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	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 the Investigation of Complaints IN00322251, IN00321705, IN00330651, IN00323878, IN00326009, IN00322583, IN00323692, IN00323224, IN00321064. This visit included an Infection Control Quality walk through. Complaint IN00322251 - Substantiated. State Residential Finding related to the allegations are cited at R147. Complaint IN00321705 - Substantiated. State Residential Finding related to the allegations are cited at R216 and R352. Complaint IN00330651 - Substantiated. State Residential Finding related to the allegations are cited at R052, R214 and R243. Complaint IN00322583 - Substantiated. State Residential Finding related to the allegations are cited at R052, R090 and R214. Complaint IN00323224 - Unsubstantiated due to lack of evidence. Complaint IN00323692 - Substantiated, no deficiencies related to the allegations are cited. Complaint IN00326009 - Substantiated, no deficiencies related to the allegations are cited. Complaint IN00321064 - Substantiated, no deficiencies related to the allegations are cited. Complaint IN00323878 - Substantiated, no deficiencies realted to the allegations are cited.	R 0000	We are writing in response to the 6/24/2020 survey as required by Indiana regulations. This response in no way is an acknowledgement of deficient practices at our facility.	

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

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

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	Survey date: June 22, 23, and 24, 2020 Facility number: 012288 Residential Census: 128 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review coompleted June 29, 2020			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review the facility failed to ensure 2 of 4 residents reviewed for abuse were free from abuse (Resident E and Resident F). Findings include: An incident report dated 3/16/20, indicated Resident F reported that Resident C beat him up in his room. Resident F was sent to the hospital per EMS. An incident note dated 3/16/20 at 7:19 A.M., indicated Resident C banged on Resident F's door and proceeded to hit him on his head and punch him in his abdomen. Resident F indicated he had fallen down and his head and his ribs were hurting. Resident F had a skin tear measuring 2 by 3.5 on his right elbow and bruising was noted on his left forehead.	R 0052	Ongoing and by 8/31/2020 -Resident rights will be reviewed with every admission upon admission. All employees are in-serviced on Resident Rights upon hire and will be re-inserviced on Resident Rights by August 31, 2020. 6 months and ongoing-Executive Director, Director of Nursing, Social Service Director and Assistant Director of Nursing will all be responsible for ensuring that our residents are not ever abused in any way, shape or form. The Executive Director and Director of Nursing will monitor this for 6 months and ongoing thereafter until 100% compliance is reached.	08/31/2020

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	A paper dated 3/16/20, indicated Resident C refused to give a statement. A nurse's note dated 3/16/20 at 3:22 P.M., indicated Resident F returned from hospital with a diagnosis of a closed head injury and a contusion of rib on left side. An incident note dated 5/11/20, indicated Resident C was intoxicated, staggered by Resident E, and was talking under his breath. Resident C grabbed Resident E's wheelchair which caused a loss of control of the wheelchair. Resident C then punched Resident E. A physical fight ensued between the two residents. The police were called and Resident C was arrested due to a warrant out for his arrest from a previous altercation at the facility. A nurse's note from 5/11/20 at 10:48 P.M., indicated Resident C was making threats to Resident E about "whooping his a**." Resident C set down an alcoholic beverage in his room, returned to the hall, and started to fight with Resident E. An incident note dated 6/8/20, indicated Resident C and Resident E got into a verbal altercation. Preventative measures that were added were looking for alternative placement for Resident C due to multiple altercations, some of which had resulted in jail time. A Psychiatric Nurse Practitioner 4 readmission note from 6/12/20 at 8:40 A.M., indicated she tried to engage in a conversation with Resident C. He was curt and agitated, admitted to drinking, and then slammed the door in her face. The note indicated Resident C had a long history of alcohol		Service plans will be updated to include free from abuse for all residents. Security is in place twenty-four (24) a day and rounds will be made every two hours and any untoward events will be reported to the Administrator immediately.	

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	addiction with anger issues, had been involved in peer to peer altercations several times, and had been just released from incarceration. The Administrator was interviewed on 6/22/20 at 3:41 P.M. During the interview the Administrator indicated during the 3/16/20 incident Resident C knocked on Resident F's door, went in, and beat him up. There had been no issues with Resident C until the altercation on 3/16/20. Resident C was drinking at the time of the incident. There was nowhere else for Resident C to go. The Administrator was interviewed on 6/23/20 at 10:02 A.M. During the interview the Administrator indicated the facility did not do anything differently after the 3/16/20, 5/11/20, or 6/8/20 incidents. No specific interventions were added for Resident C to prevent further altercations, but they have been encouraging the residents involved in the altercations to stay away from each other. Staff were trying to keep Resident C from fighting with other residents, but he would get drunk and do what he wants to. Staff would try to intervene as much as possible when an altercation was occurring and they wolud try to keep him away from other people that he has had altercations with before. After the incidents Resident C refused to participate in alcohol counseling and he also refused to be seen by the Psychiatric Nurse Practitioner for an evaluation. Resident C was arrested for the 3/16/20 incident on 5/11/20 after another altercation in the facility. The facility has tried to find somewhere else for Resident C to go. "There is nowhere else for him to go. Unless the facility finds somewhere for him to go, Resident C has to stay in the building." The Social Service/Admissions Director on was interviewed on 6/23/20 at 10:20 A.M. During the			

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	interview the Social Service/Admissions Director indicated the Director of Nursing (DON) and Psychiatric Nurse Practitioner 4 were working on finding a place for Resident C to go because of the altercations that took place on 3/16/20, 5/11/20 and 6/8/20. Resident C was in jail from 5/11/20 to 6/8/20 and he "got into it" with Resident E as soon as he was back in the facility. The Social Service/Admissions Director indicated she had spoken with Resident C and Resident E and told them to stay away from each other. Psychiatric Nurse Practitioner 4 was interviewed on 6/23/20 at 10:35 A.M. During the interview, Psychiatric Nurse Practitioner 4 indicated she had seen Resident C a few times and she had not been talking with the DON about other placement for Resident C. The facility had informed her that he was not going to be readmitted after the 3/16/20 incident. She also indicated she had informed the facility in March that if Resident C did not quit drinking he would not be safe to be around other people. Resident C has told her he was not going to quit drinking. There was no documentation Resident C had a service plan to addressed his behavioral issues. There was no documentation the facility was looking for different placement for Resident C. The Administrator was interviewed on 6/23/20 at 10:53 A.M. During the interview the Administrator indicted the facility had not been looking for anywhere else for Resident C to go. An undated policy was provided by the Administrator on 6/22/20 at 4:45 P.M., titled "Elder Abuse Policy and Procedure". The policy indicated "...Each resident has the right to be free			

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	from abuse, corporal punishment, mistreatment, and involuntary seclusion. Residents must not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals ...Verbal abuse- the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples include threats of harm, saying things to frighten a resident. Physical abuse- Includes hitting, slapping, pinching, and kicking." This State citation is related to Complaint IN00322583 and IN00330651			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall			

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	be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review, and interview, the facility failed to ensure an unusual occurrence was reported to the Indiana State Department of Health for 1 of 3 residents reviewed. Findings include: A review of Resident D's closed record on 6/22/2020 at 4:44 p.m., indicated the following diagnoses: paraplegia, pain, and a pressure sore.	R 0090	Immediately and ongoing-Lamplight Inn of Fort Wayne has hired a new Executive Director/Administrator-Brandi Lehman effective 8/3/2020. The new VP of Operations, Mercedes Andrus, trained with Brandi this week and we had the occasion to discuss the need to inform the division within twenty-four (24) hours of becoming aware of an	08/31/2020

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	A Progress Note, dated 4/7/2020 at 10:15 a.m., indicated the NP (Nurse Practitioner) was seeing the resident for a refill on pain medication. The note further indicated the resident had been admitted to the hospital recently for a gun shot wound to his left arm. A Progress Note, dated 4/9/2020 at 7:50 p.m., indicated Resident D had been found unresponsive in his room, sitting on his wheelchair at 4 p.m. The staff were attempting CPR (Cardio Pulmonary Resuscitation), and the EMS was called to the facility. The medics pronounced the death of Resident D at 4:10 p.m. A review of a form, Allen County Coroner's Office, provide by the ED (Executive Director) on 6/23/2020 at 3:53 p.m., indicated the resident was a full code status, and had last been seen alive at 11:30 a.m., on 4/9/2020, outside the facility in the parking lot. The ED had completed the form. The date of death on the form indicated 4/10/2020. During an interview on 6/23/2020 at 10:59 a.m., the ED indicated there was no other investigation completed on the occurrence, and was unsure if the date was 4/9/2020 or 4/10/2020. She further indicated she had reported the incident to ISDH (Indiana State Department of Health). During an interview on 6/23/2020 at 3:22 p.m., the Allen County Coroner's office indicated the date and time of death was 4/9/2020 at 4:10 p.m. They further indicated cause of death was due to intoxication with methamphetamines and bronchopneumonia (inflammation of the lungs). During an interview on 6/24/2020 at 4:30 p.m., the ED indicated there was no report available regarding the incident reported to the state. She		unusual occurrence. They will be made by telephone and followed up by a written report that is either faxed or emailed. This is effective immediately, will be monitored by the Administrator and DON and reviewed by the VP of Operations immediately upon occurence.	

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	indicated she had not thought of it as an unusual occurrence, so she did not report it. A current procedure, related to death policy, Resident Found Dead in Apartment (Unattended Death), undated, and provided by the ED on 6/24/2020 at 4:30 p.m., indicated the following: "...Circumstances under which the resident expired..." There was nothing in the policy/procedure that regarded reporting of an unusual death. This State citation is realted to Complaint IN00322583			
R 0147 Bldg. 00	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on observation, interview, and record review, the facility failed to ensure resident safety from an accidental hazard inside the facility. This had the potential to affect 128 of the 128 residents who reside at the facility. Findings include: An observation on 6/23/2020 at 11:44 a.m., in the facility stair well beside Room 302 on the 3rd floor, showed a broken, burnt out, 1/2 smoked cigarette on the stair landing. At that same time, in the same stair well, 4 steps down from the landing, a burnt out cigarette butt was observed on the step. Black particle substances, and black marks were observed on	R 0147	Immediately and Ongoing-Unsafe smoking and smoking in undesignated areas such as stairwells, resident apartments, inside the community in any location is strictly prohibited. Residents are to smoke in designated areas only which are the smoking shed and on the sides of the community. The Security Guard who is on duty twenty-four (24) hours a day, the Maintenance Director, the Housekeepers, the Resident Aides, Social Services Director, Activity Director, DON and Administrator will all be	01/24/2021

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	the 1st and 5th steps beside the open railing. An observation on 6/23/2020 at 1:05 p.m., in the facility stair well beside Room 323 on the 3rd floor, showed 2 bent cigarettes 1/2 smoked with burnt ends on the stair landing. On the stair steps were black particle substances, and black marks were observed on two of the steps. At that same time, the Housekeeping Supervisor was observed scooping up the cigarettes with a piece of paper. At 1:10 p.m., the Housekeeping Supervisor was observed scooping up cigarettes and black particles from the other stairwell by Room 302. At 1:15 p.m., the Housekeeping Supervisor was observed in the ED's (Executive Director) office. She showed the ED what was found in the stair wells. At that same time, during an interview, the ED indicated the burnt cigarettes were a safety hazard. She further indicated the stair wells do not have cameras installed yet, and the residents were to be smoking in the outside smoking hut in the south parking lot behind the facility. A review of an undated form, Smoking Policy, provided on 6/23/2020 at 2:02 p.m., by the ED, had no indication of a designated smoking location. The form was what the resident's receive upon admission. The ED indicated it was to be dated and signed by the resident and a facility representative. A current, undated, facility policy, Smoking: Prohibited, provided by the ED on 6/23/2020 at 2:02 p.m., indicated the following: "...Resident		responsible for monitoring smoking behaviors of all residents. We will strive for 100% compliance.	

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	agrees he or she will smoke only in designated areas at the Community. The Community reserves the right, at its sole discretion, to change areas designated for smoking from time to time. When smoking in designated areas, Resident will properly dispose of cigarette butts and packaging in appropriate receptacles..." This State citation is related to Complaint IN00322251.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview, and record review, the facility failed to ensure 3 of 3 residents had a Service Plan for residents reviewed for Service Plans. (Resident B, Resident C, and Resident D) Findings include: 1. The clinical record for Resident C was reviewed on 6/22/20 at 2:10 p.m. Diagnoses included, but were not limited to, major depressive disorder, chronic obstructive pulmonary disease, and alcohol dependence. Resident C did not have a service plan available for review. The Administrator was interviewed on 6/22/20 at 3:41 p.m. During the interview the Administrator indicated Resident C did not have a service plan	R 0214	On or before 8/31/2020 and Ongoing upon admission, every 6 months and with any change in condition-All residents will receive an evaluation of their individual needs prior to admission and at least every six (6) months thereafter and/or upon change in condition. A licensed nurse will evaluate the nursing needs of every resident. Service plans will be implemented, reviewed and completed for all residents by the DON. 100% compliance is expected.	08/31/2020

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	and he should have had one. 2. A review of Resident B's record was begun on 6/22/2020 at 4:10 p.m. Diagnoses included, but were not limited to: insomnia (difficulty sleeping), bipolar disorder, high blood pressure, and asthma. A review of Resident B's record indicated there was no Service Plan implemented. 3. A review of Resident D's closed record was begun on 6/22/2020 at 4:44 p.m. Diagnoses included, but were not limited to: paraplegia, pain, and a pressure sore. A review of Resident D's record indicated there was no Service Plan implemented. During an interview on 6/24/2020 at 11:32 a.m., the DON (Director of Nursing) indicated there were no Service Plans for Resident's B and D. She further indicated, there should have been. An undated policy was provided by the Administrator on 6/23/20 at 10:32 p.m., titled "Assistance/Service Plan. The policy indicated " 1. An assistance/service plan will be completed by Resident Services Coordinator prior to moving into the residence." This State citation is related to Complaint IN00322583 and IN00330651			
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 assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and			

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	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 record review, and interview the facility failed to complete evaluations to self administer medications for 2 of 2 residents reviewed. (Resident C and Resident D) Findings include: 1. A review of Resident C's record was begun on 6/22/2020 at 2:10 p.m. Diagnoses included, but were not limited to: depression, lung disease, and alcohol dependence. A Physician's Order, dated 3/13/2020, indicated Resident C could self administer his own medications. There was no documented evaluation in Resident C's record that they had the ability to self administer medications. 2. A review of Resident D's closed record begun on 6/22/2020 at 4:44 p.m. Diagnoses included, but were not limited to: paraplegia, pain, and a pressure sore. The Physician Order's for 4 different medications indicated the resident could have unsupervised self-administration of those specific medications. There was no documented evaluation in Resident D's closed record that they had the ability to self administer medications.	R 0216	8/20/2020 and Ongoing-The Director of Nursing will complete an evaluation on every resident prior to admission. This evaluation will include a needs assessment including: (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. Evaluations for Resident C and Resident D will be completed by 8/15/2020 by the new DON. The Administrator will review and ensure 100% compliance.	08/31/2020

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	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	An undated, unsigned statement, that was provided by the ED (Executive Director) on 6/23/2020 at 3:53 p.m., regarding a 3/3/2020 incident that involved Resident D indicated: "...He administered his own medications..." During an interview on 6/24/2020 at 4:18 p.m., the DON (Director of Nursing) indicated there were no self administer evaluations completed on Resident C or Resident D and there should have been. An undated procedure, Assistance with Self-Administration of Medication, provided by the ED on 6/24/2020 at 4:30 p.m., indicated no evaluation to be performed for ability to administer own medications. This State citation is related to Complaint IN00321705			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review, and interview the facility failed to ensure medications were administered to 1 of 3 residents reviewed. (Resident B) Findings include: A review of Resident B's record on 6/22/2020 at 4:10 p.m., indicated diagnoses included, but were	R 0243	Immediately and ongoing-All Qualified Medication Technicians and Licensed Nurses who assist with and/or administer medications and/or treatments will complete proper documentation which will include: (A) time; (B) name of medication or treatment;	08/07/2020

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	not limited to: insomnia (difficulty sleeping), bipolar disorder, high blood pressure, anemia and asthma. A review of the monthly MAR's (Medication Administration Record) indicated the following: The April 2020 MAR had no documentation for the following medications: Atorvastatin, Montelukast sodium, Trazodone, and Requip during the evening shift on 4/27/2020. The May 2020 MAR had no documentation for the following medications: Abilify, Atorvastatin, Montelukast sodium, Trazodone, Buspirone, Diclofenac, Ferrous sulfate, Oxcarbazepine, Requip, and Protonix during the evening shift on 5/20/2020. The June 2020 MAR had no documentation for the following medications: Atorvastatin, Montelukast, and Trazodone during the evening shifts of 6/8 and 6/9/2020. During an interview on 6/24/2020 at 4 p.m., the DON (Director of Nursing) indicated she was unsure why the medications were not documented. She was unsure if the resident was out of the facility at that time, but if so the MAR should have reflected a code that indicated such. A undated current facility policy, Medication Assistance, provided by the ED on 6/24/2020 at 4:30 p.m., indicated nothing regarding medications to be documented in the residents medical record. This State citation is related to Complaint IN00330651		(E) dosage (if applicable); and (F) name or initials of the person administering the drug or treatment. The DON and Administrator will be responsible for reviewing the Electronic Medication Administration Record daily. The ADON and Supervising Licensed Nurses will be responsible for this monitoring in the absence of the DON and/or Administrator. Immediately and ongoing. 100% compliance is expected.	

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R 0352 Bldg. 00	410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on record review, and interview, the facility failed to ensure documentation of resident status and condition in the medical record for 1 out of 3 residents reviewed. Findings Include: A review of Resident D's closed record on 6/22/2020 at 4:44 p.m., indicated the following diagnoses: paraplegia, pain, and a pressure sore. The residents date of birth was 10/3/1986. A Progress Note, dated 4/7/2020 at 10:15 a.m., indicated the NP (Nurse Practitioner) was seeing the resident for a refill on pain medication. The note further indicated the resident had been admitted to the hospital for a gun shot wound to his left arm. A Progress Note, dated 2/28/2020 at 4:53 p.m., indicated the resident be sent out to a clinic for behaviors, the resident refused to go. There were no Progress Notes regarding the resident's gun shooting incident off the facility premises on 3/3/2020, and admission to a local hospital. On 3/5/2020 at 11:13 a.m., the facility self reported the incident to ISDH (Indiana State Department of Health).	R 0352	Immediately and ongoing-The DON, ADON, Social Services Director and Administrator are responsible for Clinical Record compliance. They are reviewing all clinical records for compliance to ensure that they all contain: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. We are striving for 100% compliance!	08/31/2020

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	During an interview on 6/24/2020 at 4:30 p.m., the ED (Executive Director) indicated the shooting incident should have been documented in the Progress Notes, and it was not. She further indicated the facility had no policy on documentation. This State citation is related to IN00321705.			