li>-Trazadone 100 mg daily at bedtime by mouth. Encircled initials for 1 of 30 doses.</li> <li>-Lantus Insulin 20 units injected subcutaneously at each bedtime. 1 blank administration block for 1 of 30 doses.</li> </ul> <p>4. The clinical record of Resident #E was reviewed on 10-30-14 at 1:55 p.m. Her diagnoses included, but were not limited to, bipolar disorder, anxiety, depression and hypertension. Her most</p>			

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	<p>recent service plan, dated 10-8-14, indicated she has short-term and long-term memory problems and requires some cueing/assistance with care needs. It indicated the facility administers her medication to her.</p> <p>In review of Resident #E's Medication Administration Records (MAR) for September, 2014, several medications were indicated to have encircled initials or blank administration blocks. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. The following listed medications were noted to have the following issues without explanations documented:</p> <ul style="list-style-type: none"> <li>-Valium 5 mg (milligrams), one- half tablet (2.5 mg total), each morning by mouth. A blank administration block for 1 of 30 doses.</li> <li>-Diclonfenac 75 mg twice daily by mouth. Encircled initials for 1 of 60 doses.</li> <li>-Lasix 40 mg, one half tablet or 20 mg, every other day by mouth. 7 of 15 doses had blank administration blocks.</li> <li>-Lasix 20 mg daily by mouth ( a new order, written on 9-12-14). 1 of 18 doses had a blank administration block.</li> </ul>			

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	<p>-Hydralazine 10 mg twice daily by mouth. 1 of 60 doses had a blank administration block.</p> <p>-Simvastatin 5 mg daily at bedtime by mouth. 1 of 30 doses had a blank administration block.</p> <p>-Topamax 50 mg twice daily by mouth. 2 of 60 doses had encircled initials.</p> <p>In interview with LPN #4 on 10-29-14 at 6:15 a.m., she indicated the Lasix orders were unclear to her in regard to the two orders for "every other day" and one order for "daily" dosing. She indicated she would request clarification from the physician.</p> <p>In review of Resident #E's MAR for October 1-30, 2014, the following listed medications had the following issues without explanations documented:</p> <p>-Valium 5 mg, one- half tablet (2.5 mg total), each morning by mouth. A blank administration block for 2 of 30 doses.</p> <p>-Valium 5 mg each bedtime by mouth. A blank administration block for 1 of 30 doses.</p> <p>-Diclonfenac 75 mg twice daily by mouth. Encircled initials for 1 of 60 doses and 2 of 60 doses with blank administration blocks.</p> <p>-Lasix 40 mg every other day by mouth. 1 of 15 doses had encircled initials.</p> <p>-Lasix 40 mg, one half tablet or 20 mg,</p>			

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	<p>every other day by mouth. 1 of 15 doses had encircled initials and 1 of 15 doses had blank administration blocks.</p> <p>-Lasix 20 mg daily by mouth ( a new order, written on 9-12-14). 2 of 30 doses had encircled initials and 1 of 30 doses had a blank administration block.</p> <p>-Hydralazine 10 mg twice daily by mouth. 2 of 60 doses had blank administration blocks.</p> <p>-Simvastatin 5 mg daily at bedtime by mouth. 3 of 30 doses had a blank administration block.</p> <p>-Topamax 50 mg twice daily by mouth. 1 of 60 doses had encircled initials and 3 of 60 doses had blank administration blocks.</p> <p>-Risperdal 2 mg at each bedtime by mouth. 2 of 60 doses had blank administration blocks.</p> <p>-Lamotrigine 150 mg, 2 tablets or 300 mg total, daily by mouth. 2 of 30 doses had blank administration blocks.</p> <p>-Lisinopril 10 mg, 2 tablets or 20 mg total, each morning by mouth. 3 of 30 doses had blank administration blocks.</p> <p>-Lisinopril 10 mg each evening by mouth. 1 of 30 doses had a blank administration block.</p> <p>-Metoprolol ER 200 mg daily by mouth. 2 of 30 doses had blank administration blocks.</p> <p>-Ferrous Sulfate 325 mg twice daily by mouth (new order written on 10-22-14).</p>			

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	<p>5 of 16 doses had blank administration blocks.</p> <p>5. The clinical record of Resident #F was reviewed on 11-3-14 at 9:15 a.m. Her diagnoses included, but were not limited to, glaucoma. Her most recent service plan, dated 10-8-14, indicated she was alert and oriented to person, place and time. It indicated the facility administered her medications to her.</p> <p>During a medication pass observation with LPN #3 on 10-28-14 at 11:26 a.m., LPN #3 was observed to instill one drop of Pred Forte Suspension into both eyes. Upon review of the Medication Administration Record (MAR) and the physician orders, it was noted the resident was to receive one drop in the left eye every other day of Prednisolone Suspension 1% for glaucoma. In interview with LPN #3 at this time, she indicated she knew one of the resident's eye drops were to be given every other day and had checked for that. She indicated she had routinely been giving this eye drop into both eyes.</p> <p>In review of the October 1 to 28, 2014 MAR, this medication had blank administration blocks for 4 of 14 doses.</p> <p>In interview with the DON on 10-30-14</p>						

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R000296	<p>at 4:45 p.m., on 10-31-14 at 2:10 p.m. and on 11-3-14 at 8:50 a.m., she indicated the facility does not have written policies on medication assistance and/or administration. On 10-31-14 at 2:10 p.m., she indicated inservices are conducted on an "as needed" basis regarding medication administration.</p> <p>This Residential tag relates to Complaint IN00157462 and Complaint IN00157816.</p> <p>2.5-4(e)(1)</p> <p>410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.</p> <p>Based on interview and record review, the facility failed to ensure the facility has written policies and procedures for medication assistance. This deficient practice has the potential to adversely affect all residents who are assisted by facility staff with the administration of medications.</p> <p>Findings include:</p> <p>In interview with the Director of Nursing</p>	R000296	<p>A. Medication Policy is under review and will be finalized by 11/25/14. Contact was made with non-contracted pharmacy who will make an adjustment in their medication refill cycle (filling one day earlier) to help ensure residents' medication is in facility and available on a timely manner. B. All current resident MARs were reviewed by DON or her designee, and no other residents were adversely affected by this citing. C. All licensed staff will be in-serviced 1-on-1, between Dec. 1 &amp; Dec. 7, 2014,</p>	12/08/2014

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R000297	<p>on 10-30-14 at 4:45 p.m., on 10-31-14 at 2:10 p.m. and on 11-3-14 at 8:50 a.m., she indicated the facility does not have written policies on medication assistance and/or administration. On 10-31-14 at 2:10 p.m., she indicated inservices are conducted on an "as needed" basis regarding medication administration.</p> <p>This Residential tag relates to Complaint IN00157462 and Complaint IN00157816.</p> <p>2.5-6(b)</p> <p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents have an adequate supply of physician-ordered medications to ensure the ability to receive their medications as ordered by their physician in a timely manner. This deficient practice has the potential to adversely affect the health of each resident for whom the facility controls, handles and administers</p>	R000297	<p>on Medication Administration Policy. DON or designee well perform audit checks randomly, at least one per shift (M-F) for 6 months. D. DON will report compliance to administrator quarterly for 6 months. Compliance will be achieved with 30 days of consecutive proper MARs documentation. E. Date of Comp. – 12/8/14</p> <p>A. Notification sent to contracted pharmacy (Grandview) to stop filling medications that are not for their assigned residents. This will ensure non-contracted pharmacy will not receive rejections when filling for their assigned residents. Non-contracted pharmacy is setting up their own EDK in facility to ensure the facility has access at all times to the most commonly used medications. Non-contract</p>	12/08/2014

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NAME OF PROVIDER OR SUPPLIER  LAMPLIGHT INN AT THE LELAND				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374			
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	<p>medication. (Resident #E)</p> <p>Findings include:</p> <p>During a Medication Pass Observation on 10-29-14 at 5:35 a.m. with LPN #1 for Resident #E, he indicated the resident did not have the physician-ordered omeprazole available. He was then observed to obtain an unopened card of 28 pills of omeprazole 20 milligrams, belonging to another resident, from a locked storage area. He indicated, "We sometimes borrow from other resident's medications from one patient to another patient until their meds come in. I've been a nurse [since early 2014]. I didn't know you couldn't do that. I worked at [name of another area facility] and we sometimes did that. I knew you couldn't do that [borrowing of medications] with narcotics."</p> <p>In an interview with the Director of Nursing (DON) on 10-29-14 at 7:05 a.m., she indicated Resident #E was in the midst of switching from one pharmacy to another pharmacy for her medication needs. She indicated, "That's why some of her meds are out."</p> <p>Resident #E's clinical record was reviewed on 10-30-14 at 1:55 p.m. The Medication Administration Record for</p>		<p>pharmacy is performing cycle fill one day early to ensure adequate coverage.</p> <p>B. All current resident MARs were reviewed by DON or her designee, and no other residents were adversely affected by this citing.</p> <p>C. DON or designee will perform written audit checks randomly, at least one per shift (M-F) for 6 months.</p> <p>D. DON will report compliance to administrator quarterly for 6 months. Compliance will be achieved with 30 days of consecutive proper MARs documentation.</p> <p>E. Date of Comp. -12/8/14</p>				

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	<p>October, 2014 indicated the resident's supply of omeprazole, Topamax and Certavite were not given as the supply was "out" and had been reordered on 10-29-14 at 6:00 a.m. A nursing note, dated 10-29-14, indicated the same. It also indicated the resident had displayed no "ill effects" and the attending physician was notified of this by fax.</p> <p>In an interview with the DON on 10-29-14 at 1:00 p.m., she indicated the facility was in the process of switching contracted pharmacies. She indicated the current contracted pharmacy had less than 10% of the current residents as customers. She indicated this was a slow process.</p> <p>In an interview with a Pharmacy Technician from the non-contracted pharmacy on 10-30-14 at 2:45 p.m., she indicated she was currently checking each resident's supply of physician-ordered medications to ensure each resident had the correct number of medications. She indicated this was being done at the request of the facility. She indicated, "I guess there were some problems with borrowing of meds," [from one resident to another resident by facility staff.]</p> <p>This Residential tag relates to Complaint</p>			

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R000349	<p>IN00157816.</p> <p>2.5-6(a)</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 follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure medications were routinely documented regarding administration by facility staff and records properly maintained for 5 of 5 residents reviewed for medication administration. (Residents #B, #C, #D, #E and #F)</p> <p>1. Resident #B's clinical record was reviewed on 10-31-14 at 11:05 a.m. Her diagnoses included, but were not limited to, chronic essential tremors, anxiety, depression, heart disease, lung disease, neuropathy and diabetes. Review of her service plan, dated 9-9-14, indicated she was alert and oriented, was able to</p>	R000349	<p>A. All admissions will be reviewed by DON or assigned designee, and proper placement in clinical record will be completed. All licensed staff has been in-serviced 11/20/14, on the proper admission requirements and paperwork completion, as well as on the proper documentation of the MARs.</p> <p>B. All current resident records were reviewed by DON or her designee, and no other residents were adversely affected by this citing.</p> <p>C. DON or designee will perform written audit checks randomly, at least one per shift (M-F) for 6 months.</p> <p>D. DON will report compliance to administrator quarterly for 6 months. Compliance will be</p>	12/08/2014			

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	<p>generally make safe decisions and had some memory problems. It indicated the facility administered her medications to her. It indicated she moved into the facility on 8-30-14.</p> <p>Review of Resident #B's Medication Administration Records (MAR) for August, 2014 indicated an inability to locate the medication administration records for 8-30-14 and 8-31-14. In interview with the Director of Nursing (DON) on 11-3-14 at 11:45 a.m., she indicated she could not locate this information.</p> <p>In review of the MAR for what should have been identified as September, 2014 and October, 2014, it indicated some of the MAR were dated for those two months, but some were also identified as for March, 2014. Some of these MAR had intermittent dates documented as medications having been documented as administered, but many had several dates for most medications left blank. A physician order, dated 9-10-14, indicated the resident was able to self-administer her medications. On the MAR, dated for September, 2014 and March, 2014, were hand-written documentation of "self-administers" with various dates in which this was initiated. These dates varied from 9-10-14 to 9-26-14. The</p>		<p>achieved with 30 days of consecutive proper MARs documentation. E. Date of Comp. – 12/8/14</p>				

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	<p>October, 2014 MAR indicated the resident self administered her medications.</p> <p>In review of her September 1 to 30, 2014 MAR, it indicated several medications which had the administrator's initials circled. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. Please note in the medications listed below, unless specifically indicated, circled entries did not specify why the medication was not administered. Several medications had blank entries with no indication as to why the administration date and time were blank. Those were as follows:</p> <ul style="list-style-type: none"> <li>-Spironolactone 50 mg (milligrams) daily at bedtime by mouth. Circled initials were documented on 9-6-14 and 9-7-14 for "6P-9P." (sic) Blank administration blocks were noted on 9-1-14, 9-2-14, 9-3-14, and 9-11-14 through 9-16-14 at "6P-9P." (sic) A handwritten note from the 9-18-14 administration block indicated "self administers."</li> <li>-Venlafaxine 75 mg daily by mouth. Blank administration blocks were noted on 9-1-14, 9-3-14, and 9-11-14 through 9-16-14 at "6A-9A." A handwritten note from the 9-18-14 administration block</li> </ul>						

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	<p>indicated "self administers."</p> <p>-Zanaflex 4 mg three times daily by mouth. Circled initials were documented on 9-10-14 for "6A-9A," on for "11A-1P," on 9-9-14 and 9-10-14 for "6P-9P." Blank administration blocks were noted on 9-1-14, 9-2-14, 9-3-14, and 9-11-14 through 9-16-14 for all three doses due on those dates. Additional blank administration blocks were noted on 9-4-14 and 9-5-14 for the dose due for "6P-9P." A handwritten note from the 9-18-14 administration block indicated "self administers."</p> <p>-Renal Caps 1 mg daily at 12 noon by mouth. Blank administration blocks were noted on 9-1-14, 9-3-14, 9-4-14, 9-7-14 and 9-11-14 through 9-14-14. A note on the back of the MAR indicated on 9-14-14 at 8:00 A.M. this medication was not administered and the pharmacy was aware of the need.</p> <p>A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Doxycycline Hyclate 50 mg each evening by mouth. Blank administration blocks were noted on 9-1-14, 9-4-14, 9-5-14, and 9-11-14 through 9-14 for "3P-5P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Cymbalta 30 mg daily at bedtime by mouth. Blank administration blocks</p>			

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	<p>were noted on 9-1-14,9-2-14, 9-3-14, 9-5-14, and 9-11-14 through 9-14 for "6P-9P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Nexium 40 mg twice daily, before breakfast and before supper, by mouth. Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, 9-6-14, and 9-8-14 through 9-14 for "5A." Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, 9-7-14 and 9-10-14 through 9-14-14 for "3P-5P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Fluoxetine 40 mg daily by mouth. Blank administration blocks were noted on 9-1-14 through 9-5-14 and 9-11-14 through 9-14-14 at "6A-9A." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>-Advair Diskus 500/50 mg one puff twice daily by mouth. Blank administration blocks were noted on 9-1-14, 9-3-14 and 9-11-14 through 9-14-14 at "6A-9A." Blank administration blocks were noted on 9-1-14 through 9-5-14, 9-8-14, and 9-11-14 through 9-14-14 at "6P-9P." A handwritten note from the 9-14-14 administration block indicated "self administers."</p> <p>- Lasix 40 mg, 2 tablets, (total of 80 mg)</p>			

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	<p>twice daily by mouth at 5:00 a.m. and 12 noon. Blank administration blocks were noted on 9-1-14, 9-2-14, 9-4-14, 9-5-14, and 9-9-14 through 9-14-14 at "5A." Blank administration blocks were noted on 9-1-14, 9-4-14, 9-6-14, 9-7-14 and 9-11-14 through 9-14-14 at "12N."</p> <p>A MAR, dated 9-3-14 to 9-30-14, indicated a new order on 9-3-14 for Lyrica 100 mg three times daily by mouth. Circled initials were documented on 9-6-14 for "6A-9A," and for "11A-1P." Blank administration blocks were noted on 9-8-14 and 9-9-14 for the "6A-9A" dose; on 9-4-14 and 9-8-14 for the "11A-1P" dose; on 9-4-14, 9-5-14, 9-7-14 for the "6P-9P" dose. A handwritten note from the 9-11-14 administration block indicated "self administers."</p> <p>A MAR, dated 9-10-14 to 9-30-14, indicated the following: -Advair Diskus 500 mcg/50mcg (microgram) inhale one puff by inhalation twice daily. Blank administration blocks were noted on 9-17-14, 9-19-14 and 9-20-14 for the "6A-9A" dose; on 9-11-14, 9-12-14, 9-15-14, 9-17-14, 9-24-14 and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers."</p>			

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	<p>-Aldactone 50 mg twice daily by mouth. Blank administration blocks were noted on 9-17-14 for the "6A-9A" dose; on 9-17-14, and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Atorvastatin 10 mg daily by mouth. Circled initials were documented on 9-11-14 and 9-18-14 through 9-24-14. Blank administration blocks were noted on 9-17-14 and 9-25-14. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Cymbalta 60 mg, 2 capsules, (total of 120 mg) daily by mouth. Circled initials were documented on 9-12-14, 9-16-14 and 9-18-14 for the "6A-9P" dose. Blank administration blocks were noted on 9-17-14, 9-20-14 and 9-21-14. On the back of the MAR, a notation on 9-12-14 and 9-14-14 at 7:45 A.M. indicated this medication was not given and "the pharmacy was notified of the need." This medication was documented as administered on the front of the MAR for 9-14-14; on 9-12-14 the medication had encircled initials. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Doxycycline Monohydrate 50 mg twice daily by mouth. Circled initials were documented on 9-18-14 for the "6A-9A" dose. Blank administration blocks were noted on 9-12-14, 9-17-14, 9-19-14,</p>			

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	<p>9-20-14 and 9-21-14 for the "6A-9A" dose; on 9-15-14 and 9-25-14 for the "6P-9P" dose. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>-Fluticasone 50 mcg 2 sprays in each nostril daily. Circled initials were documented on 9-14-14, 9-15-14, 9-16-14 and 9-18-14 dose for "6A-9A" dose. Blank administration blocks were noted on 9-12-14, 9-13-14, 9-17-14, 9-19-14, 9-20-14 and 9-21-14 for the "6A-9A" dose. A notation on 9-14-14 at 8:00 A.M. indicated the medication was not given and the pharmacy was aware of the need for the medication. A handwritten note on the 9-26-14 block indicated, "self administers."</p> <p>A MAR, dated 3-28-14 to 3-31-14 was documented for Resident #B. Resident #B was not admitted to the facility until August, 2014. Medication administration was documented from the 10th through the 26th, with a handwritten notation on the 26th which indicated, "self administers." This MAR indicated indicated the following:</p> <p>-Ropinirole 2 mg one tablet. No frequency or administration route indicated. Time slots were marked for twice daily. Blank administration blocks were noted on 3-17-14 for the "6A-9A" dose and on 3-25-14 for the "6P-9P"</p>			

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	<p>dose.</p> <p>-Venlafaxine ER 75 mg one cap with food. No frequency or administration route indicated. Time slot was marked for once daily. Circled initials were documented on 3-22-14 for the "6A-9A" dose. Blank dose administration blocks were noted on 3-15-14, 3-17-14, 3-19-14, 3-20-14 for the "6A-9A" dose.</p> <p>-Zanaflex 4 mg three times daily by mouth. Blank administration blocks were noted on 3-17-14 and 3-20-14 for the "6A-9A" dose; on 3-18-14 and 3-25-14 for the "11A-1P" dose; on 3-25-14 for the "6P-9P" dose.</p> <p>2. In review of Resident #C's clinical record on 10-30-14 at 2:35 p.m., it indicated her diagnoses included, but were not limited to, Parkinson's disease, high blood pressure, CVA (cerebrovascular accident or stroke), Parkinson's disease and COPD (chronic obstructive pulmonary disease). Her service plan, dated 10-12-14, indicated she was alert and oriented to person, place and time, but required some cueing related to memory issues. It indicated the facility administered her medications to her.</p> <p>In review of her September, 2014 MAR, it indicated multiple medications which had the administrator's initials circled. In</p>			

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	<p>an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. Several medications had blank entries with no indication as to why the administration date and time were blank. Those were as follows:</p> <ul style="list-style-type: none"> <li>-Advair Diskus 500/50: inhale one puff by mouth twice daily. Circled initials were documented on 9-3-14 and 9-28-14 for "6A-9A" and 9-28 and 9-29-14 for "5P-9P." A blank administration block was noted on 9-12-14 at "5P-9P."</li> <li>-Aspirin 81 mg (milligrams) one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A."</li> <li>-Atenolol 25 mg one tablet twice daily by mouth. Circled initials were documented as follows on 9-3-14 for "6A-9A."</li> <li>-Calcium Carb 500 mg plus Vitamin D one tablet twice daily by mouth. Circled initials were documented on 9-3-14, 9-20-14 and 9-21-14 for "6A-9A."</li> <li>-Sinemet 25/100 mg one tablet four times daily by mouth. Circled initials were documented on 9-3-14 at "6A-8A" and "11A-1P" on 9-20-14.</li> <li>-Aricept 5 mg two tablets (10 mg total) daily by mouth. Circled initials were documented on 9-7-14, 9-23-14 and 9-24-14 for "5P-9P." A blank administration block was noted on 9-5-14</li> </ul>			

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NAME OF PROVIDER OR SUPPLIER  LAMPLIGHT INN AT THE LELAND				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374			
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	<p>at "5P-9P." -Lasix 20 mg one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." -Neurontin 100 mg three tablets (total of 300 mg) twice daily by mouth. A blank administration block was noted on 9-5-14 at "5P-9P." -Lexapro 20 mg one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A." -Prilosec 20 mg one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A." -Potassium Chloride Micro 20 mg, extended release, one tablet daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A." A blank administration block was noted on 9-17-14 at "6A-9A." -Trihexyphen 2 mg three times daily by mouth. Circled initials were documented on 9-3-14 for "6A-9A."</p> <p>An entry on the backside of the MAR, dated 9-24-14 by LPN #2, indicated, "Waiting for del [delivery]. This entry did not indicate what medications were not present or for what time. The MAR did not indicate any circled or blank</p>						

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	<p>entries for 9-24-14.</p> <p>3. Resident #D's clinical record was reviewed on 10-31-14 at 9:45 a.m. Her diagnoses included, but were not limited to, stroke, bipolar disorder, anxiety, depression and diabetes. Her most recent service plan, dated 10-8-14, indicated she was alert and oriented to person, place and time, had poor decision-making skills and had poor memory. It indicated the facility administered her medications to her.</p> <p>In review of Resident #D's Medication Administration Records (MAR) for September, 2014, several medications were indicated to have encircled initials or blank administration blocks. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. The following listed medications were noted to have the following issues without explanations documented:</p> <p>-Ativan 0.5 mg (milligrams) twice daily by mouth. Blank administration blocks for 3 of 60 doses.</p> <p>-Metformin 500 mg daily by mouth. Encircled initials for 2 of 30 doses and blank administration blocks for 1 of 30</p>						

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	<p>doses.</p> <p>-Omeprazole 20 mg daily by mouth. Encircled initials for 1 of 30 doses.</p> <p>-Trazadone 100 mg daily at bedtime by mouth. Encircled initials for 1 of 30 doses.</p> <p>-Lantus Insulin 20 units injected subcutaneously at each bedtime. 1 blank administration block for 1 of 30 doses.</p> <p>4. The clinical record of Resident #E was reviewed on 10-30-14 at 1:55 p.m. Her diagnoses included, but were not limited to, bipolar disorder, anxiety, depression and hypertension. Her most recent service plan, dated 10-8-14, indicated she has short-term and long-term memory problems and requires some cueing/assistance with care needs. It indicated the facility administers her medication to her.</p> <p>In review of Resident #E's Medication Administration Records (MAR) for September, 2014, several medications were indicated to have encircled initials or blank administration blocks. In an interview with the DON on 10-31-14 at 10:00 a.m., she indicated this practice indicated the medication was not administered and should have a written notation as to why it was not administered. The following listed medications were noted to have the</p>			

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	<p>following issues without explanations documented:</p> <ul style="list-style-type: none"> <li>-Valium 5 mg (milligrams), one- half tablet (2.5 mg total), each morning by mouth. A blank administration block for 1 of 30 doses.</li> <li>-Diclonfenac 75 mg twice daily by mouth. Encircled initials for 1 of 60 doses.</li> <li>-Lasix 40 mg, one half tablet or 20 mg, every other day by mouth. 7 of 15 doses had blank administration blocks.</li> <li>-Lasix 20 mg daily by mouth ( a new order, written on 9-12-14). 1 of 18 doses had a blank administration block.</li> <li>-Hydralazine 10 mg twice daily by mouth. 1 of 60 doses had a blank administration block.</li> <li>-Simvastatin 5 mg daily at bedtime by mouth. 1 of 30 doses had a blank administration block.</li> <li>-Topamax 50 mg twice daily by mouth. 2 of 60 doses had encircled initials.</li> </ul> <p>In interview with LPN #4 on 10-29-14 at 6:15 a.m., she indicated the Lasix orders were unclear to her in regard to the two orders for "every other day" and one order for "daily" dosing. She indicated she would request clarification from the physician.</p> <p>In review of Resident #E's MAR for October 1-30, 2014, the following listed</p>						

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	<p>medications had the following issues without explanations documented:</p> <ul style="list-style-type: none"> <li>-Valium 5 mg, one- half tablet (2.5 mg total), each morning by mouth. A blank administration block for 2 of 30 doses.</li> <li>-Valium 5 mg each bedtime by mouth. A blank administration block for 1 of 30 doses.</li> <li>-Diclonfenac 75 mg twice daily by mouth. Encircled initials for 1 of 60 doses and 2 of 60 doses with blank administration blocks.</li> <li>-Lasix 40 mg every other day by mouth. 1 of 15 doses had encircled initials.</li> <li>-Lasix 40 mg, one half tablet or 20 mg, every other day by mouth. 1 of 15 doses had encircled initials and 1 of 15 doses had blank administration blocks.</li> <li>-Lasix 20 mg daily by mouth ( a new order, written on 9-12-14). 2 of 30 doses had encircled initials and 1 of 30 doses had a blank administration block.</li> <li>-Hydralazine 10 mg twice daily by mouth. 2 of 60 doses had blank administration blocks.</li> <li>-Simvastatin 5 mg daily at bedtime by mouth. 3 of 30 doses had a blank administration block.</li> <li>-Topamax 50 mg twice daily by mouth. 1 of 60 doses had encircled initials and 3 of 60 doses had blank administration blocks.</li> <li>-Risperdal 2 mg at each bedtime by mouth. 2 of 60 doses had blank</li> </ul>			

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	<p>administration blocks.</p> <p>-Lamotrigine 150 mg, 2 tablets or 300 mg total, daily by mouth. 2 of 30 doses had blank administration blocks.</p> <p>-Lisinopril 10 mg, 2 tablets or 20 mg total, each morning by mouth. 3 of 30 doses had blank administration blocks.</p> <p>-Lisinopril 10 mg each evening by mouth. 1 of 30 doses had a blank administration block.</p> <p>-Metoprolol ER 200 mg daily by mouth. 2 of 30 doses had blank administration blocks.</p> <p>-Ferrous Sulfate 325 mg twice daily by mouth (new order written on 10-22-14). 5 of 16 doses had blank administration blocks.</p> <p>5. The clinical record of Resident #F was reviewed on 11-3-14 at 9:15 a.m. Her diagnoses included, but were not limited to, glaucoma. Her most recent service plan, dated 10-8-14, indicated she was alert and oriented to person, place and time. It indicated the facility administered her medications to her.</p> <p>During a medication pass observation with LPN #3 on 10-28-14 at 11:26 a.m., LPN #3 was observed to instill one drop of Pred Forte Suspension into both eyes. Upon review of the Medication Administration Record (MAR) and the physician orders, it was noted the resident</p>			

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	<p>was to receive one drop in the left eye every other day of Prednisolone Suspension 1% for glaucoma. In interview with LPN #3 at this time, she indicated she knew one of the resident's eye drops were to be given every other day and had checked for that. She indicated she had routinely been giving this eye drop into both eyes.</p> <p>In review of the October 1 to 28, 2014 MAR, this medication had blank administration blocks for 4 of 14 doses.</p> <p>In interview with the DON on 10-30-14 at 4:45 p.m., on 10-31-14 at 2:10 p.m. and on 11-3-14 at 8:50 a.m., she indicated the facility does not have written policies on medication assistance and/or administration. On 10-31-14 at 2:10 p.m., she indicated inservices are conducted on an "as needed" basis regarding medication administration.</p> <p>This Residential tag relates to Complaint IN00157462 and Complaint IN00157816.</p> <p>2.5-8.1(a)(1) 2.5-8.1(a)(2)</p>						