STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 03/19/2018
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 completed on at Lamplight Inn, an assisted living facility (license #5096) in Fort Myers, Florida. This was a follow-up to a complaint survey completed on .

The following is description of the uncorrected deficiencies found at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and staff interview, the facility failed to document a change in status for 1 (Resident #37) of 6 closed records reviewed.

The findings included:

Record review for Resident #37 found a check request form showing that the resident , and family removed the belongings on . The resident's , 2018 Medication Observation Record on simply noted, "hospital." The last Service Notes for Resident #37 was dated . The record had no documentation of a change in status requiring a higher level of care or information about the of the resident.

During an interview on at 2:30 p.m., the Administrator said Resident #37 went to the hospital and never returned. There was no record of what happened. The record had no physician's order for a transfer.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on staff interview, observation, and review of facility policy and procedure, the facility failed to ensure residents who are identified as an elopement risk, have identification on their person.

The findings included:

On at 1:30 p.m., the Administrator said the residents that are identified as an elopement risk live in the memory care unit. The facility made identification bracelets for these residents showing their name, the facility name, and phone number. He said at this time, they are not wearing the identification bracelets. Since the change of ownership in of 2017, the facility phone number was changed

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but and the Administrator has not changed the bracelets as of yet.

On at 1:45 p.m., observation showed the residents living in the memory care unit were not wearing any type of personal identification showing who they are, where they live, or the phone number.

On at 1:45 p.m., Medication Aide Staff M said these residents are not wearing identification bracelets at this time. She confirmed all residents living in this unit are at risk for elopement.

A review of the facility's Policy: Elopement Protocol (revised) for prevention of and response to resident elopement showed it did not mention anything about persons who are identified as elopement risk having identification on their person.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility has failed to ensure Medication Observation Records (MOR) accurately documented residents receiving medication for 4 (Resident #27, #31, #32, and #33) of 4 MORs reviewed.

The findings included:

1. The 2018 MOR for Resident #27 had no documentation of 81 milligrams (mg) being given on . The MOR did not have any documentation on the reverse side indicating the resident received or did not receive the medication. The MOR documented the ER (a medication) was not given on , and . The medication was documented as given on , and . The back page of the MOR notes was not available on , and . There was no documentation explaining why the medication was not available.

2. The 2018 MOR for Resident #31 had no documentation for receiving the medication (an drug) at the 4:00 p.m. dose on . The MOR had no documentation for (a medication) on . The MOR had no documentation that (an) was or was not given on and . The MOR documented the morning dose of was not given on , and and noted on the back that it was not available. The MOR documented the evening doses were given for these same dates. There was no documentation that Resperidone (an) was or was not given on at 8:00 p.m. The

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MOR did not document that , (an anti- drug) was or was not given on and . The MOR did not document the , (an ,) was or was not given on . These totaled 11 doses missed over 19 days.

3. The 2018 MOR for Resident #32 did not document that the resident did or did not receive (an ,) on . It did not document the resident did or did not received the morning dose of (a , medication) on .

4. The 2018 MOR did not document whether Resident #33 did or did not receive all 7 morning medications for . The medications included , 81 mg, , and , (, medications), Mono ER (for chesty pain), , and (medications), and D3.

During an interview on at 1:30 p.m., the Administrator said they have a nurse auditing the MOR daily to identify medications are not noted as given.
This issue is still occurring.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and staff interview, the facility failed to provide a safe living environment, free from hazards and structures in good working order, creating the potential for resident injury and/or discomfort. This is an uncorrected class II deficiency.

The findings included:

1. On at 12:00 p.m. observation revealed the fence outside of the memory care unit had three gates. The maintenance staff was present at this time. He punched in the code on the second gate and the gate did not open. He said this gate had been like this for three weeks. He observed the third gate and it had a cable and padlock keeping this gate from opening. He said this gate has been broken for four weeks and the padlock has been on this gate since then.

These gates would provide emergency egress in the event of a fire or emergency.

During an interview on at 12:40 p.m., the Administrator said he was not aware that these two gates were not working, one of which had a padlock on it.

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2. On [redacted] at 9:40 a.m., a tour was conducted throughout the facility. The following is a list of issues that were observed during this tour:

- Outside on the patio, in the memory care unit, there were many snack wrappers on the ground, a palm tree cut down with tree sections and other horticulture lying on ground, and a broken wooden bracket lying on ground;
- [redacted]: floor tiles peeling, missing, and broken blinds;
- [redacted]: no toilet paper holder;
- [redacted]: no toilet paper holder, toilet seat loose sitting sideways;
- [redacted]: missing floor tile, corner of wall marred with plastic piece that was falling off, closet doors off hinges, clothes on floor and dresser drawers empty;
- [redacted]: ripped tile by back door;
- [redacted]: blinds broken;
- [redacted]: [redacted] bar broken, hole in closet door from front door knob;
- [redacted]: paint peeling on the wall in the [redacted];
- [redacted]: no toilet paper holder;
- [redacted]: tile missing on the floor, toilet paper holder missing;
- [redacted]: tile missing by bed and back door;
- [redacted]: towel bar missing in [redacted];
- [redacted]: tile floor peeling by front door and dressers;
- [redacted]: floor tile has holes;
- [redacted]: holes and stains on the floor;

- Hallway outside [redacted] had carpet soaked with water. At 10:24 a.m., maintenance staff person said the facility staff used the shower in [redacted] and plugged up the drain. The water flowed out of the [redacted] into the hallway.

- [redacted]: holes on vinyl floor;
- [redacted]: closet door off hinges;
- [redacted]: floor has holes, discolored, and a large rip;
- [redacted]: holes in floor tile, ripped, and peeling tile.

3. The above description of disrepair was consistent with the [redacted] unsatisfactory 18-page report issued by the Department of Health.

Class II