STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R /
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**	

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

0000 Initial Comments

An unannounced revisit survey was conducted on / at Lamplight Inn (license # 5096), an Assisted Living Facility in Fort Myers, Florida. This was a follow-up to the complaint survey, CCR #2016003247 completed on .

One previous deficiency was found uncorrected and no new deficiencies were identified.

0056 Medication - Labeling and Orders

Based on record review and staff interview, the facility failed to make every reasonable effort to ensure medications were filled or refilled in a timely manner for 2 (Residents #9 and #5) of 4 residents' Medication Observation Reports (MOR) reviewed.

The findings included:

1. On / through /, staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #9's was "unavailable or not available." On and staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #9's was "unavailable or not available. On staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #9's was "unavailable or not available."

2. On 7/2 /, staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #5's Cap was "unavailable."

On /, staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #5's C was "unavailable."

On and , staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #5's was "unavailable."

On , staff initialed the front of the MOR and circled their initials, then wrote on the back of the MOR, Resident #5's was "unavailable."

3. In an interview with Staff J (Certified Nursing Assistant) on / at 10:58 a.m. Staff J sated the norm is to let the nurses know and they will make sure medications refill on timely manner. Staff J said, "Don't know what happened. Have no idea. I think the nurse forgot to order them."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R . . . I/ . . .
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

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

4. Review of the facility's policy for refilling medications revealed the facility was to refill mediations 5 days in advance.

5. During an interview conducted with facility's Administrator on . . . I/ . at 1:00 p.m., she acknowledged that indeed medications for both residents were not refill on timely manner.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11953349 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	1896 PARK MEADOW DRIVE FORT MYERS, FL 33907

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0025 Reg. # 429.26(7) FS; 58A-5.0182(1) FAC LSC	Correction Completed	ID Prefix A0054 Reg. # 58A-5.0185(5) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) [signature]	DATE 9-7-16	SIGNATURE OF SURVEYOR [signature] for: Stefania Sarros, HFE II	DATE 9-7-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Lamplight Inn
1896 Park Meadow Drive
Fort Myers, FL 33907

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

BBT7

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