STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943023	07/25/2016
NAME OF PROVIDER OR SUPPLIER **LIGHTHOUSE INN NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3208 N.E. 11 STREET** **POMPANO BEACH, FL 33062**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Standard Relicensure and Limited Mental Health survey was conducted on at Lighthouse Inn North, License #8339. The facility had deficiencies at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews, the facility failed to honor residents' rights to privacy for 4 randomly sampled Residents (#1, #9, #12 and #13) by improperly disposing of resident medical records which included information identifying the residents.

The findings included:

On , the following observations were made:

1. At 9:00 AM, Employee D was observed to ball up a copy of Resident 1's medication observation record (MOR) which included the his name, date of birth and currently prescribed medications, and place it in a trash can located next to the medication cart. At 11:10 AM, A prescription document issued to Resident 1 for 5-325 was found in the same trash can.

2. At 11:10 AM, a copy of a written prescription issued to Resident 13 for 500 milligram tabs which included the his name and date of birth, and an excerpt from a prescription document issued to Resident 13 which included his name and address, were found in the trash can next to the medication cart.

3. At 12:15 PM, Employee D was observed to leave the medication cart unattended with the facility's MOR binder left open to Resident 12's MOR. The MOR included his name, date of birth and currently prescribed medications.

4. At 1:30 PM, a crumbled copy of a prescription for Resident #9 was observed in trash can underneath desk used by Psych Nurse in Administrator's Office.

On at 1:52 PM, the above concerns were brought to the Administrator's attention. He was

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943023	07/25/2016
NAME OF PROVIDER OR SUPPLIER **LIGHTHOUSE INN NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3208 N.E. 11 STREET** **POMPANO BEACH, FL 33062**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

asked about a shredding unit observed under the "nurses table" located in the dining room. He stated it should be in working condition, but after several attempts, the unit did not function. In interview conducted at 5:05 PM with the facility's Home Health Nurse, she last used the shredder two weeks prior. In an interview conducted at 5:07 PM, Employee D stated she last used the shredder one week before.

This was further discussed with the Administrator on at 5:20 PM.

Class III

0056 Medication - Labeling and Orders

Based on record review and interviews, the facility failed to ensure unlicensed staff who assist residents with self-administration of medications do so only with a written medication order issued and signed by a Health Care Provider (HCP) for 1 of 4 sampled Residents (#5).

The findings included:

A medication systems review conducted revealed the following:

1. At 9:00 AM, a three-ring binder located on the "nursing table" in the dining observed to contain HCP telephone orders waiting for signatures from the HCP's. Review of the binder revealed a multitude of written physician telephone orders, separated by HCP name. It was estimated that 90% of the telephone orders present in the binder were not signed by HCP's.

2. Review of Resident 5's records revealed the following:

A. He was admitted to the facility / with diagnoses including /bi-polar type and high .

B. His / AHCA Form 1823 (medical examination) documented he requires assistance with self-administration of non-injected medications.

C. Unsigned HCP telephone orders in the three-ring binder included:
i. for 30 milligrams (MG) at time of sleep
ii. for 400 MG every 4 weeks

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943023	07/25/2016
NAME OF PROVIDER OR SUPPLIER **LIGHTHOUSE INN NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3208 N.E. 11 STREET** **POMPANO BEACH, FL 33062**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

iii. 04/22/2016 for 1 MG three times daily
for 16 MG, half tablet twice daily
v. for: 2 MG three times daily; SOD ER 500 MG, 2 tablets daily
vi. Diphenhydroxicine 50 MG at hour of sleep
vii. 3 MG at house of sleep
viii. for 3 MG at hour of sleep; 4 MG daily; Invega Sustenna 234 MG every 4 weeks
ix. / / for 4 MG daily; 50 MG daily; 1 MG daily; 2 MG twice daily
x. / for 400 MG every 4 weeks; ER II twice daily

In an interview conducted at 12:23 PM, a Registered Nurse from a home health agency (contracted with the facility in a consulting and skilled nursing capacity, and contracted individually with multiple facility residents ordered for home health nursing services) reviewed the telephone orders, acknowledged their order dates, and stated she would have to contact the HCP's and/or pharmacies to see if any were "not filled". She acknowledged licensed nurses may honor HCP telephone orders but must obtain the HCP-signed order within 10 days. She further acknowledged unlicensed staff must have signed written HCP orders before assisting with, changing instructions for use of, or discontinuing, any medication they assist residents with.

This was discussed with and acknowledged by the facility's Administrator on at 3:50 PM.

3. On at 2:00 PM, a review of Resident #5' s MOR (Medication Observation Record) revealed a telephone order, dated , for 1mg which had not been signed and dated by the physician. Further review of Resident # 5's health assessment (AHCA Form 1823) documented the date of Resident's examination was / /.
These findings were discussed with the Administrator at approximately 6:30 PM, and he acknowledged the findings.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and staff interview, the facility failed to provide a clean, safe living environment for all residents who eat their meals in the main dining area.

The findings include:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943023	**07/25/2016**
NAME OF PROVIDER OR SUPPLIER **LIGHTHOUSE INN NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3208 N.E. 11 STREET POMPANO BEACH, FL 33062**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

During tour of main dining room located in Building 1 on at 9:10 AM, the following items were noted:
a) All of the upholstered dining room chairs were heavily soiled and at least 6 of 27 chairs needed repaired due to wobbly or loose chair legs;
b) Heavy dust build up on bi-fold doors next to medicaiton cart, ceiling fans and areas on ceiling surrounding the fans which are situated over the resident's dining tables;
c) Walls with dirt buildup and black marks, and unpainted patched areas;

These areas of concern were discussed and acknolwedged by the Administrator on at 6:00 PM.

Class III

0162 Records - Resident

Based on record review and interviews, the facility failed to provide required information to and obtain written informed consent from residents or their legal representatives related to unlicensed staff providing assistance to residents with self-administration of medications for 2 of 2 sampled Residents (#3 and #15).

The findings included:

1. Review of Resident 3's records conducted revealed an AHCA Form 1823 (medical examination) dated which documented she required assistance with self-administration of medications. Her / Assisted Living Facility Contract and admission documentation revealed none of the required provisions related to "informed consent" per Florida Statute 429.256, such as informing them the facility is not required to have a licensed nurse on staff, that the resident may receive assistance with self-administration of medications from an unlicensed staff, and if the unlicensed staff will or will not be overseen by a licensed nurse.

Further, the facility did not inform the resident or her legal representative of the professional qualifications of facility staff who provide residents with assistance with self-administration of medications. If unlicensed staff provide residents with assistance with self-administration of medications, the facility must obtain written informed consent from the resident or their legal representative first. There was no documentation showing the resident or her legal representative gave the written consent described above.

In an interview conducted at 3:54 PM, the Administrator was asked and stated he was not

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943023	07/25/2016
NAME OF PROVIDER OR SUPPLIER **LIGHTHOUSE INN NORTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **3208 N.E. 11 STREET** **POMPANO BEACH, FL 33062**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

familiar with this requirement, and would check on it. No additional information or documentation was received. At 5:15 PM, this was discussed with and acknowledged by the Administrator.

2. A review of Resident #15's Admission Record revealed no signed Informed Consent Form acknowledging assistance with self-administered medications being provided by unlicensed staff.

During interview with Administrator on / at 4:00 PM, he confirmed there was no signed Informed Consent Form for Resident #15.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lighthouse Inn North
3208 N.E. 11 Street
Pompano Beach, FL 33062

RE: Limited Mental Health (LMS) survey

Dear Administrator:

This letter reports the findings of a state LMS licensure survey that was conducted on , 2016 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso\
Enclosure:State form 5000-3547
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com