STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/08/2019

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LAMPLIGHT INN OF FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit was done in conjuction with Investigation of Complaint IN00303070. Complaint IN00303070 - Substantiated. Deficiencies related to the allegations are cited at R0349. Survey dates: August 5, 6, 7, & 8, 2019 Facility number: 012288 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 13, 2019.	R 0000	The Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state regulation.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents '			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on interview and record review the facility failed to ensure Resident Rights for 4 out of 10 residents reviewed for Resident Rights. (Resident 2, Resident 4, Resident B, and Resident R) Findings include: 1. A review of Resident 2's record on 8/7/2019 at 10:30 a.m., indicated diagnoses included, but were not limited to: lung disease. The DON (Director of Nursing) indicated Resident 2 was able to be interviewed. The admission record file indicated no documentation that the Resident 2 was provided the Resident Rights and signed that they received the rights. 2. A review of Resident 4's record on 8/7/2019 at 2:45 p.m., indicated diagnoses included, but were not limited to: heart disease, arthritis, and depression. The DON indicated Resident 4 was able to be interviewed. The admission record file indicated no documentation that the Resident 4 was provided the Resident Rights and signed that they received the rights. 3. A review of Resident B's closed record on 8/7/2019 at 12:45 p.m., indicated diagnoses included, but were not limited to: brain disease,	R 0026	Element One The social services coordinator reviewed the Residents Rights statements with the four identified residents lacking a signed Residents Rights statement. Acknowledgement signatures were obtained and copies placed into their resident record. Element Two All residents could potentially be effected by this deficiency. The administrative staff reviewed each resident record to verify that they had a signed copy of the residents' rights statement in their record. Those without were contacted by the SSC and a time set for reviewing the document and obtaining an acknowledgement signature. Signed copies were placed into individual resident record. Element Three It is the assigned responsibility of the Executive Director and/or Admissions Director to review the Indiana Resident's Rights statement with each new admission as part of their move-in	09/27/2019

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	and anemia. The admission record file indicated no documentation that the Resident B was provided the Resident Rights and signed that they received the rights. 4. A review of Resident R's closed record on 8/7/2019 at 4:50 p.m., indicated diagnoses included, but were not limited to: liver cancer. The admission record file indicated no documentation that the Resident R was provided the Resident Rights and signed that they received the rights. During an interview on 8/8/2019 at 4 p.m., the Admissions Coordinator indicated they were unsure if the 4 residents received the Resident Rights and signed documentation that they received such Rights.		process. In addition the Executive Director will request permission to review the Resident's Rights statement at each Resident Council meeting. The social services coordinator will also review with individual residents at their regularly scheduled plan of care meeting.. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Executive Director/designee will perform a monthly audit of 10% of current resident records to confirm that there is a signed copy in their chart. Those without will be promptly resolved. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure a back ground check and references were completed and on site for 1 of 9	R 0116	Element One It is Lamplight Inn of Fort Wayne's intention to conduct	09/27/2019

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	employee personnel records reviewed. (Employee 8) Findings include: A review of personnel records on 8/8/2019 at 2:55 p.m., indicated Employee 8 had no pre employment screening completed and on site. During an interview on 8/8/2019 at 3:30 p.m., the Human Resource Coordinator indicated they had no personnel record for Employee 8 at the facility. There was no policy provided by the facility pertaining to pre employment procedures.		Reference Checks and a Criminal Background check as part of the post job offer phase of employment. The individual who's file was not present was a traveling administrator; full file was obtained and updated within the LLFW personnel records. Element Two Administrative staff conducted an audit of all current employees records to verify presence of requried backgorund checks. Those employees without such information in their file were rescreened accordingly and completed at that time and placed in their personnel file. No residents were noted to be affected by the alleged noncompliance. Element Three The facility's Business Office Manager/desgnee are responsible for ensuring background checks are completed; department heads assist with the process. We use a 3rd party service to do the criminal background checks. BOM. HR Director and Department Heads were inserviced on the expectations. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Business Office Manager/designee will perform a monthly audit of all	

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			news hires of that month and 10% of curent staff records to confirm that the required checks have been completed and are in their respective personnel file. Those without will be promptly resolved. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			

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	Based on interview and record review, the facility failed to ensure at least one working staff member had First Aid Certification. This had the potential to affect 110 residents that were residing in the facility. Findings include: A review of the nursing Daily Assignment Schedule, provided by the DON (Director of Nursing) on 8/8/2019 at 1:49 p.m., indicated on Wednesday July 31, 2019, 2nd shift had no employee working with documented First Aid certification. During an interview on 8/8/2019 at 5:26 p.m., the DON indicated they had no one scheduled with First Aid certification. None of the 6 employees working on 2nd shift on 7/31/2019 had been certified. There was no facility policy provided pertaining to First Aid certifications.	R 0117	Element One It is Lamplight Inn of Fort Wayne's intention to ensure that trained staff in First aid and CPR are on duty and are within the guidelines of 1 staff member to every 50 residents. Those employees identified as missing CPR and First Aide training were scheduled for such training. Element Two Administrative staff audited all current employees records for documentation of CPR and First Aid training. First aid and CPR training will be scheduled and/or completed no later than 9/27/2019. Training is provided to all staff who chose to attend. Personnel files will be updated with a copy of First aid and CPR certification once obtained. Element Three CPR and First Aid training classes are being offered for all interested staff; nursing staff are required to participate in the class and obtain needed certifications. In addition, the Nursing Manager will identify on the daily schedule the staff that are First aid and CPR certified. All new employees will be scheduled for First aid and CPR certification in the following quarterly class schedule. Element Four	09/27/2019

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			Compliance will be monitored by use of an Audit Process and Tracking Form. The Business Office Manager/designee will perform a monthly audit of daily schedule templates to ensure compliance with the CPR and First Aid staffing rules. They will also review 10% of the current personnel records to verify for CPR and First Aid certification Those without will be encouraged to take the class; to be offered quarterly at facility. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart;			

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	(B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review the facility failed to ensure orientations were completed and signed by the instructor for 9 out of 9 employees reviewed. (Employee 6, Employee 8, Employee 13, Employee 14, Employee 15, Employee 16, Employee 17, Employee 18, and Employee 19) Findings included: A review of personnel records on 8/8/2019 at 2:45 p.m., indicated no documentation of General Orientation and Job Specific Orientation, for the following employees: Employee 6, Employee 8, Employee 13, Employee 15, Employee 16, Employee 17, and Employee 19. Employee 14 and Employee 18 had no documentation of Job Specific orientation in their personnel record. During an interview on 8/8/2019 at 3:30 p.m., the Human Resource Coordinator indicated there were no signed General or Job Descriptions completed	R 0119	Element One The nine staff members identified with missing orientation documentation in their personnel file have been retrained and signed off on the necessary forms. Element Two All current and future staff have the potential to be affected by this deficiency. The Human Resources Coordinator has audited each current employee file for missing orientation documentation. Those witout such documents have been retrained and signed off on the necessary forms. Element Three The facility has implemented the following new system: 1. The Human Resources Coordinator	09/27/2019

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	for the 9 employees. They further indicated they were working on the orientation process. There was no policy provided by the facility pertaining to the orientation procedures of the facility.		shall be responsible for compliance of this requirement. 2. Each new hire will receive a comprehensive general orientation, with training input from primary department heads and via use of an onlie training software. Employees will sign designated orientaiton form to verify training, which will be placed in their personnel file. 3. Job Specific Orientation will use the employee's job description as the basis for their trianing. In some cases a reference manual is available and some online training tools. Employees will sign a designated orientation form to verify training, which will be placed in their personnel file. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Executive Director/designee will perform a monthly audit of all new hires for that moth to confirm that there is a signed copy of both general and job specific orientation training. Those without will be promptly resolved. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility	R 0120	Element One	09/27/2019

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	failed to ensure dementia training was completed for 2 of 9 employees reviewed. (Employee 6 and Employee 8) Findings include: A review of personnel records on 8/8/2019 at 2:40 p.m., indicated there was no documentation of dementia training for Employee 6 and Employee 8. During an interview on 8/8/2019 at 3:30 p.m., the Human Resource Coordinator indicated they have no documentation that the 2 employees received dementia training within the 6 month time period of hire. There was no policy provided by the facility pertaining to dementia training requirements.		It is Lamplight Inn of Fort Wayne's intention to provide all employees with annual Dementia training. The two individual employees identified as missing demehtia training have received such training and documentation has been placed in their personnel file. Element Two The Business Office Manager/designee has conducted an audit of all current employees records to verify dementia training documentation. All staff without such training will recieve such, via onsite insrevice training, on line learning or 1:1 training. No residents were noted to be affected by the alleged noncompliance. Element Three The facility has implemented the following new system: 1) new hires will be required to complete dementia training as part of their attendance to the monthly face-to-face general orientation. Dementia training will be completed within 1 week of the general orientation. 2) Existing employees will obtain their demetnia training referesher yearly via the facility's CEU training program. Every employee will be required to complete 3-5 hours of annual dementia training. Maintenance of the completion records will be the responsibility of	

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			the Business Office Manager/designee. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Business Office Manager/designee will perform a monthly audit of all news hires of that month and 10% of current staff records to confirm that the required dementia training has either been scheduled or completed and documentation of such is in their respective personnel file. Those without will be promptly resolved. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for			

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	tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure TB (Tuberculosis) testing was completed for 7 of 8 employees reviewed. (Employee 6, Employee 8, Employee 13, Employee 14, Employee 16, Employee 17, and Employee 18) Findings include: A review of personnel records on 8/8/2019 at 2:35 p.m., indicated the following: Employee 6 was hired on 11/5/2018. They had a Step 1 Tuberculosis skin test on 11/12/2018 in their left forearm, but there was no documentation	R 0121	Element One It is Lamplight Inn of Fort Wayne's policy and intention to provide new employees a health screen prior to resident contact. This screen shall include a Tuberculin skin test, using the mantoux method, unless a previous positive reaction can be documented. The employees identified as not having the required Tuberculin skin test received such and it has been read. No concerns noted.	09/27/2019

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	of it being read, and a second step being completed. Employee 8 had no hire date, and no documentation of any Tuberculosis skin test being completed. Employee 13 was hired on 7/1/2019. They had no documentation of any Tuberculosis skin test being completed. Employee 14 and Employee 16 had no documentation of an annual Tuberculosis skin test completed. Employee 17 was hired on 3/20/2019. There was no documentation of any Tuberculosis skin test being completed. Employee 18 was hired on 4/3/2019. There was no documentation of any Tuberculosis skin test being completed. During an interview on 8/8/2019 at 3:30 p.m., the Human Resource Coordinator indicated there were no Tuberculosis skin tests completed for the 7 employees. A current facility policy, Testing, that was not dated, indicated no procedure for employee Tuberculosis testing.		Element Two Administrative staff conducted an audit of all current employees records to verify presence of required Health Screening and TB test results. Those employees without such information in their file were rescreened accordingly and tests completed at that time and placed in their personnel file. No residents were noted to be affected by the alleged noncompliance. Element Three Going forth, upon employment offer,all employees will be scheduled for a Physical Health Screen and a Tuberculosis skin test. Upon completion of skin test, it will be required that the results are returned to the Business Office/Designee. The Business Office Manager/Designee will then determine if a second step process need to be completed. When both steps are completed, a copy of the form will be placed in the employees' file as well as the Physical Health Screen. Annual TB test will be administered to all staff with the exception of anyone with an allergy or has a history of positive reactor, who will submit a chest x-ray if necessary every 5 years or with any signs or symptoms of active TB.	

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		A. BUILDING 00 B. WING	08/08/2019

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			Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Business Office Manager/designee will perform a monthly audit of all news hires of that month and 10% of current staff records to confirm that the required TB tests/chest x-rays have been completed and are in their respective personnel file. Those without will be promptly resolved. Audits shall be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights.			

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		A. BUILDING 00 B. WING	08/08/2019

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	(9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure job descriptions were completed for 4 of 9 personnel records reviewed. (Employee 8, Employee 13, Employee 14, and Employee 15) Findings include: A review of personnel records on 8/8/2019 at 2:30 p.m., indicated the following employees did not have signed Job Descriptions completed in their individual personnel record: Employee 8, Employee 13, Employee 14, and Employee 15. During an interview on 8/8/2019 at 3:30 p.m., the Human Resource Coordinator indicated there were no signed and completed Job Descriptions for the 4 employee's, and there should have been one completed for each employee. There had been no policy provided by the facility pertaining to the procedure for job descriptions at the facility.	R 0123	Element One It is Lamplight Inn of Fort Wayne's intention to maintain current and accurate personnel records for all employees. The four individual employees who were missing signed job descriptions were given copy of their job description, reviewed it and then signed for placement in their personnel file. Element Two Administrative staff conducted an audit of all current employees records to verify presence of required signed job description. Those employees without such documentation in their file were given a copy of their job description, reviewed it, signed it and then placed into their personnel file. Element Three Business Office Manager/designee/department heads were retrained on new employee orientation and training programs, including need to review job description and have them sign the job description. Going forth, upon completion of new hire paperwork, employees will be given their Job descriptions and they will be read over, discussed, reviewed and signed during new	09/27/2019

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			hire paperwork. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Business Office Manager/designee will perform a monthly audit of all news hires of that month and 10% of current staff records to confirm that the required job description has been reviewed and signed off by the employee and that it is in their respective personnel file. Those without will be promptly resolved. Audits will be conducted monthly, times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, interview and record review, the facility failed to ensure wanderguard (device used to protect memory care resident from elopement) equipment was monitored for placement and/or function for 1 of 1 residents reviewed. (Resident 7) Findings include: On 8/6/19 at 1:23 p.m., Resident 7 was not observed to be on the 9th floor. At this time,	R 0145	Element One The Wander Guard device for Resident #7 was replaced and verified as fully functioal. Element Two All residents who wear a Wander Guard have the potential to be affected by this deficient practice. The Maintenance Director checked all currently in use Wander Guards and veified that	09/27/2019

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	CNA (certified nursing assistant) 2 was interviewed. She indicated the resident was down on the first floor in activities. On 8/6/19 at 1:30 p.m., the resident was observed in the activity room on the first floor. Activity staff was with the resident in the room. The resident was sitting at a table the farthest away from the door. On 8/7/19 at 10:30 a.m. the resident was observed ambulating in the hall with a wanderguard (WG) bracelet in place to her left wrist. On 8/7/19 at 3:12 p.m., the Maintenance Supervisor was interviewed. He indicated he talked to the nurses and they indicated the way they are aware the WG alarm was working was when the resident would go to near the elevator and the alarm would sound. The Maintenance Supervisor indicated staff keep an eye on Resident 7 because, she wanders. He indicated he looked at her WG and it had a date of 4/23/19 to "activate by." He indicated he called the 800# to find out what this information meant. He indicated the company indicated this was the expiration date. He indicated he was not sure who checked the WGs at the facility to ensure they were in working order. He indicated he was unaware who, if anyone, monitored the expiration dates to the WG bracelets. He indicated he was unaware of who verified the function of the WG sensors located at the exit doors to the facility. He indicated he did not have another WG to replace this one that was expired, currently on Resident 7. He indicated there were extra WGs at the facility but he didn't know where they were as he had recently been hired at the facility. On 8/7/19 at 3:34 p.m., the CNA 3 was interviewed.		they were fully functional. He also verified that the transponders were workng properly on the Memory Care Unit. Element Three The facility has implemented the following new system: 1. Oversight of the Wander Guards is the responsibility of the Maintenance Director/designee. 2. The evening shift nurse will verify daily that each Wander Guard device worn by a resident is working properly. They will record that check in the resident's MAR. Any non functioing devices will be immediately replaced. 3. The Maintenance Director/designee will verify each day that the trasnponders are working properly, using a mew tracker form. The system will be promptly serviced if a concern is found. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Executive Director/designee will perform a weekly audit of 25% of in use Wander Guard records to confirm that they are working properly, that the resident is wearing the device and that the daily checks are being recorded in the MAR. They will also verify that the maintenance person is cheking the transponders and tracking their testings. Any concerns will	

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LAMPLIGHT INN OF FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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	She indicated she worked the evening shift. She indicated the WG for Resident 7 was in working order. She indicated she knew this because the resident was taken off the unit every day to go to activities and when she left the floor and/or returned to the unit via the elevator, the alarm would sound. She indicated this alarm sound was activated by the WG being close to the elevator doors and/or exit door to the unit. She indicated she would not know how to check if the WG worked if the resident did not get close to the elevator and/or doors. She indicated the elevator will not move when it was alarming due to the WG but the doors would still open. She indicated the staff do not document these observations of the WG working. On 8/7/19 at 3:40 p.m., the resident was observed to get off the elevator with visitors and the WG alarm did sound. The doors to the elevator remained open and the elevator didn't move until the staff was able to turn the alarm off. On 8/7/19 at 4:04 p.m. the Maintenance Supervisor was interviewed. He indicated he found more WGs at the facility and they all have the same expiration date, 4/23/19. He indicated he called the 800# and was informed the WGs were good for 90 days after the "activation by date" and since the "activation by date" on these WGs was April 23, 2019, "these WG were technically no good." He indicated even though the WG Resident 7 had on still worked, by activating the sensor by the exits to the unit, it was considered expired. He indicated he found out there were several different types of WGs...some are good for 90 days before they expire and others are good for 1 year. He indicated he ordered a WG with a 1 year expiration time frame for Resident 7. He indicated he had the WG overnighted to the facility and it would be at		be promptly resolved. Audits shall be conducted weeky, times two months, then monthly times six months, and reported to the QAPI Committee. Compliance Date is September 27, 2019	

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	the facility in the morning. On 8/7/19 at 4:35 p.m., the Director of Nursing (DON) was interviewed. She indicated the facility ensured the resident's WG was working by walking Resident 7 near the elevators. The DON was unsure if these observations of the WG working were documented or not. The DON was made aware the current WG was technically expired and the Maintenance Supervisor was having a new WG mailed overnight to replace the expired one she had on. The DON indicated she would stay the night at the facility to ensure the resident's safety. On 8/7/19 at 5:00 p.m., the DON provided a current, undated copy of the facility policy and procedure for "Wander Guard Policy." The policy included, but was not limited to, the following: "..If the Resident is in need of the Wander Guard, it will be attached to their ankle, wrist or clothing. This will prevent exit from doors and elevators and will alert the staff of the area at risk for the wandering resident..." On 8/8/19 at 9:46 a.m., the DON provided a copy of the manufacturer's instruction for the "Wanderguard Departure Alert System" dated 2012. The instructions included, but were not limited to, the following information: "...Test each signaling device before using. Thereafter, test the device daily and record the results in the resident's record...testing without a signaling device tester..." On 8/8/19 at 9:48 a.m., the DON provided copies of the Service Care plan, dated 4/15/19. The plan included the following: admitted 4/15/19; independent ambulation; resident often needs redirection and reorientation, may become			

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	combative; may become agitated with redirection; rarely/never understands information conveyed; ability to express self is limited; always disoriented; needs daily support and reassurance while change is discussed, when decisions are being made and while changes are being implemented; decisions are poor, requiring cueing and supervision in planning, organizing and correcting daily routines; cannot remember or use information. Requires continual verbal reminding; difficulty understanding self maintenance; wanders within the facility or residence. May wander outside less than 3 times in a 7 day period. Wanders into other resident rooms and may take belongings of others and can get around inside without assistance but needs assistance of another person outside. On 8/8/19 at 10:22 a.m., the Maintenance Supervisor was interviewed. He indicated the new wanderguard (WG) arrived this morning and he was going to place it on the resident. He indicated he had already tested the function of the WG and it worked. He indicated he was going to put the WG that was good for 1 year on Resident 7. He indicated the "activate by" date on the new wanderguard was 9/13/2020. He indicated he ordered two additional wanderguards for backups and these two wanderguards were good for 90 days. He indicated he was not aware at this time, whose responsibility it was to check the function of the WGs and monitor the expiration dates of them. He indicated he had called the 800 number and they indicated the following to him: if WG was not activated by the "activate by" date, the WG was good for 90 days after the activation date. The WG can be activated 30 days after the "activate by date" but then the WG was only good for an additional 60 days. The Maintenance Supervisor indicated 90 days was the window for			

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	the usage of the wanderguard, if it was a 90 day WG. The Maintenance Supervisor indicated he was not aware when Resident 7's wanderguard was activated, but she had been admitted in mid April 2019. He indicated he was unaware who was responsible for checking the WG function of the front and back door alarm. On 8/8/19 at 11:53 a.m., the Maintenance Supervisor provided a current copy of the facility policy and procedure for "Wandering Resident Safety System" dated 7/1/05. The policy included, but was not limited to, the following: "...Residents who wear a safety-monitoring device are evaluated at frequent time intervals during the day for placement of the device...Safety monitoring device (sic) are tested weekly, with results recorded on the Safety Monitoring Device form...The Safety Monitoring System is tested daily by the Maintenance Coordinator or designee and documented on the Safety Monitoring Testing form kept in a centralized location..." On 8/8/19 at 1:50 p.m. the DON was interviewed. She indicated the facility was going to put the expiration date of the WG on the medication administration record to monitor compliance with keeping the WG current. On 8/8/19 at 4:30 p.m., the DON was interviewed. She indicated she was unable to locate documentation of the staff having verified the WG was in place on the resident and/or working to activate the alarms.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs			

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	assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure self administration evaluations were completed for 2 of 9 resident's reviewed. (Resident 2 and Resident 4) Findings include: 1. A review of Resident 4's record on 8/7/2019 at 2:45 p.m., indicated diagnoses included, but were not limited to: heart disease, arthritis, and depression. Resident 4 was confirmed, by the DON (Director of Nursing) to be cognitively intact and able to be interviewed. On 8/7/2019 at 1:13 p.m., Resident 4 was observed in their room, sitting in a wheelchair, and agreed to be interviewed. During the interview on 8/7/2019 at 1:13 p.m., Resident 4 indicated they administer their own medications and did not need assistance from the nursing staff. A review of the assessments in Resident 4's record indicated no self administration evaluation had been completed. During an interview on 8/7/2019 at 4:35 p.m., the	R 0216	Element One The Director of Nursing assessed the two identified residents needing a medication self-administration evaluations and updated their plan of care. Element Two The Director of Nursing/designee audited all resident records to ensure that a self administration evaluation had been completed and the plan of care updated. Any identified concerns were addressed. Element Three The Regional Clinical Nurse has reviewed and retrained the nursing leadership and licensed nurses on the facility's Self Administration of Medication protocols and procedures including use of the designated assessment form, process for determining when a review is necessary and means of monitoring for needed changes. Nurses will also review with the	09/27/2019

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		A. BUILDING 00 B. WING	08/08/2019

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	DON indicated the resident should have had an assessment in the electronic chart, and a copy in their paper chart. The DON further indicated the assessments should be completed every 6 months. A policy, not dated, titled Assistance with Self-Administration of Medications, provided during the survey, indicated no evaluation or assessment was to be completed. 2. On 8/6/19 at 11:00 a.m., the tour of the facility was conducted with the DON. She identified Resident 2 as having been alert and oriented to person, place and time and was able to self administer his nebulizer (machine used to administer breathing treatments) treatments. On 8/6/19 at 1:14 p.m., Resident 2 was interviewed. He indicated he self administered his albuterol (medication used to treat wheezing and shortness of breath) breathing treatments. He indicated he takes his albuterol treatments three times a day at 9:00 a.m., 1:00 p.m. and 6:00 p.m. The resident provided his log of where he documented the day and time he gave himself his albuterol treatments. On 8/6/19 at 3:00 p.m., the clinical record of Resident 2 was reviewed. Diagnoses included, but not limited to, the following: chronic obstructive pulmonary disease. A BIMS (Brief Interview for Mental Status) dated 7/3/19 indicated the following: repeated two of three words after first attempt; correctly reported the year, month and day of week; and was able to recall two of the three previously presented words with cueing and one word without any cueing. On 8/8/19 at 5:53 p.m., the DON was interviewed. She indicated the resident was alert and oriented		resident during their regularly scheduled plan of care reviews. Element Four The Director of Nursing/designee will audit resident records for compliance with the self administration guidelines as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee. Compliance Date is September 27, 2019	

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		A. BUILDING 00 B. WING	08/08/2019

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LAMPLIGHT INN OF FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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	to person, place and time. She indicated he was very capable and reliable to administer his own nebulizer. The DON indicated at this time, she was unable to find a completed assessment for the resident regarding his ability to self administer his medications.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility	R 0217	Element One	09/27/2019

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	failed to ensure service plans were updated for 2 of 10 residents reviewed. (Resident 3 and Resident 8) Findings include: 1. The record review for Resident 3 began on 8-7-2019 at 11:00 a.m. Diagnoses included but were not limited to, hypothyroidism, macular degeneration, osteoarthritis, and dry eye syndrome. The most recent service plan found for Resident 3 was dated 3-7-2016. The last resident assessment was dated 7-2-2019. An interview with the DON (Director of Nursing) on 8-7-2019 at 1:30 p.m. indicated the service plans were completed quarterly. She indicated she became the DON in January 2019 and none of the resident service plans had been entered into the computer system. The DON indicated she began to work on entering the service plans in the computer and still has not gotten all of them entered. She indicated she could not find a current service plan in place for Resident 3. The DON indicated the last service plan completed for Resident 3 was dated 10-9-2018. The DON provided a signature page without a resident name or a staff signature as the most recent service plan. The DON indicated there should have been an updated service plan completed in January 2019 and quarterly thereafter. The DON indicated the Resident Assessment and Service Form dated 7-3-2019 in the computer for Resident 3 was not the service plan. 2. The record review for Resident 8 began on 8-7-2019 at 4:20 p.m. Diagnoses included but were not limited to,		The Director of Nursing updated the service plans of the two identified residents and reviewed those updates with the resident and obtained their signatures. Element Two The Director of Nursing/designee audited all resident records to ensure that service plans were current and signed by the resident and other designated individuals. Any identified concerns were addressed and the plan of care updated and service plan reviewed with the resident/representative. Element Three The Regional Clinical Nurse has reviewed and retrained the nursing leaderhsip and licensed nurses on the facility's Service Plans. The Director of Nursing has, in turn, reviewed the purpose and function of service plans with the remaining care staff. Traning included protocols and procedures including use of the designated assessment form, how to create and update a service plan and the importance of personally reviewing it with resident/representatve and obtaining signatures. Also reviewed when a service plan should be updated. Element Four The Director of Nursing/designee will audit resident records for compliance with the service plan	

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		A. BUILDING 00 B. WING	08/08/2019

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	chronic obstructive pulmonary disease with exacerbation, hypothyroidism, hyperlipidemia, high blood pressure, and coronary atherosclerosis. There was not an electronic service plan entered for Resident 8 in the facility computer program. A paper service plan binder was provided by the DON on 8-8-2019 at 4:15 p.m. The most current service plan for Resident 8 was dated 8-21-2018. A missing service plan list was observed in the service plan binder with Resident 8's name listed on the paper. There was not a more current service plan provided for Resident 8 by the facility. An undated, current policy, "Coordination/Individualization of Services" was provided by the Activity Director on 8-8-2019 at 5:29 p.m. The policy indicated "...All services will be tailored to each individual's specific needs. The assistance/service plan will be developed prior to move-in. The plan will be established by the Resident Services Coordinator and the Manager with input from the resident and family/responsible person...."		guidelines as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropraite. Findings will be reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure kitchen and dining room sanitation was maintained. This had the potential to affect 110 of the 110 residebts residing in the facility.	R 0273	Element One It is Lamplight Inn of Fort Wayne's intention to ensure food is stored, prepared and served in sanitary conditions. Concerns identified were corrected including deep	09/27/2019

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	Findings include: An initial tour of the kitchen with the Food Service Manager (FSM) was conducted on 8/6/19 at 10:20 a.m. The handwash sink was observed to build up and dark residue along the interior of the basin. The knobs of the handwash sink were also observed to have a build up of gray colored residue as well as white build up of residue around the top perimeter of the sink. The automated paper towel holder was not working at this time and the FSM assisted in obtaining a roll of paper towels for hand drying, placed on the counter. On 8/6/19 at 10:25 a.m., the reach in cooler was observed. Crumbs and dried spills were observed along the interior floor of the cooler. The gasket along the perimeter of both doors were observed to have a build up of black matter throughout the length of the door gaskets. The surface of the reach in refrigerator at the gasket contact, was observed to have build up of dark matter around the perimeter of the door opening. On 8/6/19 at 10:42 a.m., the walk in cooler was observed. A covered container with a "Use by" date of 8/5/19 was observed to contain chicken. The FSM indicated the chicken was prepared yesterday and used last evening. She indicated the staff didn't understand how to use the "Use by" labels. She indicated the staff was used to using tape for labels. A covered pan of cabbage rolls was observed to have been opened but was not dated as to when it was used or a "use by date." The FSM indicated the cabbage rolls were served this past Sunday, 8/4/19, but they would be thrown out. A plastic pitcher with tomato juice was observed with no "use by" date. A box of shelled eggs was observed. The FSM opened the		cleaning the handwashing sink, reach in cooler, walk in cooler, storage areas, main dining room service area, 9th floor dining room and dish room. Element Two Potentially all residents could be affected by this alleged deficient practice. Kitchen sanitation is a priority for Lamplight Inn and all systems have been reviewed with the Dietary Director by the Regional Director of Operations, Regional Nurse and dietary consultant. A "deep cleaning" day was scheduled and dietary staff will be inserviced on food storage practices and cleaning routines. Element Three Systemic changes include: 1) reorganized cleaning schedules to address areas of concern including food storage areas, hand washing sinks and coolers. 2) Regional Director of Operations as re-trained dietary staff members on the facility's Food Storage and Sanitation policies, Cleaning Schedules and Expectations and reportig of maintenance needs. 3) The facility is obtaining quotes for the repair or replacement of the dining room flooring, which will be budgeted for as a Capital Improvement Project as soon as feasible. 4) The facility has contracted with a registered dietician service for regular	

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	box and observed stuck to the inside of the box, was 1/2 of an eggs with the yolk inside and exposed, partially liquid yet. On the metal ceiling in the back of the cooler, was observed to be a smaller mechanical unit covered by louvers or vents. Around this metal unit, was observed to be rusty colored corroded areas. Condensation was observed on the ceiling as well. The corroded areas were observed to be about 2 feet by 1 foot and was located over the shelving unit in the cooler, which currently had food placed on it. On 8/6/19 at 10:44 a.m., the dry storage racks were observed to have dried spills, dust and crumbs along the outer edges and tracks. The ice machine was placed back to back with the food prep counter in the center of the kitchen. The ice machine was observed to have a large container of "rotor rooter" with a hose in it. The empty container was laden with crumbs, dust and debris. Surrounding the container on the floor was dark matter, crumbs, dust and debris. On 8/6/19 at 10:45 a.m., the handwash sink, located on the food prep counter, was observed to have gray color residue buildup throughout the bowl of the sink. The knobs were also laden with grayish residue as well. A white color residue was observed along the top surface of the sink bowl. The paper towel holder and soap dispenser were also observed to have dried splatters of various colors. The shelves underneath the food prep table, were observed to have a scattered accumulation of dust and crumbs. The ends of the food prep counter were observed to have dried splatters. In one of the 3 compartment sinks was observed to be a sealed bag of what appeared to be gravy, meat, peas and carrots, placed in a pan. This bag was warm to the touch. The sticker		sanitation reviews and training. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Dietary Director/designee will perform regular audits according to the following schedule: 5 times a week for four weeks; 3 times a week for four weeks; weekly for four weeksa; then monthly thereafter. Any identified areas of concern will be addressed and retraining and/or disciplinary action of staff for violations will occur. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	

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	on the package said "Use by 4/23/19." The FSM was interviewed at this time and indicated this was chicken pot pie filling and should have been thrown out yesterday. The tiled wall behind the tilt skillet was observed to have brown dried splatters on the wall. On 8/6/19 at 10:48 a.m., the dishwashing area was observed. A shelf underneath the dishwashing area was observed to have vinyl dish racks placed on their sides. These racks were observed to be removed and used to place dishes in. When the racks were removed, the shelves were observed to have an accumulation of dark matter observed along the back of where the racks were housed. At 11:00 a.m. the FSM was interviewed. She indicated they were going to throw out the chicken dated 8/5/19, the stuffed cabbage rolls and the chicken pot pie filling as well. On 8/6/19 at 11:32 a.m., the 9th floor dining room was observed. Dietary Staff 4 was observed to open the drawer on the steam table to obtain the thermometers. The interior of the drawer was observed to have crumbs, dust and dried spills throughout. The sanitizing wipes for the thermometer were also in this drawer. The noon meal service was observed on 8/6/19 at 11:50 a.m. Flooring in the main dining room was observed with areas which appear to have the dark finish worn off, exposing the light surface beneath. Also observed on the dining room floor, were patches on the floor covered with black tape. The tape was observed to have the edges that were worn and frayed. The handwash sink in the dining room by the food service area was observed to have a grayish build up in the interior bowl of the sink. The knobs of the sink were also			

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	observed to have grayish buildup. The top rim of the sink was observed to have a white colored buildup. A roll of paper towels was observed sitting on the top of the sink counter. There was a paper towel dispenser on the wall over the sink. Dietary Staff was oberved to wash hands, then pick up the roll of paper towel sitting on the counter, tear off a patch of paper and dry their hands. On 8/7/19 at 11:28 a.m., the food service area in the dining room was observed. The interior of the cupboards were observed with scattered crumbs and debris observed through the cupboards. Clean dishes were being stored in several of these cabinets. Of the 12 cabinets on the bottom level, 5 doors were missing off the cupboards and the doors were observed to be placed inside the cupboard with the shelving and dishes exposed. Two of seven knobs were missing off of the cupboard doors. A griddle on the counter was observed to have accumulation of grease and crumbs on the surface, handles and edges. Interior the drawers were also observed to have crumbs, dust and debris as well. The drawers included storage of condiments, serving utensils and various kitchen items. The steam table wells were observed. The wells were observed to have cloudy water in them and also a thick accumulation of dark, gray, cloudy build up along the edges, sides and base of the wells. The material of the wells was of a non metal material. The heating element in the bottom of the wells appeared to be corroded and have a rusty color. The paper towel dispenser by the handwash sink was observed to not be working at this time and/or empty of paper towels. Dietary Staff 7 was observed to approach the hand wash sink in the dining room. He was observed to turn the water on, put soap on his hands, wet them and rubbed			

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	his hands together for about 5 seconds. He then turned off the water with his wet hands, then reached for the roll of paper towels and tore off a sheet to dry his hands. Dietary Staff 7 was then observed to distribute beverages to the residents. On 8/7/19 at 11:35 a.m., the dining room floor was observed. Areas of wear on the dark floor were observed with the lighter colored material visible beneath. Observed in 3 areas of the floor were placement of wide black tape on the flooring. The edges of the tape were frayed and in some areas rolling up. The two areas which were located directly in the vicinity of resident dining room tables, were approximately 2 1/2 feet by 2 1/2 feet and 3 feet by 1 foot. A third area of tape was in located just inside the dining room from the entrance to the kitchen and measured 5 feet x 3 feet. On 8/7/19 at 1:10 p.m., the FSM provided a current copy of the "Refrigerated Storage Quick Reference Guide" dated 2017. This document indicated juices were good for 1 week after they are opened and were to be placed in a glass or plastic container after opening. On 8/7/19 at 1:10 p.m., the FSM provided a current copy of the "Food storage" policy and procedure, dated 2018. The policy and procedure included but was not limited to, the following: "...Use use by dates on all foods stored in refrigerators and use dates according to the timetable in the...found in this section..." The policy and procedure also indicated "...walls, ceiling and floor should be maintained in good repair and regularly cleaned..." On 8/7/19 at 1:10 p.m., the FSM provided current copies of the completed "Weekly/Daily Cleaning Chart: Dietary" from 7/22/19 to 8/7/19. The chart			

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	had cleaning tasks listed to completed and the frequency they were to be completed, as in morning, afternoon and/or both. Several items, such as the steam table wells, were not observed to be on the cleaning chart. The FSM indicated these items should be clean anyway. She indicated the steam table wells should be cleaned daily by the cook. She indicated the gaskets should be cleaned when the refrigerators were cleaned. Documentation was incomplete for each of the days from 7/22/19 to 8/6/19 with at least 2 to 22 of the 28 total tasks not documented as completed. On 8/7/19 at 1:50 p.m., the dining room was toured with the FSM. Regarding the fraying, patches of black tape on the dining room floor, she indicated when the flooring was starting to "come up" the facility put the black tape down over those areas. On 8/7/19 at 4:15 p.m. the Maintenance Supervisor was interviewed. He indicated he was aware of the condition of the dining room floor and it's need to be repaired and/or replaced. On 8/8/19 at 10:30 a.m. the Maintenance Supervisor was interviewed. He indicated he is aware of the deteriorating condition of the flooring in the dining room. He indicated he had discussed the condition of the flooring and replacing the flooring in the dining room with the Executive Director (ED) shortly after he (the Maintenance Supervisor) was hired this spring. The Maintenance Supervisor indicated he had been in contact with the ED for documentation of the repair and/or replacement of the flooring. At this time, the Maintenance Supervisor has not yet received this information. On 8/8/19 at 1:53 p.m., the FSM was interviewed.			

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	She indicated all of the residents eat food from the kitchen and of the total census of 110, approximately 103 residents ate in the main dining room. At this time, she provided a current copy of the undated facility policy and procedure for "Handwashing." The policy included, but was not limited to, the following: "...for routine washing, wash the hands for 15-30 seconds...Rinse hands...dry hands with a clean paper towel...Using the paper towel, turn off the faucet. (Don't use your hands to turn off the water as they are clean and the faucet is contaminated)..." The FSM indicated the tomato juice in the pitcher, should have been dated when it had been opened as well as the pan of cabbage rolls.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview and record review the facility failed to ensure medications were stored appropriately. This practice had the potential to effect 101 of 101 residents whose medications were administered by the facility.	R 0298	Element One It is Lamplight Inn of Fort Wayne's intention is to store all medications appropriately in accordance with stated facility and	09/27/2019

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	Findings include: Observation of medication storage began on 8/7/19 at 10:00 a.m., in the Nurse's Station on the 2nd Floor with the ADON (Assistant Director of Nursing). The Medication Refrigerator was observed at 10:00 a.m., the face of the round thermometer was frozen to the back wall of the refrigerator. The condensation on the surface of the back wall of the refrigerator was icy from the top to the bottom shelf of the refrigerator section. The needle of the round thermometer read 62 degrees Fahrenheit (F). The ADON indicated there was another thermometer in the refrigerator. A tubular shaped thermometer was found in a space behind the lower shelf against the refrigerator wall. The tubular shaped thermometer read 56 degrees F. Several medications were observed to be stored in the refrigerator. Observation of the freezer compartment had pale brown and white ice collected on the surface. A popsicle in its wrapper was observed in the freezer, was not tabled with date nor a name. There were 2 ice packs in the freezer that were frozen hard. Observed the nurse remove the popsicle and discarded it in the trash. The ADON was observed to remove the thermometer from the small refrigerator, clean it with sanitizer, dried it off and put it on the middle shelf of the medication refrigerator. An interview with the ADON on 8/7/19 at 10:05 a.m., indicated the DON (Director of Nursing) indicated had taken the refrigerator logs to make copies. The ADON indicated food should not be stored in the medication refrigerator. The Treatment Cart in the 2nd Floor Nurses Station was observed with the ADON at 10:10		pharmacy policies and practices. The items in the identified treatment and medication carts were either disposed of and replaced or appropriately labeled. The medication refrigerators and freezers were cleaned and thermometers replaced. Element Two All residents have the potential to be affected by this deficient practice. However the facility did not identify any residents affected as such. Element Three Systemic changes include: 1) Regional Nurse will retrain licensed nurses and QMA's on facility's Medication Storage policy and medication regimes. 2) Pharmacy representative will provide additional training for nurses and QMA's regarding medication safety. 3) Director of Nursing/designee will check medication refrigerators and freezers and their respective thermometers weekly for cleanliness and function and verify temperatures are being recorded daily. Any identified concerns will be addressed and disciplinary action issued or retraining , as appropriate. 4) Pharmacy consultants, during their scheduled visits, will randomly inspect medication carts for cleanliness and proper storage of	

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	p.m., two used spray bottles of Wound Cleanser was in the treatment cart and were not labeled with a resident's name nor and open date. The ADON was observed to remove the two spray bottles of wound cleanser from the treatment cart and discarded them in the trash. An interview with the ADON at 10:12 p.m., indicated the Treatment cart was the storage for all of the treatments in the facility. She reported the wound cleaners were form the facility stock and the wound cleanser was for individual use. She also indicated the wound cleanser bottles should have been labeled with the residents' names, the physician's name and date it was opened. She indicated the wound cleansers were not longer used on the residents. The 9th floor Medication Cart was observed with QMA(Qualified Medication Assistant) 9 on 8/7/19 at 10:30 a.m. A 500 count bottle of Acetaminophen 500 mg (milligram, a dose measurement) caplets was labeled with a residents name, but was lacking the physician's name on the bottle. A 100 count bottle of Ibuprofen 200 mg tablets was labeled with a residents name, but was lacking a physician's name on the bottle. A 130 count bottle of Multivitamin tablets was not labeled with a resident's name, nor a physician's name. An interview with QMT 9 on 8/7/19 at 10:34 a.m., indicated the OTC (Over the Counter) medications should be labeled with the resident's name, the resident's room number, the physician's name and the directions for administration. She also indicated the facility had printed labels to put on the bottle with the required information. The 6th floor Medication Cart was observed with		medications. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Director of Nursing/designee will perform regular audits of medication carts for compliance according to the following schedule: 5 times a week for four weeks; 3 times a week for four weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be addressed and retraining and/or disciplinary action of staff for violations will occur. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	

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	QMA 10 on 8/7/19 at 10:47 a.m. Two small tubes of Neo/Poly/Dex Eye Ointment (Maxitrol, an antibiotic and steroid eye ointment) 3.5 gm (gram, a measurement) for Resident 6 was observed in the medication cart. One tube was opened, but was not labeled with an open date. The Rx (prescription) filled date was 1/28/19, the unopened tube, Rx filled date was 6/6/19. An interview with the QMA 10 on 8/7/19 at 10:54 a.m., indicated Resident 6 was still receiving the Maxitrol eye ointment. She indicated the Maxitrol eye ointment should have been labeled with an open date and could not determine when it was opened or if it would be expired. Review of Resident 6's record began on 8/7/19 at 11:15 a.m., indicated diagnoses included, but were not limited to: schizoaffective disorder, dementia, diabetes mellitus with diabetic neuropathy, asthma and chronic obstructive pulmonary disease. Review of Resident 6's physician orders, an order dated 6/6/18 for Maxitrol Ointment 3.5-10000-0.1 (dosage) in both eyes every 12 hours for infection. Review of Resident 6's MAR (Medication Administration Record) for June 2019 indicated the Maxitrol eye ointment was administered 59 times. The July 2019 MAR indicated the Maxitrol eye ointment was administered 57 times. The August 2019 MAR indicated the Maxitrol eye ointment was administered 11 times from 8/1/19 through 8/7/19 at 8:00 a.m. On 8/7/19 at 12:52 p.m., the 2nd floor Nurse's Station medication refrigerator temperature was observed to be 28 degrees F. on the 3rd			

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		A. BUILDING 00 B. WING	08/08/2019

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	thermometer. The mercury was observed to be divided in one space. The 2nd floor Nurse's Station medication refrigeration stored the following medications: Two vials of Aplisol (tuberculosis skin test) 1 vial was opened and 1 vial was not opened, both with expiration date of 5/20/20. 23 vials of Olanzapine (an antipsychotic) Injection 10 mg, single dose vials. 1 Levemir (insulin) FlexTouch pen 2 vials of Levemir 19 vials of Lantus (insulin) 5 vials of Novolog (insulin) 2 boxes, Bydureon (a non-insulin diabetes medication) with a total of 6 pens 2 mg pens. The front of box read, "Store 36 degrees F to 46 degrees F, Do not Freeze Observed the open box and the liquid med in the syringe was not frozen. 31 Basaglar Insulin Pens 1 Novolog (insulin) Flex pen 2 Lantus Pens 5 vials of Novolog (insulin) 2 vials Lantus 2 vials An Insulin EDK (Emergency Drug Kit) with exp date of 3/2020 was in the refrigerator. The EDK contained 1 Humalog (insulin) Pen, 1 Levemir Pen, 1 Lantus Pen and 1 Novolog Pen. The following suppositories (Supp) were stored in the refrigerator: 130 Bisacodyl (laxative)10 mg. Suppositories. Six of the Bisacodyl suppositories had an expiration date of 7/13/19 Acetaminophen 650 mg Suppositories had an expiration date of 7/8/19. The ADON was observed to removed the expired Bisacodyl and Acetaminophen Suppositories from the refrigerator. An interview with the DON (Director of Nursing)			

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	on 8/7/19 at 12:57 p.m., indicated the facility did not have any other thermometers. She indicated she would have to go buy a new thermometer. She indicated she did not know if any staff had adjusted the medication refrigerator's settings. An interview with the DON on 8/7/19 at 1:36 p.m., indicated Maintenance was going to get a new thermometer for the medication refrigerator. The DON provided the Medication Refrigerator Daily Temperature Log for January 2019 through July 2019. The August 2019 Refrigerator Log was requested. An interview with QMA 12 on 8/7/19 at 2:15 p.m., she indicated she worked evening shift. She also indicted eye ointments should have an open date written on the Rx label when it was opened. She indicated the Maxitrol ointment did not appear to be opened and was not labeled with an open date. An interview with the ADON on 8/7/19 at 2:25 p.m., indicated QMA 11 had told her the Maxitrol for Resident 6 was not labeled with an open date and had discarded the opened Maxitrol ointment. An interview with the ADON on 9/7/19 at 3:10 p.m., indicated she had adjusted the medication refrigerator setting around 11:15 a.m. to 11:30 a.m. when the temperature was to high. She indicated they needed a new thermometer or a new refrigerator or maybe both. The DON provided the August Refrigerator Temperature Log for Floor 2 on 8/7/19 at 3:58 p.m., the log was reviewed and was lacking the year documented on it. The log indicated the "Medication Fridge Temp" was documented 8/1 through 8/6 with a temperature range 36 to 40 degrees F.			

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	The DON provided the [Name] Pharmacy Service Policy and Procedure Manual on 8/8/19 at 11:50 a.m. and indicated the facility should follow the Pharmacy's policy for medication Storage. Review of the current facility's Pharmacy Policy, dated 11/18, titled, "Medication Storage In The Facility" indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier....K. Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separated for fruit juice, applesauce, and the foods...Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator....Temperature. A. Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopoeia guidelines for temperature range... C. Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees F and 46 degrees F with a thermometer to allow temperature monitoring...Expiration Dating...C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufactures's expiration date to insure medication purity and potency...c...Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is:...2. An item for which the manufacturer has specified a usable life after opening...D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) A "date opened" sticker shall be placed on the medication...The expiration date of the vial or			

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	container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating...E. The medication administration personnel will check the expiration date of each medication before administering it...F. No expired medication will be administered to a resident...G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining...." Review of the manufacturer's recommendation per the Maxitrol Ointment Package Leaflet on 8/8/19 at 12:15 p.m., The manufacturer's package leaflet indicated, "...Stop using the tube 4 weeks after first opening, to prevent infections...."			
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on observation, interview and record review, the facility failed to ensure the resident was provided with prescription medication as ordered for 1 of 1 residents reviewed for self administration of medication. (Resident 2) Findings include: On 8/6/19 at 11:00 a.m., the tour of the facility was conducted with the Director of Nursing (DON).	R 0305	Element One It is Lamplight Inn of Fort Wayne's intention to order and provide residents with all prescribed medications. Resident #2's medication was ordered and provided to the resident, allowing him to self administered accordingly.	09/27/2019

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	She identified Resident 2 as having been alert and oriented to person, place and time and was able to self administer his nebulizer (machine used to administer breathing treatments) treatments. On 8/6/19 at 1:14 p.m., Resident 2 was interviewed. He indicated he self administered his albuterol (medication used to treat wheezing and shortness of breath) breathing treatments and had not gotten the treatments for a few days. He indicated he takes his albuterol treatments three times a day at 9:00 a.m., 1:00 p.m. and 6:00 p.m. He indicated he had been unable to get the medicine from the facility for a few days. He indicated the last time he gave himself an albuterol treatment was on 8/4/9 at 1:15 p.m. After this last dose, he indicated he was not provided the albuterol medicine. The resident provided his log of where he documented the day and time he gave himself his albuterol treatments. The last treatment documented on 8/4/19 was at 1:15 p.m. The resident had documented "no" for the evening dose on 8/4/19. Resident 2 had also documented he had not given himself any albuterol treatments on 8/5/19 and on 8/6/19 as of this time, due to not having the medication. The resident indicated the facility changed pharmacies about a month ago and the facility told him then don't have the medicine on the unit where the resident resided. The resident indicated "for awhile" they were getting my medicine, but he didn't know where they got it from. He indicated the facility was aware he was not getting the albuterol to give himself his breathing treatments. He indicated when he asked for albuterol for his treatments, they say they will get him some but they never come back and give him any as the facility staff indicated they can't find any albuterol for him. On 8/6/19 at 1:50 p.m., the DON was interviewed.		Element Two All residents who self-administer have the potential to be affected by this deficient practice. The Director of Nursing/designee confirmed that all medications were in stock for all residents who self-administer. Any concerns were immediately addressed by clarifying if there was an order change or if the medications needed to be reordered. Element Three The Regional Clinical Nurse will inservice all licensed nurses and QMA's on the facility's Self Administration policies including the restocking of such medications. Nurses will be instructed to reorder any needed medications on their shift, if they identify such need. Pharmacy consultants, during their scheduled visits, will randomly inspect medication carts to confirm that medications are in stock, per physician order. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Director of Nursing/designee will perform regular audits of medication carts for compliance according to the following schedule: 5 times a week for four weeks; 3 times a week for four weeks; weekly for four weeks; then monthly	

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	She indicated the physician sent in a refill prescription yesterday for the resident's breathing treatments. She indicated the facility had recently changed pharmacies. She indicated the pharmacy would deliver the medication the next day if the pharmacy received the order before noon. On 8/6/19 at 1:58 p.m., the DON was observed to go to the second floor medication room. She found a box of Albuterol nebulizer treatments for the resident with a delivery date of 1/19/19. She indicated the dosage was Albuterol 2.5 mg/0.5 ml. She opened the box and indicated there were 20 treatments in the box. She indicated the resident must not have had any treatments in his room. On 8/6/19 at 3:00 p.m., the clinical record of Resident 2 was reviewed. Diagnoses included, but not limited to, the following: chronic obstructive pulmonary disease. A "BIMS" (Brief Interview for Mental Status) dated 7/3/19 indicated the following: repeated two of three words after first attempt; correctly reported the year, month and day of week; and was able to recall two of the three previously presented words with cueing and one word without any cueing. On 8/7/19 at 12:14 p.m., Resident 2 was interviewed. He indicated the facility had given him some breathing medicine packets for his nebulizer on 8/6/19. He he had opened the medication packet, put the medication in his nebulizer and indicated "there's nothing in there." Resident 2 provided the package of medication he had been given by the facility on 8/6/19. The package was labeled as followed: albuterol sulfate inhalation solution, 0.5%; 2.5 mg (milligrams)/0.5 ml (milliliters). "Dilute before use." The instructions indicated to twist open the top of one albuterol sulfate inhalation solution unit.		thereafter. Any identified areas of concern will be addressed and retraining and/or disciplinary action of staff for violations will occur. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	

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	Squeeze the solution into the nebulizer reservoir. Add 2.5 ml of sterile normal saline solution, as your doctor had directed. Gently swirl the nebulizer to mix the contents and connect it with the mouthpiece or face mask and the compressor. He indicated the facility "just gave him the medicine" and did not provide any additional information regarding the dilution for administration of this medication. The resident was not provided with any sterile normal saline to dilute the medication with. The resident compared the dose of the medication he had been given previously, of Albuterol 2.5 mg/3 ml to the current dose of Albuterol 2.5 mg/0.5 ml. The resident pointed out the difference in the concentration. He indicated he was not taking any more of the medication at this time. On 8/7/19 at 12:16 p.m., Resident 2 provided his documentation of his medication administration. He indicated he wrote down daily when he gave himself his albuterol nebulizer treatments. Resident 2 indicated his last dose of albuterol he had available to administer to himself was on Sunday, 8/4/19 at 1:15 p.m. He indicated he did not have a dose 8/4/19 in the evening, he had no doses at all on 8/5/19 or 8/6/19. He had documented in his calendar on 8/5/19 and 8/6/19 he had not given himself any albuterol treatments on those days. On 8/7/19 at 12:21 p.m., QMA (Qualified Medication Aide) 1 was interviewed. She indicated she was working on the resident's unit. She indicated the resident had doses of albuterol for self administration available in the medication cart and his room. She indicated the resident administered his own albuterol treatments. She indicated the staff do not administer his albuterol treatments. She indicated the resident had been			

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	saying he didn't have the correct dosage "but he does." QMA 1 provided the package of Resident 2's albuterol treatments. The individual packages were labeled as followed: albuterol sulfate inhalation solution, 0.5%; 2.5 mg (milligrams)/0.5 ml (milliliters). "Dilute before use." The instructions indicated to twist open the top of one albuterol sulfate inhalation solution unit of use container. Squeeze the solution into the nebulizer reservoir. Add 2.5 ml of sterile normal saline solution, as your doctor has directed. Gently swirl the nebulizer to mix the contents and connect it with the mouthpiece or face mask and the compressor. QMA 1 indicated the resident was "getting the right dose." QMA 1 indicated the only information she documented in the MAR (medication administration record) was the resident self administered the medication. She indicated this was documented by a "Yes or No" on the MAR for this medication. On 8/7/19 at 12:40 p.m. the DON was interviewed. She indicated when a resident self administered their own medication, the nurse only documented the "self administration." She was made aware of the resident having used the Albuterol medication dose 2.5 mg/0.5 ml and was not provided any sterile normal saline to dilute the medication with as instructed on the package. She was also made aware the resident was not provided with any instruction for the dilution process. On 8/7/19 at 1:35 p.m., the DON provided a current but undated copy of the facility policy and procedure for "Assistance with Self-Administration of Medication." The policy and procedure included, but was not limited to, the following: "...Assistance with re-ordering refills can be provided..."			

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	On 8/8/19 at 10:00 a.m. the DON was interviewed. She indicated she had provided the resident with sterile normal saline solution, to dilute his albuterol with 2.5 ml for his treatment as instructed on the package. She indicated she provided this normal saline to the resident last evening and also instructed him as to how to mix it with the normal saline as instructed on the package. On 8/8/19 at 12:00 p.m., the DON provided a current copy of the resident's physician orders. The orders, dated 10/30/17 included, but were not limited to, the following: "Albuterol Sulfate Nebulization Solution (5 mg/ml) (milligrams/milliliter) 0.5%. 1 application inhale orally via nebulizer three times a day related to Chronic Obstructive Pulmonary Disease..." On 8/8/19 at 1:42 p.m., RN 5 was interviewed. She was made aware of the discrepancy of the physician order dated 10/30/17, "Albuterol Solution...5 mg/ml, 0.5%...via nebulizer three times a day..." versus both of the strengths of Albuterol the resident indicated he had been receiving and had an empty package of "Albuterol...0.083%, 2.5 mg/3 ml..." The package of Albuterol provided by the from the medication cart was labeled "Albuterol...2.5 mg/0.5 ml" and indicated on the package to dilute with 2.5 ml of sterile normal saline. She indicated she would clarify the Albuterol order as to which was correct. She indicated she had talked to the pharmacy a couple of days ago to clarify the Albuterol order. She indicated the Albuterol was to be the 5 mg/ml, 0.5% dose. She indicated she didn't document the clarification as "it was already written as an order in 2017." She indicated she would call the pharmacy to see when they will send this dose.			

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	On 8/8/19 at 1:45 p.m., the DON was made aware of the concern with the Albuterol dose provided to the resident not the same as what the physician order indicated. The DON indicated she would call the pharmacy to clarify. On 8/8/19 at 3:46 p.m., the DON provided a copy of the current medication administration record (MAR) for Resident 2 for August 2019. The physician order for "Albuterol Sulfate Nebulization Solution (5 mg/ml) 0.5%, 1 application inhale orally via nebulizer three times a day related to chronic obstructive pulmonary disease..." On 8/4/19, the resident was documented on the MAR has having had the medication administered as 8:00 a.m., 2:00 p.m. and 6:00 p.m. A pulse was documented for each one of these entries. On 8/5/19, the 8:00 a.m. dose was documented to "see progress notes." The clinical record was reviewed at this time for 8/5/19 and no entry was observed. The medication was not documented as having been given. The remaining two doses for the date 8/5/19 had been documented they had been given and had a pulse rate to accompany the administration. The resident also had 3 daily doses documented for 8/6/19 and 8/7/19 with pulse rates for each dose documented given. On 8/8/19, the 8:00 a.m. and 2:00 p.m. doses had been documented as given with an pulse rate documented for each dose as well. On 8/8/19 at 5:53 p.m., the DON was interviewed. She indicated she had just contacted the both the former pharmacy and the current pharmacy and the physician in an attempt to get clarification of the dose of Albutrol the resident was to be receiving. The DON indicated she had just received an order from the physician for "Albuterol 2.5 mg/3 ml" for the nebulizer treatment			

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	three times a day. She indicated the current pharmacy would be supplying this medication for the resident. The DON indicated at this time, she was unable to find a completed assessment for the resident regarding his ability to self administer his medications.			
R 0349 Bldg. 00	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 interview and record review, the facility failed to ensure accurate documentation of medication administration by the nursing staff for 5 of 10 residents reviewed. (Resident 6, Resident 1, Resident 3, Resident 8 and Resident B) Findings include: 1. Review of Resident 6's record began on 8/7/19 at 11:15 a.m., indicated diagnoses included, but were not limited to: schizoaffective disorder, dementia, diabetes mellitus with diabetic neuropathy, asthma and chronic obstructive pulmonary disease. Review of Resident 6's physician orders, an order dated 6/6/18 for Maxitrol Ointment 3.5-10000-0.1 (dosage) in both eyes every 12 hours for infection.	R 0349	Element One It is the intent of Lamplight Inn of Fort Wayne to provide adequate and thoughtful and accurate documentation of medication administered in the eMAR system. Once notified of cited Noncompliance issue the Director of nursing began and completed an overall audit for proper documentation. Thus, ensuring that the residents needs were met without adverse effects associated with medication administration documentation. Element Two All residents receiving medications have the potential to be affected by this deficient practice. The Director of Nursing has reviewed	09/27/2019

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	Review of Resident 6's MAR (Medication Administration Record) for June 2019 indicated the Maxitrol Ointment 3.5-10000-0.1 (Neomycin-Polymyxin-Dexameth) Instill 1 ribbon in both eyes every 12 hours for infection. Administration times were 0800 (8:00 a.m.) and 2000 (8:00 p.m.). The June 2019 MAR was lacking documentation of administration on the following dates and times: 6/8/19 at 2000 hour, 6/8/19 at 0800 hour, 6/9/19 at 0800 hour, 6/14/19 at 0800 hour, 6/17/19 at 0800 hour. Review of Resident 6's July 2019 MAR indicated the Maxitrol Ointment 3.5-10000-0.1 (Neomycin-Polymyxin-Dexameth) Instill 1 ribbon in both eyes every 12 hours for infection. The July 2019 MAR was lacking documentation of administration on the following dates and times: 7/4/19 at 0800 hour, 7/9/19 at 0800 hour, 7/14/19 at 2000 hour, 7/18/19 at 0800 hour, 7/28/19 at 2000 hour. Review of Resident 6's August 2019 MAR the Maxitrol Ointment 3.5-10000-0.1 (Neomycin-Polymyxin-Dexameth) Instill 1 ribbon in both eyes every 12 hours for infection. The August 2019 MAR was lacking documentation of administration on the following dates and times: 8/2/19 at 2000 hour, 8/4/19 at 0800 hour. 2. The record review for Resident 1 began on 8-6-2019 at 12:15 p.m. Diagnoses included but were not limited to diabetes with peripheral vascular disease, dependence on renal dialysis, chronic kidney disease stage 5, hyperlipidemia, hypertension, and angina pectoris (chest pain). A review of Resident 1's June, July and August 2019 MAR indicated nursing staff lacked any documentation for administration of the following		current documentation for medication administration to identify trends or areas of concern. Together with the Regional Clinical Nurse the DON and RCN have providing training to the licensed nurses and QMA's regarding proper documentation for medication administration including required monitoring and evaluation notes. Element Three A quality-assurance program will be completed under the supervision of the director of nurses/designee to monitor medication administration in the eMAR for correct documentation. The Director of nursing/ designee will perform the following systematic changes: 1) The director of nursing/designee will monitor/audit all missed documentation of medication administration the next business day using reports that can be drawn from the eMAR system. 2) Any deficiencies found in audits will be corrected at the time discovered and reviewed with the nurse/QMA who erred. 3) All Nurses and QMA's will participate in a training on documentation, either in person or on line. 4) Pharmacy consultant, on their regularly scheduled visits, will randomly review eMAR documentation.	

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		A. BUILDING 00 B. WING	08/08/2019

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	medications: Furosemide (a water pill) 80 mg (milligrams) give 1 tablet one time a day was not marked as administered on 6-8, 9, and 14, 2019, and 7-4-2019. Lipitor (cholesterol medication) tablet 40 mg give 1 tablet one time a day was not marked as administered on 6-3 and 28, 2019, 7-14 and 28, 2019 and 8-2-2019. Norvasc (blood pressure pill) 5 mg give 2 tablets at bedtime was not marked as administered on 6-3 and 6-28-2019, 7-14 and 28-2019 and 8-2-2019. Spironolactone (a water pill) tablet 25 mg give 1 tablet by mouth one time a day was not marked as administered on 6-8, 9, and 14, 2019, and 7-4-2019. Carvedilol (blood pressure pill) tablet 12.5 mg give by mouth two times a day was not marked as administered on 6-8, 9, and 14, 2019 and 7-4-2019 for either dose. The medication was also not marked as given for the morning dose on 7-22-2019 and for the afternoon dose on 7-9 and 18-2019. Cilostazol (for peripheral vascular disease) tablet 50 mg give by mouth two times a day was not marked as administered on 6-8, 9 and 14-2019 for the morning dose and on 6-3 and 28-2019 for the evening dose. The medication was not marked as administered on 7-4 and 21-2019 morning dose and on 7-14 and 28-2019 evening dose. On August 2, 2019, the medication was not marked as administered for the evening dose. Clonidine HCl tablet (blood pressure medication) 0.1 mg give 1 tablet two times a day was not marked as administered for the morning dose on 6-8, 9 and 14-2019 and 7-4-2019. The medication was lacking documentation for the evening dose administration on 6-3-2019, 7-14-2019 and 8-3-2019. Gabapentin tablet (for pain) give 100 mg by mouth three times a day was not marked as administered		Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Director of Nursing/designee will perform regular audits of medication administration records for proper documentation. Compliance audits according to the following schedule: 5 times a week for four weeks; 3 times a week for four weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be addressed and retraining and/or disciplinary action of staff for violations will occur. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	

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	on 6-8, 9, and 14-2019, 7-4-2019 for the morning dose, on 6-3-2019, 7-14-2019 and 8-2-2019 for the afternoon dose and on 6-27-2019 and 8-3-2019 for the evening dose. A review of Resident 1's progress notes from 6-1-2019 through 8-6-2019 indicated documentation was lacking as to a reason the medications were not marked as not given. 3. The record review for Resident 3 began on 8-7-2019 at 11:00 a.m. Diagnoses included but were not limited to, hypothyroidism, macular degeneration, osteoarthritis, and dry eye syndrome. A review of Resident 3's June, July and August 2019 MAR indicated nursing staff lacked any documentation for administration of the following medications: Levoythyroxine Sodium tablet (thyroid medication) 75 mcg (micrograms) give one tablet one time a day was not marked as administered on 6-10, 14, 28, 29, and 30-2019, 7-19, 20, 22, 26 and 27-2019 and 8-3 and 6-2019. Combigan Solution 0.2-0.5% (for macular degeneration) instill 1 drop in left eye two times a day was not marked as administered on 6-10, 14, 28, 29, and 30-2019, 7-19, 20, 22, 28 and 29-2019 and 8-2 and 5-2019 in the morning and on 6-8, 16, 17 and 19-2019, 7-11 and 13-2019 and 8-2-2019 in the evening. Artificial Tears Solution 1.4% instill one drop in each eye four times a day was not marked as administered on 6-14-2019 and 8-6-2019 in the morning. There was documentation lacking for the administration of the eye drops at noon on 6-2, 7, 8, 10, 14, 28, 29, 30-2019, 7-8, 19, 20, 22, 26, and 27-2019 and 8-2 and 5-2019. There was documentation lacking for the 5:00 p.m.			

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	administration of the eye drops on 6-8, 14, 16,17, and 19-2019, 7-6, 11, and 13-2019 and 8-2-2019. Documentation was lacking for the 8:00 p.m. administration of the eye drops on 6-8,14,16,17, and 19-2019, 7-5, 6, 11, 13, 15, and 17-2019, and 8-2-2019. A review of Resident 3's progress notes from 6-1-2019 through 8-6-2019 indicated documentation was lacking as to a reason the medications were not marked as not given. 4. The record review for Resident B began on 8-7-2019 at 12:45 p.m. Diagnoses included but were not limited to anemia in chronic diseases, history of bi-polar disorder, depression, and encephalopathy (a disease in which the functioning of the brain is affected by a condition such as a viral infection or toxins in the blood). A review of Resident B's June, July and August 2019 MAR indicated nursing staff lacked any documentation for administration of the following medications: Ariprazole tablet (for bipolar disorder) 5 mg give 1 tablet one time a day was not marked as administered on 6-9, 14, 16, 17, 18, 22, 23, 25, and 28-2019, and 7-1, 4, 6, 7, 12, 13, 14, and 20-2019. Desvenlafaxine ER tablet for depression 100 mg give by mouth one time a day was not marked as administered on 6-23-2019 and 7-20-2019. Famotidine 40 mg tablet for acid reflux give one tablet by mouth at bedtime was not marked as administered on 6-21 an 24-2019, 7-3, 4 and 28-2019 and on 8-1-2019. Levothryroxine sodium capsule 200 mcg give 1 capsule by mouth one time a day for thyroid was not marked as administered on 6-12, 13, 21 and 27-2019, 7-10, 22, 26, and 29-2019 and on 8-3-2019. Pantoprazole sodium tablet 40 mg give 1 tablet by			

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	mouth one time a day for acid reflux was not marked as administered on 6-12, 14, 21, 26, and 27-2019, 7-10, 13, 22, and 29-2019 and 8-3-2019. Queitiapine fumarate 100 mg tablet for mood disorder was ordered on 6-8-2019 and was not marked as administered in June 2019 and in July 2019 until 7-15-2019 when nursing initials and a check mark indicated the medication was administered. The medication was not marked as administered on 7-20-2019 and 8-1-2019. A stool softener 100 mg tablet give 1 time a day and tiotripium bromide monohydrate capsule 18 mcg for COPD (chronic obstructive pulmonary disease) was not marked as administered on 6-23-2019 and 7-20-2019. A review of Resident B's progress notes from 6-1-2019 through 8-3-2019 indicated documentation was lacking as to a reason the medications were not marked as not given. 5. The record review for Resident 8 began on 8-7-2019 at 4:20 p.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease with exacerbation, hypothyroidism, hyperlipidemia, high blood pressure, and coronary atherosclerosis. A review of Resident 8's June, July and August 2019 MAR indicated nursing staff lacked any documentation for administration of the following medications: Amlodipine besylate (for high blood pressure) 10 mg give 1 tablet by mouth one time a day was not marked as administered on 7-7-2019. Aspirin 81 mg by mouth one time a day was not marked as administered on 7-7-2019. Atorvastatin calcium (for high lipid levels) tablet 20 mg give two tablets at bedtime was not marked			

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	as administered on 6-21 and 24-2019, 7-4, 14, 27 and 28-2019 and 8-1-2019. Levothyroxine sodium tablet 50 mcg give 1 tablet one time a day was not marked as administered on 6-12, 14, 21, 26 and 27-2019, 7-10, 13, 17, and 29-2019 and 8-1 and 7-2019. Lisinopril (high blood pressure medication) 10 mg give 1 tablet one time a day and loratadine 10 mg tablet for allergies give one tablet one time a day were not marked at administered on 7-7-2019. Melatonin 3 mg give one tablet at bedtime for sleep was not marked as administered on 6-21 and 24-2019, 7- 4, 14, 27 and 28-2019 and 8-1-2019. A review of Resident 8's progress notes from 6-1-2019 through 8-7-2019 indicated documentation was lacking as to a reason the medications were not marked as not given. An interview with QMA (Qualified Medication Aide) 10 on 8-8-2019 at 9:26 a.m., indicated after administering a resident's medication, the administration was documented in the resident's MAR. She indicated if the resident refused or was not to be found there were codes to enter on the MAR to indicate what happened and why the medication was not administered. She indicated code 9 meant you would document in the resident's progress notes. QMA 10 was shown a MAR from June 2019 for a resident with several blanks on different dates. She indicated if the nurse did not document on the MAR then the medication was not given. An interview with the DON (Director of Nursing) on 8-8-2019 at 6:00 p.m., indicated nursing should be documenting on the MAR after administering a resident's medication. She indicated each day she will create a 24 hour report that will let her know of the missing documentation, but she indicated she			

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	and the ADON (Assistant Director of Nursing) lacked the time to follow up on the report. A current policy, "Resident Medication Administration" updated 2/2019 was provided by the DON on 8-7-2019 at 3:26 p.m. The policy indicated "...medications are to be documented by qualified staff member per state guidelines...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure the Resident Emergency Binder was kept current for 2 of 8 residents reviewed. (Resident 1 and Resident 7) Findings include: 1. On 8/7/19 at 10:30 a.m. the Director of Nursing (DON) was interviewed. She indicated the file	R 0356	Element One It is the intention of Lamplight Inn of Fort Wayne to maintain current and accurate resident emergency files for immediate accessibility in case of an emergency. The Business Office Manager updated the emergency binder to include the two identified missing	09/27/2019

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	book used to reference resident information in the event of an emergency was the "Face Sheet Book" which was to be kept at the front desk. She indicated all the resident's face sheets with appropriate information were kept in this book. At 10:40 a.m., the Face Sheet Book was retrieved from the front desk and was reviewed. Documentation was lacking in the Face Sheet Book for Resident 7, who resided on the 9th floor. 2. On 8-7-2019 at 12:15 p.m., the Face Sheet Book was reviewed for Resident 1's information. A review of the Face Sheet Book page by page indicated Resident 1's information was lacking in the facility's Face Sheet Book which would be used for emergencies. An interview with the DON on 8-7-2019 at 1:35 p.m., indicated the staff at the front desk would update the Face Sheet book with new resident admission face pages. An interview with Concierge 11 on 8-7-2019 at 3:10 p.m., indicated the third shift receptionist was supposed to keep the Face Sheet Book up to date. Concierge 11 indicated they haven't had a third shift receptionist for at least a month. She indicated our regional person just updated the Face Sheet Book last week. Concierge 11 indicated they would get a current census and compare the census to the current pages of the book. She indicated we need to assign someone the duty to keep the book updated and we have not done so yet. On 8-7-2019 at 4:30 p.m., the DON reviewed the Face Sheet Book and was unable to find Resident 1's face page information. The DON indicated she could not understand who would have removed Resident 1's face page information/picture from		residents. Element Two All residents have the potential to be affected by this alleged deficient practice. The Business Office Manager conducted a page by page review of the facility's emergency binder to verify that all current residents had an a current face sheet in the book. Residents who have discharged or are on LOA were removed; new residents were added to the binder. Element Three The Business Office Manager/front desk receptionist are responsible for ensuring the Emergency Resident Binder is kept current. It will be reviewed daily by 2nd shift and also updated by the BOM or staff member on duty if a resident discharges or goes LOA for medical reasons. A Master Census Sheet will be kept at the front of the binder to show the daily update. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Executive Director/designee will audit the Resident Emergency Binder for correctness according to the following schedule: 2 times a week for one month; 1 time a week for two months, monthly thereafter. Those residents	

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	the Face Sheet Book. An undated, current policy, "Emergency Information" was provided by the DON on 8-27-2019 at 4:29 p.m. The policy indicated "...A Resident Information Record will be completed for each person moving to the residence. The record will be updated annually or as needed...."		without a face sheet will be promptly resolved. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure a chest xray was completed 6 months prior to admission for 1 of 10 resident's reviewed. (Resident R) Findings include: A review of Resident R's closed record on 8/7/2019 at 4:50 p.m., indicated diagnoses included, but were not limited to: liver cancer. The xray located in the closed record was dated 11/8/2017, the resident was admitted on 11/5/2018, and the facility failed to produce a more current chest xray within the first 6 months prior to admission. During an interview on 8/7/2019 at 4:35 p.m., the DON (Director of Nursing) indicated the resident should have had a more current X-ray because there was a copy of an order for one. The facility could not produce a current X-ray and had no policy that regarded chest X-ray's prior to admission.	R 0408	Element One It is Lamplight Inn of Fort Wayne's intention to provide every resident with a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infection. The facility obtained a new chest x-ray for Resident R to ensure he was free of tuberculosis. Element Two All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing/designee audited all resident records to ensure that each resident had a chest x-ray completed within acceptable time frames. Any resident not current was offered a new chest x-ray and their record updated. Element Three	09/27/2019

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			The Admissions Director is responsible for gathering all required pre-admission paperwork; the Director of Nursing is responsible for reviewing such paperwork including the state required chest x-ray within the past six months of admission. No resident shall be admitted without that information on file and in their medical record. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Administrator/designee will perform audit the records of all new admissions records to ensure proper documentation including chest x-ray in included in the record. Compliance audits according to the following schedule: 2 times a week for four weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be addressed. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The			

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	result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, a TB (tuberculosis) skin test was not completed for 1 of 10 residents reviewed. (Resident R) Findings include: A review of Resident R's record on 8/7/2019 at 4:50 p.m., indicated diagnoses included, but were not limited to: liver cancer. A review of a form, Tuberculosis Skin Test, dated 11/6/2018, indicated the resident had a Step 1 TB skin test administered in the left arm at 4:25 p.m. There was no documentation in the record indicating that qualified staff had read the test, and a second step had not been completed. There was no documentation in the record that Resident R had any prior testing before admission. During an interview on 8/7/2019 at 4:35 p.m., the	R 0410	Element One It is Lamplight Inn of Fort Wayne's intention to provide every resident with a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infection. The Director of Nursing obtained orders to have a new tuberculin skin test completed on Resident R to ensure he was free of tuberculosis. Element Two All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing/designee audited all resident records to ensure that each resident had the required tuberculin skin test in accordance with state regulations. Any	09/27/2019

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	DON indicated they had no documentation of a completed TB test. They also had no documentation of a risk assessment for the refusals of the annuals for this resident or Resident 4. A current facility policy, x Testing, provided by the Activity Director on 8/8/2019 at 5:26 p.m., and not dated, indicated the following: "...All residents will be given a 2-step mantoux test per guidelines within 3 days of entering the residence. If a test has been completed within 3 months of admission to the residence and copies of the test results are available, there is no need to repeat the test..."		resident not current was offered a new TB skin test to ensure they are free of tuberculosis and their record updated. Element Three The Admissions Director is responsible for gathering all required pre-admission paperwork; the Director of Nursing is responsible for reviewing such paperwork including the state required tubercullin skin test within three months prior to admission. No resident shall be admitted without that information on file and in their medical record. Current residents will be monitored for yearly screen and tuberculin skin test by use of a reminder on the eMAR and a report reminder to the Director of Nursing. The Regional Clinical Nurse alos inserviced nurses and QMA's on the facility Infection Control policies pertaining to tuberculosis. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Administrator/designee will audit the records of all new admission records to ensure proper documentation including evidence of a tuberculin skin test within three months prior to admission. Compliance audits according to the following schedule: 2 times a week for four weeks; weekly for	

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		A. BUILDING 00 B. WING	08/08/2019

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			four weeks; then monthly thereafter. Any identified areas of concern will be addressed. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure an annual risk assessment was completed for 2 out of 2 resident's reviewed for refusal of the annual TB skin test. (Resident 4 and Resident R) Findings include: 1. A review of Resident 4's record on 8/7/2019 at 2:45 p.m., indicated diagnoses included, but were not limited to: heart disease, arthritis, and depression. Resident 4 was confirmed, by the DON (Director of Nursing) to be cognitively intact and able to be interviewed. A review of Resident 4's Progress Notes, dated 5/6/2019, indicated the resident refused to receive	R 0412	Element One It is Lamplight Inn of Fort Wayne's intention to provide every resident with a safe, sanitary and comfortable environment and to help prevent the development and transmission of diseases and infection. Resident #4's record was updated with a new risk assessment was completed; Resident R has already been discharged and can not be addressed. Element Two All residents have the potential to be affected by this alleged	09/27/2019

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	the annual Mantoux test. The documentation indicated the resident had refused to have the test completed 3 times and the risks and benefits were explained to them. There was no documentation located in the record regarding the risks and benefits, nor was there a risk assessment completed for the symptoms of TB. In the facility TB binder, a form, Tuberculosis Skin Test, 5/6/2019 indicated the resident 3 times, and that the risks and benefits were explained. A review of the form, Update Immunization, dated 6/12/2019, indicated the resident refused. 2. A review of Resident R's closed record on 8/7/2019 at 4:50 p.m., indicated diagnoses included, but were not limited to: liver cancer. A review of Resident R's Progress Notes, dated 5/6/2019, indicated the resident refused to receive the annual Mantoux test. The documentation indicated the resident had refused to have the test completed 3 times and the risks and benefits were explained to them. There was no documentation located in the record regarding the risks and benefits, nor was there a risk assessment completed for the symptoms of TB. In the facility TB binder, a form, Tuberculosis Skin Test, 5/6/2019 indicated the resident refused 3 times, and that the risks and benefits were explained. The current facility policy, x Testing, provide by the Activity Director on 8/8/2019 at 5:26 p.m., and		deficient practice. The Director of Nursing/designee audited all resident records to ensure that each current resident that had refused the required tuberculin skin test was then assessed using the Risk Assessment form and their medical record updated. Element Three Our facility system remains unchanged: if a resident refuses to do the tuberculin skin test then the nurse completes the Risk Assessment Form to determine any concern about TB infection. If the assessment identifies a concern the resident will have a chest x-ray and be seen by a physician for further evaluation. The Regional Clinical Nurse also inserviced nurses and QMA's on the facility Infection Control policies pertaining to tuberculosis. Element Four Compliance will be monitored by use of an Audit Process and Tracking Form. The Director of Nursing/designee will audit the records each time of 10% of the current resident's records, randomly selected, to ensure proper documentation including evidence of Risk Assessment if the resident refused to do a tuberculin skin test. Compliance audits according to the following schedule: 2 times a week for four	

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	was not dated, did not indicate any information regarding the risk assessment for tuberculosis.		weeks; weekly for four weeks; then monthly thereafter. Any identified areas of concern will be addressed. Audit results will be regularly reported to the QAPI Committee. Compliance Date is September 27, 2019	