STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 05/31/2018
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

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0000 - Initial Comments

An unannounced second revisit survey was conducted on through at Lamplight Inn, an assisted living facility (license # 5096) in Fort Myers, Florida.

This was the follow-up to the first revisit on which was follow-up to the complaint survey completed on

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

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

Based on record review, interview, and observation, the facility failed to provide supervision and monitoring to meet the needs for 4 (Resident #52, #51, #54, and #9) of 26 sampled residents. The facility failed to monitor the wandering of a resident (Resident #52) who eloped from the facility and sustained a with injury requiring a higher level of care; failed to monitor a resident (Resident #51) with a worsening ; failed to monitor a resident (Resident #54) with unintended weight loss; and failed to monitor a leg (Resident #9) to ensure healing. This was the third consecutive survey resident supervision was cited.

The findings included:

1. The facility's Elopement Policies and Procedures (revised) defined elopement as exit-seeking behavior demonstrated by residents who are typically . The procedures and interventions included: every resident will be screened prior to admission; any resident diagnosed with a memory/ , will not leave building without an escort; after an elopement reevaluate if appropriate to be retained in the facility and a complete investigation will be done of the elopement.

On at 1:41 p.m., during a tour of the secure memory unit, Resident #52 was observed to have a large on the left side of his face extending from his forehead to his neck. A large localized area of was also noted on his forehead over his left eye that was about 1.5 inches by 0.75 inches in size. The resident was and unable to answer questions.

On at 2:45 p.m., the Administrator said there had been no elopements from any residents on the memory unit but a new resident (#52) had went out towards the parking lot and had a with injury. The Administrator said the resident had gone outside before and would walk around to the end of the driveway and come back in the front door. He said on , the resident had gone outside, went

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around the loop, and .

On Resident #52's record was reviewed including the resident assessment Form 1823 dated . Under physical or sensory limitations, the resident was noted to have severe hearing loss and memory , . There was no Elopement Risk Assessment Form found in the record.
Service Notes indicated the resident was admitted to the facility on and was alert with .
On at 6:00 a.m., LPN Staff N noted upon her arrival to the facility, she was notified Resident #52 was outside walking saying he was going to work. After redirecting, the resident was willing to come back inside the facility. On at 4:00 p.m., LPN Staff N noted the resident was found outside sitting on the bench by the front door. The resident was redirected inside and required constant redirection and monitoring.
On at 8:00 p.m., LPN Staff M noted the resident had a and sustained a "lump" on the left side of his forehead. Staff M called 911 and Resident #52 was transported to the emergency .
On at 6:40 p.m., the resident returned to the facility.

In an interview on at 11:49 a.m., LPN Staff M said on , the night shift Resident Care Assistant (RCA) reported Resident #52 had been found outside in the parking lot by the trees getting close to the road. Staff M said there had been no injury and was not sure what time he had been outside, but was on the night shift (10 p.m. to 6:00 a.m.) when it occurred. Staff M said the resident was still allowed to go outside unescorted after this incident. Staff M said the resident had been since admission, would want to go to work or to one of the exits and needed constant redirection.

On at 12:15 p.m., the facility Wellness Director (WD) said Resident #52 needed frequent monitoring. She said the resident would go stand by the door and on one occasion she went to retrieve him outside in the grassy area. The WD said she was not notified of the incident on where the resident was found outside by the night shift.

On at 2:06 p.m., LPN Staff N said on , one of the RCA's came to get her and said Resident #52 had . She said the resident at that time was sitting in a chair in the lobby. The resident said he , and got a "lump" on his head. Staff N said she was not sure if he was inside or outside when he . Staff N said the resident had been in bed around 7:30 p.m.. She said according to staff the resident was outside near the bench area. Staff N said the resident has been since admission and staff had to watch him all the time.

On at 2:40 p.m., Med Tech Staff X said all the staff would watch Resident #52 as he liked to go out and he did not know where he was going. Sometimes he would say he was going to see his wife (who is), or he was going home as his wife is cooking. Staff X said every time he went out the

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door, he said he wanted to go home.

On at 2:54 p.m., Med Tech Staff J said on the evening of , he was passing medications in the hallway where Resident #52 resided. He had last seen the resident around 6:00 p.m., and about 30 minutes later, said "they found him" and "brought him inside". Staff J said he saw staff walking the resident back inside and put him in a chair in the lobby.

On at 11:00 a.m., the Administrator confirmed Resident #52 had been outside when he but he did not know how far the resident had walked, or where he . He confirmed no identification bracelet had been placed on the resident yet as he had not typed one up for him. The Administrator acknowledged the identification bracelets were being used for the residents at risk for elopement.

2. On at 10:50 a.m., Resident #54 said the food is horrible and is so bad she does not even eat it. The resident said she has lost 6 pounds in a week from not eating. She said the portions are getting smaller and pretty soon it will just be bread and water. The food is too salty and thinks they are trying to give her high , . Resident #54 said she attends resident council meetings and complains about the food but nothing improves.

The weight record for Resident #54 was reviewed and revealed the resident had lost 10 lbs in 5 months. Between and the resident lost 7 lbs.

On at 4:08 p.m., LPN Staff N confirmed Resident #54's weight record indicated the resident had lost 10 lbs. Staff N said she was not aware of the weight loss and did not know any reason for it.

On at 4:10 p.m., the Wellness Director said she was not aware of any weight loss for Resident #54. She said the resident is , about what she eats but was not sure why she was losing weight.

3. On at 9:54 a.m., Resident #9 was observed sitting in her wheelchair self propelling down the hallway. The resident had a soiled gauze dressing sticking up over a sock on her right leg. A foul odor was noted from the area. The stocking over the dressing had a large area approximately 4 inches by 3 inches of dried reddish/yellow drainage. The resident said she did not know what had happened to her leg. At 11:15 a.m., the resident's soiled dressing was observed again to be present on her leg. The resident pulled down the stocking and the outside of the Kerlix rolled gauze dressing was soiled with dried reddish/yellow drainage.

On at 11:18 a.m., LPN Staff M said she was not aware of any on the resident's right

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lower leg and did not know she had a dressing.

On at 2:10 p.m., LPN Staff N said she did not know of any or dressing on Resident #9's right lower leg. She said the resident wears protective stockings so unless they were removed she would not see it. Staff N said she relies on the resident care assistants to let her know of any skin issues as they give the resident baths. Staff N said the resident gets a shower twice a week in the evenings and staff would have to remove the stocking on her leg.

On at 9:55 a.m., the Wellness Director (WD) said the dressing that was applied to Resident #9's leg was a regular dressing and not just first aid. The WD confirmed she had not been able to identify who placed the dressing on Resident #9 and only has 2 nurses on staff. The WD said there was no documentation of any showers after .

On at 2:30 p.m., Med Tech Staff X said she takes care of Resident #9 and was aware she had a bandage on her right leg. She said the bandage has been there for about a week and the resident does refuse showers so has been getting a sponge bath.

On at 4:04 p.m., the Advanced Registered Nurse Practitioner (ARNP) for Resident #9 said he was not aware of any on the resident's right lower leg and had not given any order for a dressing.

4. On at 4:12 p.m., Resident #51 was observed coming up the hallway in his power chair with his shirt off. A reddened area was noted on his stomach area just below his cage. The area of redness was approximately 3 inches wide by 4 inches long. The area had a hole in the center where the resident had a feeding tube prior. The area was red & . Secretions were coming out of the hole when the resident talked and moved his stomach muscles. Resident #51 indicated through gestures, writing, and attempting to talk that the area was and he needed to have someone look at it. Med tech on duty said he would get the nurse.

On at 4:30 p.m., in an interview Resident #51 stated through gestures, writing, and attempting to talk that he had his feeding tube removed about 4 weeks ago and it was not healing. He said that he was admitted to the facility on and he was caring for the site on his own since then. He said that he does not have the supplies such as dressing to care for it but uses paper towels to cover it and put paper tape around it that was given to him by the nurse. He said that the area was very and he has told many staff members about it.

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at 11:59 a.m., Resident #51 said that he was going to the doctor to have his feeding tube site looked at.

On . . . . . at 12:15 p.m., while speaking with Wellness Director about Resident #51's . . . . area on his stomach, she said that she did know about it and it had concerned her since his admission. She thought that it was something that the nurses should be monitoring, but when she brought it to the Administrator's attention, he reported to her that the nursing home that the resident was admitted from said that the resident could care for the site on his own. She was aware that the resident did not want added cost and said he would care for it on his own due to that point.

On at 12:20 p.m., LPN Staff N said she was aware of Resident #51's feeding tube site, as he had come to her early last week. Staff N said the resident had asked her for dressing supplies so he could take care of his , ˙ tube site. She said at the time she had noted it was red and and had asked the ARNP to see the resident. Review of nurse's notes on . . . . . had no mention of the feeding tube site or that the nurse practitioner had been notified.

Record review of admitting orders (Form 1823) on , revealed that there were no orders for dressing changes to feeding tube site but did record . . . . . ointment to mid-abdomen daily and at bedtime. The area for nursing/treatment/ ˙ , service requirements indicated "as needed". Nurse's notes only recorded tube feeding site was covered, with no assessment of skin condition or if there was any sign of . No other facility progress notes on feeding tube site condition for 18 days, until . . . . . .

Record review showed a ˙ . . . . doctor saw Resident #51 on . . . . . . Chief problem was recorded, as "tube site won't heal." Order received for to be taken 3 times a day for for 7 days. Resident then returned to ˙ . . . . doctor on . . . . . after resident voiced concern on . . . . . about his feeding tube site still being red and . Doctor now ordered again to be taken twice a day times 10 days and the site to be cleaned twice a day with dressing change. Doctor also requested the nurse call with update on Resident #51's condition on Thursday, Friday and Monday of next week.

On at 4:00 p.m., while speaking to Resident #51 after his doctor's appointment, he said that he was worried about having to pay more money to have his feeding tube site on his stomach taken care of by the facility staff. He said that this is the reason he has been taking care of it on his own. He said that he does not have the supplies to take care of it and the facility is unable to provide him with them, so he uses paper towels and tape gotten from the nurse. He said that he changes the paper towel several times a day when it gets wet for the drainage coming out of the hole in his stomach. Resident #51 stated again that he told the Wellness Director about his site several weeks ago , as well as LPN Staff N

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and M. When Resident #51 was asked if he was aware that the facility had limited nursing services to take care of his with no extra charge to him, he stated that he was never told. He agreed to let facility nurses take care of his if there was no additional charge to him.

Class II

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

Based on record review, interview, and observation, the facility failed to ensure 7 (Resident #52, #56, #57, #58, #14, #59, and #60) of 7 sampled residents who were identified as an elopement risk had identification on their person. Resident #52 was not assessed at risk for elopement upon admission to the facility per contract and facility policy. Resident #52 eloped from the facility and sustaining a head injury requiring a higher level of care. This was the third consecutive survey elopement standards were cited.

The findings included:

The facility's Elopement Policies and Procedures (revised) defined elopement as exit-seeking behavior demonstrated by residents who are typically . . The procedures and interventions included: every resident will be screened prior to admission; any resident diagnosed with a memory/ . . will not leave building without an escort; after an elopement reevaluate if appropriate to be retained in the facility; and a complete investigation will be done of the elopement.

On at 1:41 p.m., during a tour of the secure memory unit, Resident #52 was observed to have a large . . on the left side of his face extending from his forehead to his neck. A large localized area of was also noted on his forehead over his left eye that was about 1.5 inches by 0.75 inches in size. The resident was . . and unable to answer questions. The resident was not wearing any identification on his person. Medication Technician (MT) Staff W said the reason for no identification bracelet was the resident had recently been moved into the secured unit. Staff W confirmed all residents residing in the memory care unit should have a identification bracelet with their name, name of facility, and phone number.

Resident #60 was observed to have no identification bracket on her person. Staff W confirmed the resident had resided on the memory unit for about a month.
Residents #56, #57, #58, #14, and #59 were not wearing any identification on their person. Staff W was present and confirmed these findings.

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On at 2:45 p.m., the Administrator said there had been no elopements by any residents on the memory unit, but a new resident (Resident #52) went out towards the parking lot and had a with injury. The Administrator said the resident had gone outside before and would walk around to the end of the driveway and come back in the front door. He said on , the resident had gone outside, went around the loop, and . He said the resident was a little so family agreed to move him into the memory unit.

On the facility contract/agreement for Resident #52 was reviewed. The contract was signed by the resident's Power of Attorney on . On page 14 of the agreement, Exhibit E, under Elopement; "All residents will be assessed at risk for elopement.."

The resident's record was reviewed on and revealed a Resident Health Assessment Form 1823, dated . Under physical or sensory limitations, the resident was noted to have severe hearing loss and memory , . There was no Elopement Risk Assessment Form found in the record. Service Notes indicated the resident was admitted to the facility on and was alert with . On at 6:00 a.m., LPN Staff N noted upon her arrival to the facility, she was notified Resident #52 was outside walking saying he was going to work. After redirection, the resident was willing to come back inside the facility. On at 4:00 p.m., LPN Staff N noted the resident was found outside sitting on the bench by the front door. The resident was redirected inside and required constant redirection and monitoring. On at 8:00 p.m., LPN Staff M noted the resident had a and sustained a "lump" on the left side of his forehead. Staff M noted 911 was called and the resident transported to the emergency . On at 6:40 p.m., the resident returned to the facility.

On at 11:49 a.m., LPN Staff M said on , the night shift resident care assistant (RCA) reported Resident #52 had been found outside in the parking lot by the trees getting close to the road. Staff M said there had been no injury and was not sure what time he had been outside, but was on the night shift (10 p.m. to 6:00 a.m.) when it occurred. Staff M said the resident was still allowed to go outside unescorted after this incident. Staff M said the resident had been since admission, would want to go to work or to one of the exits and needed constant redirection.

On at 12:15 p.m., the facility Wellness director (WD) said Resident #52 needed frequent monitoring. She said the resident would go stand by the door and on one occasion she went to retrieve him outside in the grassy area. The WD said she was not notified of the incident on where the resident was found outside by the night shift.

On at 2:06 p.m., LPN Staff N said on , one of the RCA's came to get her and said Resident #52 had . She said the resident at that time was sitting in a chair in the lobby. The

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resident said he , and got a "lump" on his head. Staff N said she was not sure if he was inside or outside when he . Staff N said the resident had been in bed around 7:30 p.m. She said according to staff the resident was outside near the bench area. Staff N said the resident has been since admission and staff had to watch him all the time.

On at 2:40 p.m., Med Tech Staff X said all the staff would watch Resident #52 as he liked to go out and he did not know where he was going. Sometimes he would say he was going to see his wife (who was), or he was going home as his wife was cooking. Staff X said every time Resident #52 went out the door, he said he wanted to go home.

On at 2:54 p.m., Staff J said on the evening of , he was passing medications in the hallway where Resident #52 resided. He had last seen the resident around 6:00 p.m., and about 30 minutes later, said "they found him" and "brought him inside". Staff J said he saw staff walking the resident back inside and put him in a chair in the lobby.

On at 11:00 a.m., the Administrator confirmed he did not do any investigation into the Resident #52's on . The resident had been outside but he did not know how far the resident walked, where he , or what staff were involved. The Administrator confirmed no bracelet had been placed on the resident yet as he had not typed one up for him. The Administrator acknowledged the identification bracelets were being used for the residents at risk for elopement and was not aware an Elopement Risk Assessment had not been done for Resident #52.

Class II

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

Based on observations, record review, and staff interviews, the facility failed to maintain an accurate Medication Observation Record (MOR) for 2 (Resident #50 and #52) of 7 residents sampled for medication pass. Resident #50 did not receive medication for pain that interfered with her activities of daily living. This was the third consecutive survey where medication records were cited.

The findings included.

1. Resident #50's Medication Observation Record (MOR) was reviewed on . The MOR showed 0.75 milligram (mg) was ordered (to decrease , and reduce pain) to be taken 3 times a day for 1 week, then 2 times a day for 1 week, then 1 times a day for 1 week. The MOR showed the medication was not given multiple days & given wrong on multiple days. Resident #50 was not given

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the medication correctly since her admission.

Resident #50's MOR showed , (to reduce stomach), , (to reduce), (for sleep), (to reduce sugars), , (to decrease ,), , (a to reduce clots). Each one of these medications were written incorrectly on the medication administration record (MOR). The medications were written double the amount or 1½ times the amount to be taken for the 13 days the resident was in the facility.

Observation during med pass on at 8:35 a.m., found a bottle of , (a , medication) 5 mg daily. Review of the MOR failed to find , ( ) listed as an ordered medication.

On at 8:35 a.m., Medication Technician Staff K acknowledged her error in giving Resident #50 the medication that was not written on the MOR. She also acknowledged that other medications above were not being given according to doctors' orders as written in the admission order.

On at 1:15 p.m., Licensed Practical Nurse (LPN) Staff N acknowledged that the medications written on the MOR were written incorrectly and she had written the above medication in error. She acknowledged that the doctor's orders were for twice a day or once a day and the medications were being given in error for 13 days that the resident was in the facility. She also acknowledged that some of the medications had missing signatures and appeared to not been given.

On at 1:15 p.m., the Wellness Director acknowledged the error Staff K had made in giving Resident #50 a medication that was not ordered and not written on the MOR. She also acknowledged that other medications were incorrectly written on the medication administration record and the resident appeared to been given double the amount or 1½ the amount ordered by the doctor.

On at 10:00 a.m., while speaking with Resident #50 she said that she had pain in her left hip and in her wrist and hands. She said that she had an operation on both of her wrists and she was having a lot of pain in her hands. She reported that her pain level was 6 on a scale of 1-10. She said because of the pain she has a hard time doing simple task such as picking things up, eating, using the reading a book and turning the pages. She was unaware of the medications that the facility is giving her.

On at 1:30 p.m., Nurse Practitioner was notified Resident #50 was not being given her medication for the pain & in her hands in the way it was ordered. The Nurse Practitioner acknowledged errors and ordered medication used for and pain to be given 2 times a day and

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ordered a new medication ( ) for pain.

2. Resident #52's MOR for , 2018 was reviewed on . According to the MOR, the resident was to receive 40 milligrams (mg) twice a day for 7 days. There was no documentation the resident received the morning dose of on and . Resident #52 was to receive , 500 mg 2 tablets twice a day. There was no documentation the resident received the morning dose of , on , , and . The resident was to receive the , medication 100 mg at bedtime. There was no documentation the resident received the medication on .

On at 10:09 a.m., the Wellness Director confirmed the missing documentation of Resident #52's medications.

Class II

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

Based on observation and interview, the facility failed to provide a safe living environment, maintained free of hazards and ensure that existing structures are in good working order creating the potential for resident injury, elopement and/or discomfort. This was the third consecutive survey safe living environment was cited.

The findings included:

On and a tour was conducted of each the facility with the administrator and 2 representatives from the Department of Health (DOH).
The following issues were observed:
45 - a live worm on wall vent. The DOH staff identified the worm as a millipede.
46 - toilet caulk cracked/stained, , peeling, window blinds in disrepair.
47 - no towel rack and no toilet paper holder.
48 - hole in closet door, half of closet door missing.
49 - large length of exposed cable wire on wall.
50 - , peeling, no outlet cover, wires exposed.
51 - live worms on ceiling and floor.
53 - light switch taped off, worms on floor, , peeling, deadbolt on door to outside not working.
55 - toilet caulking cracked, , peeling.
56 - worms on floor.

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58 - multiple exposed nails at head/chest level throughout , holes in wall, , peeling.
59 - hole in wall, closet doors not flush, closet knob hanging off.
60 - ceiling plastered, exposed screw at eye level.

Memory care hallway - floor molding blackened, live worms on floor, dining in hallway dirty/scuffed, wall with hole.
Memory care activity - unfolded laundry/gloves, McDonalds cup thrown on table, sheet thrown on floor near door to outside, two tables in activity missing paint/varnish exposed wood/undersurface.
Memory care TV - ceiling tile by light hanging down.
Memory care outdoor walkway/patio - entry from outdoors to TV , soiled and doorknob hanging off, screw connecting memory care fence to wall not secure, unattached spring on memory care gate, random metal piece screwed to memory care walkway, exposed , /roots and rocks, outdoor entry to dining , soiled, outdoor wall separated, outdoor wall with multiple worms, planter box placed next to fence facilitating the possibility of climbing over the fence.

- flooring peeling in closet and in .
- flooring peeling.
4 - , in disrepair.
5 - closet door bent, laminate flooring peeling.
6 - paint chipping on trim, door and wall, worms on floor.
7 - chipped.
9 - and closet molding with chipped paint, toilet loose with leaking water, missing, gaps in laminate floor.
10 - , peeling/chipping, door off, paint chipping ,
12 - exposed nails in walls and door.
16 - strong foul odor, flooring cracked/stained.
17 - window blinds in disrepair, paint chipping in , and closet.
18 - flooring stained and peeling, vanity peeling, paint peeling/chipped , .
20 - gap between flooring and baseboard, floor stained.

Gym/Equipment - flooring in disrepair.

24 - worms on floor, wall vent taped over.
25 - cable wiring loose.
26 - , , chipping, smoke detector missing, wires exposed, worms.

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LAMPLIGHT INN	**1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**

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

On at 11:13 a.m., Resident #22 who resides said he has a problems with worms. They come in under the door. He said he runs over them with his wheelchair to get rid of them.

On at 11:20 a.m., Resident #12 said there is a problem with worms throughout the building. Resident#12 said that he woke up one night because he felt something near his ear, he reached up and it was a worm crawling on his face. At the time of the interview, 2 worms were observed on the floor of the resident's .

27 - worm on floor.
28 - worms on floor, flooring in disrepair.
29 - shower chair soiled with brown substance .
30 - missing/cracked near toilet, toilet missing safety caps over screws.
32 - worms on floor.
35 - , peeling, worms on floor, laminate floor pulled up.
36 - worms on floor.
37 - worms on floor, hole in floor.
38 - floor stained.
61 - long length of exposed cable wiring.
62 - worms on floor, , peeling.

On 11:39 a.m., Resident #62 said she has had worms on her while in bed. Resident #64 said she has had ants on her while in bed.

63 - , peeling, wall air vent blocked.
65 - flooring peeling, , peeling.
68 - , peeling.
71 - worms on floor, floor stained.
73 - brown substance on wall above toilet.
74 - flooring stained.
75 - worms on floor, shower ceiling leaking.
76 - shower ceiling peeling.
80 - worms on floor.

Common TV /library - internet connector hanging off wall, exposed nails over doorway.

Coffee/refreshment - small ants noted to be crawling on countertop and walls, worms noted on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 05/31/2018
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

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floor, cabinets with areas of laminate missing.

On at 2:15 p.m., the Administrator said pest control comes once a month, can't explain the problem with the millipedes, been dealing with it here for years.

The facility provided pest sighting log from exterminators which indicated date of sighting reported centipedes all over bed in . Per contract, the exterminators come once per month. The had not been here since citing reported. The last invoice provided showed service dated .

On at 6:45 p.m., the Administrator admitted he was aware problems concerning the environment in the building continue.

Class II

Photos on file

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observation, record review and interviews, the facility failed to develop plans of action to correct deficiencies cited on previous surveys, and prevent reoccurrence of the same deficient practices. This failure led to another resident (Resident #52) eloping from the facility, falling and sustaining an injury. The facility continued to not have identification on the residents identified as at risk for elopement (Residents #56, #57, #58, #14, #59, and #60); Resident #50 did not receive medication as ordered to control pain; and medications continue not being documented as given.

The findings included:

An unannounced complaint survey was conducted through . The facility received the following deficiencies: A025 was cited for failure to provide supervision to prevent and a elopement; A032 for failure to ensure 6 of 6 residents identified as at risk for elopement had identification on their person and to prevent elopement; and A054 for failure to document medications as being given.

An unannounced revisit survey was completed on . The following deficiencies were cited again: A025 for failure to document a change in status; A032 for failure to ensure residents at risk for elopement on the memory unit have identification on their person; and A054 for failure to ensure the medications were being accurately documented.

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An unannounced revisit survey was completed on and the same deficient practice was identified at A025 for the failure to provide supervision and monitoring to meet the needs for 4 of 26 sampled residents. The facility failed to monitor the wandering of a resident who eloped from the facility and sustained a with injury requiring a higher level of care (Resident #52); failed to monitor a resident with a worsening (Resident #51); monitor a resident's unintended weight loss (Resident #54) and monitor a leg to ensure healing (Resident #9).

The facility was recited at A032 for the facility failed to ensure 7 (Resident #52, #56, #57, #58, #14, #59, and #60) of 7 sampled residents identified as an elopement risk had identification on their person. Resident #52 was not assessed at risk for elopement upon admission to the facility as per contract and facility policy. Resident #52 eloped from the facility and sustaining a head injury requiring a higher level of care.

The facility was recited at A054 for failure to maintain accurate documentation of assistance with medications and failure to provide medications as ordered.

On at 3:08 p.m., the Administrator said the facility did not currently have a quality assurance or risk management program. He said part of his plan of action was to put identification bracelets on all the residents residing in the memory unit. He acknowledged the 7 residents identified did not have any identification on their person in the event they eloped. The Elopement Risk Assessment tool was initiated as part of the plan of correction and he confirmed Resident #52 was recently admitted to the facility and no Elopement Risk Assessment Form had been done. He acknowledged the resident had been allowed to wander outside unescorted and no interventions were in place to prevent accidents. The Administrator said in-services had been conducted in regards to medications and monitoring or residents. He acknowledged the medication training had not been effective if there is still missing documentation of medications.

Class II