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	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAMPLIGHT INN OF FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00255323 and IN00255750 completed on March 22, 2018. Complaint IN00255323 - Not Corrected. Complaint IN00255750 - Corrected. Survey date: May 2, 2018. Facility number: 012288 Residential Census: 135 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 7, 2018.	R 0000	The Plan of Correction constitutes our 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 and federal law.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to administer medications as ordered by the physician for 2 of 5 residents reviewed for medication administration (Resident X and Resident Z).	R 0241	1. It is the intent of this facility to provide adequate and thoughtful medication administration. 2. Because all residents are potentially affected by the cited offense, the facility has audited	06/04/2018

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

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	Findings include: 1. a. On 5/2/18 at 11:59 A.M., Resident X's record was reviewed. Diagnoses included, but were not limited to, diabetes and seizures. A census report on Resident X's electronic medical record, indicated on 5/1/18, the resident was on an "unpaid leave of absence". A Move-Out/Discharge Note, dated 5/2/18 at 2:27 P.M. and written by the ADON (Assistant Director of Nursing), indicated "writer was told in report" that Resident X was in the hospital and that her "roommates" family member had taken the resident to a doctor's appointment where she was directly admitted to the hospital. A LNAR (License Nurse Administration Record) for April 2018, indicated the resident was to receive Lantus insulin 45 units subcutaneously every morning and bedtime for diabetes. The LNAR indicated the resident had not received her Lantus insulin on the following dates and times: 4/24 at 6:00 p.m., 4/25 at 6:00 p.m. and 4/26/18 at 6:00 a.m. A LNAR for April 2018, indicated Resident X was to have her blood sugar checked at 6 A.M., 12 P.M., 5 P.M., and 8 P.M. and was to receive Humalog insulin per sliding scale 4 times a day for diabetes. The LNAR indicated the resident had not received her insulin or had her blood sugar checked on the following days/times: 4/20 at 6:00 a.m., 4/24 at 8:00 p.m., and 4/25 at 12:00 p.m. A NP (Nurse Practitioner) note, dated 4/27/18 at 12:14 P.M., indicated the NP had been "asked to see pt (patient) today for increase BS (blood sugars)". "Pt states her BS have been 'running		and reviewed the current process of administering medication as ordered by the residents' Physician. All Nursing staff with access to administer medication will be re-educated in the form of verbal and written in-servicing no later than June 4, 2018 to include the importance of proper medication administration, including eMAR documentation. The eMAR will be checked daily Monday through Friday by the Director of Nursing/Designee. Any inaccurate findings will be clarified and/or notification made to the prescribing provider at that time. If a medication administration is missed, the Director of nursing/designee will ensure that proper documentation is completed, and that the provider is notified. Weekly monitoring by the Executive Director/Designee will be completed to ensure more oversight is being provided by the DON/Designee. 3. These audit findings will be reviewed at the quarterly quality-assurance committee meeting for further review or corrective action needed. The director of nursing/designee will monitor/audit all Residents' medication administration the next business day x 5 day/wk. for 4 wks., then 3x wk., thereafter ongoing.	

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	high' with no notable changes in diet or exercise". The NP ordered Lantus insulin to be increased to 50 units subcutaneous 2 times per day. A Physician order, dated 2/5/18, was for Humalog insulin per sliding scale 4 times a day for diabetes. The order indicated "Blood sugar greater than 400, call M.D.". The LNAR for April 2018 indicated the resident's blood sugar on 4/30/18 at 12:00 p.m. was "421". Progress notes did not indicate the physician had been notified of the blood sugar result of 421 and there was no documentation on the LNAR to indicate the resident had been administered Humalog insulin on 4/30/18 at noon. On 5/2/18 at 3:02 P.M., the ADON was interviewed. During the interview, he indicated he was the nurse caring for Resident X on 4/30/18. He indicated the NP had been in the facility and was notified of the resident's high blood sugar result of 421 at 12:00 p.m. and had ordered 12 units of Humalog insulin to be given at that time. The ADON was unable to locate the order or documentation that the 12 units of Humalog insulin had been administered. An NP note, dated 4/20/18 at 11:50 A.M., indicated the NP was asked to see Resident X for itching to her bilateral lower legs. The NP ordered Keflex (antibiotic) for cellulitis. A Physician order, dated 4/20/18 at (no time), was for Keflex 500 mg (milligram), 1 tablet 2 times per day for 7 days. A MAR (Medication Administration Record) for April 2018, indicated Resident X received Keflex 500 mg by mouth 2 times per day on 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, and		4. Any deficiencies found in audits will be corrected at the time discovered and the findings of the quality-assurance checks will be documented and submitted by the DON/Designee at the monthly quality-assurance committee meeting for further review or corrective action, monthly for 6 mos., then re-evaluated for continued monitoring with our goal being full, ongoing compliance.	

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	4/30/18 for a total of 11 days. 2. On 5/2/18 at 1:30 P.M., Resident Z's record was reviewed. Diagnoses included, but were not limited to, diabetes, neuropathy, above knee amputation of right leg, and chronic kidney disease with dependence on dialysis. A Physician Order, with a start date of 1/25/18, was for Lispro Insulin, inject as per sliding scale, subcutaneously before meals and at bedtime. A Licensed Nurse Administration Record (LNAR) for April 2018, indicated Resident Z had not had his blood sugar checked nor had he received insulin per sliding scale on the following days/times: 4/19 at 6:00 a.m. and 4:00 p.m., 4/23 at 6:00 a.m., 4/25 at 11:00 a.m., 4/27 at 11:00 a.m. and 4/30/18 at 8:00 p.m. A Physician Order, dated 4/18/18, was for Coumadin (blood thinner) 7.5 mg give 1 tablet by mouth in the evening every Sun, Mon, Tue, Wed, Thu, Fri, Sat for blood thinner. A MAR for April 2018, indicated Coumadin 7.5 mg was not administered as ordered on 4/22, 4/28, and 4/29/18. The MAR indicated the medication was not available. There was no documentation to indicate why the medication had not been available or that the physician had been notified of it's unavailability. This deficiency was cited on March 22, 2018. The facility failed to implement a systemic plan of correction to prevent recurrence.			