STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	09/25/2018
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 complaint survey CCR #2018014177 was completed on through at Lamplight Inn, an assisted living facility (license #5096) in Fort Myers, Florida.

The complaint contained 1 allegation which was substantiated.
Class I deficiencies were identified at A0025 (supervision) and A0030 (resident rights). A Class II deficiency was identified at A0056 (medication).

The following is a description of the deficiencies.

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

Based on record review and interviews, the facility failed to ensure each resident receives the supervision necessary to meet the resident's needs for 7 (Residents #1, #3, #4, #6, #8, # 11 and #13) of 12 residents interviewed. The facility failed to document all significant issues for 1 (Resident #1) of 3 residents reviewed. Failure to provide adequate supervision lead to the elopement of Resident #1 who was gone for 3 days and required hospitalization when found. Failure to provide adequate supervision lead to a second resident (#3) laying on the floor for 3 hours without staff discovery after a . Lack of documentation of the resident's inability to return to the facility, may allow the resident to leave without the ability to return. These systemic failures put these and other residents in imminent danger.

The findings included:

1. Record review revealed Resident #1 was admitted with diagnoses including , with rapid rate (uncontrolled rapid heartbeat), (swallowing difficulty), , and due to protein and calorie deficiency. The resident ambulated with a rolling walker.

On at 9:00 a.m., the Executive Director (ED) said Resident #1 left the facility on Wednesday night after supper ( ). The resident was not here for breakfast and had not signed out. On at 7:00 a.m. to 8:00 a.m. the ED was told she did not come down for breakfast. The resident was independent, kept her door locked and would not let people in her . The ED said the resident went to church next door that night, did not return, and went to a hotel.
The ED verified it was not normal for the resident to spend time at a hotel. The resident would take the bus down town and go to the mall, but always returned at night.
The ED said the resident was last seen by Licensed Practical Nurse (LPN) Staff A, who works the 2:00

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p.m. to 10:00 p.m. shift. Supper is 5:00 p.m. to 6:00 p.m. and medications are passed at 8:00 p.m. That was the last time Resident #1 received her . . . . . or . . . medications until 9-1-1 took her to the hospital on .

On at 1:43 p.m., LPN Staff A said she gave Resident #1 her medications at 7:00 p.m., for an 8:00 p.m. medication pass. She said the resident was sitting in "her" chair by the activity . . . . her walker. She said she did not see her again after that. LPN Staff A said she checked the resident's . . . . . going off duty, but the door was locked and no one answered so she thought the resident was asleep. LPN Staff A said the facility staff only check on those who need assistance. She said she did not hear that the resident was talking about going to New York until after she left the facility.

On . . . . . at 12:10 a.m., Resident Assistant ( ) Staff G said she came in on . . . . . and tried to give the resident her medications at 8:00 a.m. that morning. When the locked door was not answered the got a nurse who opened the door and they discovered the resident was missing.

On . . . . . at 3:24 p.m., a Missing Person's Detective from the Sheriff's Office said she was notified around 11:00 a.m. on and other detectives were already at the facility when she arrived The Detective verified she had viewed the facility's video recordings and saw Resident #1 leave the building at 6:55 p.m. That was the last time the resident was seen on any facility video. She said, LPN Staff A reported she gave Resident #1's medications at 7:30 p.m. to 8:00 p.m. but it was not seen on the video, and that time could not be confirmed. The detective said the resident is well known to the police and she and her daughter were homeless and used to live in the parks. The detective said the daughter was still homeless and when interviewed, said the mother did not like it at the facility because it was dirty and they "don't take care of her." The detective verified the resident was found on . . . . . when she called Emergency Medical Services ( ) from a local motel. The detective said the resident did not have a . . . . . the motel, but used the phone to make the call.

On . . . . . at 8:40 a.m., Resident #1 was interviewed at the hospital. The resident said she had gone to a hotel, but denied being gone for 3 and 1/2 days; she felt she had been gone only 1 night. The resident said she needed to go to New York to get money left to her by her brother before her aunt's daughter could get it and "drink it away."

On at 11:22 a.m., Resident #4 (a friend of Resident #1) told about a time in , when she and Resident #1 went shopping and returned on the wrong bus. They were dropped at an unfamiliar shopping mall. They were able to find a policeman who took them for hamburgers and fries before returning them to the facility.
Review of Service Notes from to did not contain documentation this episode of police

intervention. The incident was confirmed by the Director of Food Service on at 3:00 p.m. The new ED and the new DON said they were unaware of the incident.

On at 11:52 a.m., Staff F said Resident #1 had told other residents she was going to New York.

On at 12:17 a.m., Staff H, who works the memory care unit from 2:00 p.m., to 10:00 p.m., said she knew Resident #1 from a prior facility. Staff H said on Resident #1 told the staff, she and her daughter would be going to New York. Staff H saw Resident #1 the evening of and spoke to her, but did not see her leave the building.

On at 9:24 p.m., Medication Tech (MT) Staff C said she was working the night shift on . She said she did not see Resident #1 that night. The MT said the facility had a list of frequently residents and she checked those every 2 hours, but did not check anyone who is not on the list. MT Staff C said most residents have cell phones and call the front desk if they need something. She verified she is now to check all residents at midnight, and every 2 hours, even if the door is locked. She said some residents do not like to be checked on and opening the door will wake them.

On at 5:10 p.m., MT Staff E said she only checked the residents on the list. She said the facility had a list of who is a "bed wetter." She would check those residents every 2 hours. She verified a few nights previously the ED had told her to check all residents from the Census List at midnight to ensure everyone is present. MT Staff E said some nights the Census List was not in the book.

Hospital record review revealed Resident #1 presented at the emergency with , midsternal chest pain and racing . She was found to be in with rapid rate. She was also noted to have a , with puss and in her . She was admitted for further care.

2. Record review showed Resident #3 was admitted with , , , , , , , , and , , ( ).

Review of the Service Notes dated at 6:00 a.m. documented Resident #3 had in his . The MT on duty was smelling an odor in the hallway and went -to- she found the resident on the floor. He was noted to be from both elbows, and left knee. 9-1-1 was called and the Resident #3 was taken to Lee Memorial Hospital.

On at 5:37 p.m., MT Staff B said on around 4:00 to 5:00 a.m., she smelled a strong odor

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in the hallway on B wing and began going door-to-door until she found Resident #3 on the floor in the 's hallway. The MT said the resident was covered with feces, and . She yelled to the other MT who called 9-1-1 while she cleaned him up and put a pillow under his head. The MT said Resident #3 said he had been laying on the floor for 5 hours. She said he had hit his head and there was a lot of mixed in with the feces and .

On at 12:02 p.m., MT Staff D said she was working the night Resident #3 . The MT said it was about 4:45 to 5:00 a.m. when he was found. She said there was fecal matter all over the place and from his skinned arms and his head. He had no clothing on. She said Staff B cleaned him up, put a brief on him and covered him before got there.
MT Staff D said besides care, the night staff does the laundry, checks the medication carts, and as needed medications, and twice a week clean the wheelchairs out back. She said they used to only check the people on the list of residents every 2 hours, but after Resident #3 they are supposed to check everyone frequently. The MT said if the door was locked the staff are supposed to open the door and peek in.

On at 9:35 a.m., Resident #3 was interviewed at the skilled nursing facility. He said he had a big bowel movement, then he in it. He said he laid in it and tried to get up 5 times, but couldn't. He said it happened around 1:50 a.m. and was found around 3:00 a.m. (The resident was found closer to 5:00 a.m. after laying there approximately 3 hours.) He said there was no way to let people know if you , you have to lay there until someone sticks their head in your . The resident said he had a few weeks ago, but had eventually gotten himself up that time. He said he had a pendent type call button which he thought was facility issued, but when he tried it and it did not work. He said if he returned to the facility he would not feel safe.

Hospital record review revealed Resident #3 presented at the emergency with , acute , (low ,), acute melena (tarry bloody stools). His hemoglobin was 6.3 (normal in men is 13.5 to 17.5), and had an elevated white count. His initial troponin level was 48 (normal is 0, troponin is caused when the muscle has been damaged) and was diagnosed with non-ST segment ( ). He was hospitalized.

3. On at 11: 22 a.m., Resident #4 said she has lived there since . She said at times you can't get help. There is not much staff at night. You have to yell to get someone.

On at 11:45 a.m., Resident #5 said he needs assistance with showering. He has lived here not quite a year. The staff asked if I can do it by myself. The resident told them OK, but lately he does not trust himself in the shower. He said if he needed someone, he would have to get on the scooter and

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look for someone. He said he has been up at 2:00 a.m. and unable to find a soul in the place. He said no one ever checks at night. He said if you you would stay there until the next time for medicine, or the cleaning people might see you.

On at 11:55 a.m., Resident #6 said her not have a phone. She said she would yell for help if she could not get to a phone. She said the staff check on her twice a day. She thought they checked on everyone.

On at 1:26 p.m., Resident #8 said staffing "sucks" at night. If you need someone, you have to go look, but "can't never find anyone." During the day, the staff are pretty good because the bosses are here. Sometimes you have to look for 5 to 10 minutes. Staff are usually found sitting in the activity sitting in library area. They sleep in the library most every night. They all work two jobs and get tired and sleep. If she needed someone at night, she would call 9-1-1. The resident said she had lived there for 3 months and there is no system to call staff.

On at 1:50 p.m., Resident #11 said she had difficulty walking. At night she would have to yell or use a phone. She said the administrators kept telling residents they were going to get a call system, but have not. She said has lived here 3 years. When she first moved in, the facility had a call system. Residents used to have a bracelet that looked like a watch. However, they broke down and the facility said it cost too much to fix. The resident said the staff don't check on people. She said she heard that someone and could not get help right away. Even if you use a cell phone, the front desk is not manned.

On at 2:30 p.m., Resident #13 said there is not enough staff in the evenings or at night. The resident said if you do not have a phone and you , you have to yell. Resident #13 said she a month ago at night. She had to "holler" for help. It took a while for help to come. If they could not hear her, it would have been a longer time. The resident said she tried to get up, but could not. She said they need more help on evenings and nights. She said she has lived here more than 1 year. They speak about getting a call system, but they are not getting it any time soon.

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interviews, the facility failed to ensure a safe environment to meet the resident's needs for 7 (Residents #1, #3, #4, #6, #8, #11 and #13) of 12 residents interviewed. Failure to provide adequate supervision lead to the elopement of 1 resident who was gone for 3 days and required

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hospitalization when found and lead to a second resident laying on the floor for 3 hours without staff discovery after a . The systemic failures put these and other residents in imminent danger.

The findings included:

1. Record review revealed Resident #1 was admitted with diagnoses including , with rapid rate, , II and due to protein and calorie deficiency. The resident ambulated with a rolling walker.

On at 9:00 a.m., the Executive Director (ED) said Resident #1 left the facility on Wednesday night after supper ( ). The resident was not here for breakfast and did not sign out. On at 7:00 a.m. to 8:00 a.m. the ED was told the resident did not come down for breakfast. The resident was independent, keeps her door locked and will not let people in her . The ED said the resident went to church next door that night, did not return and went to a hotel.
The ED verified it was not normal for the resident to spend time at a hotel. The resident would take the bus down town and go to the mall, but always return at night.
The ED said the resident was last seen by Licensed Practical Nurse (LPN) Staff A, who works the 2:00 p.m. to 10:00 p.m. shift. Supper is 5:00 p.m. to 6:00 p.m. and medications are at 8:00 p.m. That was the last time Resident #1 received her or medications until 9-1-1 took her to the hospital on .

On at 1:43 p.m., LPN Staff A said she gave Resident #1 her medications at 7:00 p.m., for an 8:00 p.m. medication pass. She said the resident was sitting in "her" chair by the activity her walker. She said she did not see her again after that. LPN Staff A said she checked the resident's she left, but the door was locked and no one answered so she thought she was asleep. She said the facility staff only check on those who need assistance. She said she did not hear that the resident was talking about going to New York until after she left the facility.

On at 12:10 a.m., Resident Assistant Staff G said she came in on and tried to give the resident her medications at 8:00 a.m. that morning. When the locked door was not answered she got a nurse who opened the door and they discovered the resident was missing.

On at 3:24 p.m., a Missing Person's Detective from the Sheriff's Office said she was notified around 11:00 a.m. on and other detectives were onsite. The Detective verified she had viewed the facility's tape recordings and saw Resident #1 leave the building at 6:55 p.m. That was the last time the resident was seen on any facility video. She said, LPN Staff A said she gave the resident medications at 7:30 p.m. to 8:00 p.m. but it was not seen on the video and the time could not be

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confirmed. The MP Detective said the resident is well known to the police and she and her daughter were homeless and used to live in the parks. She said the daughter was still homeless and when interviewed, said the mother did not like it at the facility as it was dirty and they "don't take care of her." The detective verified the resident was found on when she called from a local motel. She said the resident did not have a the motel, but used the phone to make the call.

On at 8:40 a.m., Resident #1 was visited at the hospital. She said she had gone to a hotel, but denied being gone for 3 and 1/2 days, but felt she had been gone only 1 night. She said she needed to go to New York to get money left to her by her brother.

On at 11:22 a.m., Resident #4, said in , when she and Resident #1 went shopping they returned on the wrong bus. They were dropped off at an unfamiliar shopping mall, but were able to find a policeman who returned them to the facility. Record review of Service Notes from to did not contain documentation the episode. The incident was confirmed by the Director of Food Service on at 3:00 p.m. The new ED and the new DON said they were unaware of the incident.

On at 11:52 a.m., Resident Assistant ( ) Staff F said Resident #1 had told other residents she was going to New York.

On at 12:17 a.m., Staff H, who works the memory care unit from 2:00 p.m., to 10:00 p.m., said she knew Resident #1 from a prior facility. Staff H said on Resident #1 told the staff, she and her daughter would be going to New York. Staff H saw Resident #1 the evening of and spoke to her, but did not see her leave the building.

On at 9:24 p.m., Medication Tech (MT) Staff C said she was working the night shift on and did not see Resident #1 that night. She said the facility had a list of frequently residents and she checked those every 2 hours, but did not check anyone who is not on the list. MT Staff C said most residents have cell phones and call the front desk if they need something. Staff C verified she is now to check all residents at midnight, and every 2 hours, even if the door is locked. She said some residents do not like to be checked on and opening the door will wake them.

On at 5:10 p.m., MT Staff E said she only checked the residents on the list. She said the facility had a list of who is a "bed wetter." She would check those residents every 2 hours. She verified a few nights previously the ED had told her to check all residents from the Census List at midnight to ensure everyone is present. She said some nights the Census List is not in the book.

Hospital record review revealed Resident #1 presented at the emergency with

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, midsternal chest pain and racing . She was found to be in with rapid rate. She was also noted to have a with pus and in her . She was admitted for care.

2. Record review showed Resident #3 was admitted with , , , , , , and .

Review of the Service Notes dated at 6:00 a.m. documented the resident had in his . The MT was smelling an odor in the hallway and went she found Resident #3 on the floor. He was noted to be from both elbows, and left knee. 9-1-1 was called and the resident was taken to Lee Memorial Hospital.

On at 5:37 p.m., MT Staff B said on around 4:00 to 5:00 a.m., she smelled a strong odor in the hallway on B wing and began going door to door until she found Resident #1 on the floor in the 's hallway. She said he was covered with feces, and . She yelled to the other MT who called 911 while she cleaned him up and put a pillow under his head. She said Resident #3 said he had been laying on the floor for 5 hours. She said he had hit his head and there was a lot of mixed in with the feces and .

On at 12:02 p.m., MT Staff D said she was working the night Resident #3 . She said it was about 4:45 a.m. to 5:00 a.m. when he was found. She said there was fecal matter present and from his skinned arms and his head. He had no clothing on. She said Staff B cleaned him up, put a brief on him and covered him up before got there. MT Staff D said they used to only check the people on the list of residents every 2 hours, but after Resident #3 they are supposed to check everyone frequently. She said if the door was locked the staff are supposed to open the door and peek in.

On at 9:35 a.m., Resident #3 said he had a big bowel movement then he in it. He said he laid in it and tried to get up 5 times, but couldn't. He said it happened around 1:50 a.m. and was found around 3:00 a.m. (The resident was found closer to 5:00 a.m. after laying there approximately 3 hours.) He said there was no way to let people know if you , you have to lay there until someone sticks their head in your . He said he had a few weeks ago, but had eventually gotten himself up that time. The resident said he had a pendent type call button which he thought was facility issued, but he tried it and it did not work. He said if he returned to the facility he would not feel safe.

Hospital record review revealed Resident #3 presented at the emergency with , acute , acute melena (tarry bloody stools). His hemoglobin was 6.3 (normal in men is 13.5 to

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17.5), and had an elevated white count. His initial troponin level was 48 (normal is 0, troponin is caused when the muscle has been damaged) and was diagnosed with non-ST segment . He was hospitalized.

3. On at 11: 22 a.m., Resident #4 said she has lived there since . She said at times you can't get help. There is not much staff at night. Have to yell to get someone.

On at 11:45 a.m., Resident #5 said he needs assistance with showering. He had lived here not quite a year. Staff asked if I can do it by myself. He said ok, but lately he does not trust himself in the shower. He said if he needed someone he would have to get on the scooter and look for someone. He said he has been up at 2:00 a.m. and unable to find a soul in the place. He said no one ever checks at night. He said if you you would stay there until the next time for medicine, or the cleaning people might see you.

On at 11:55 a.m., Resident #6 said her not have a phone. She would yell for help, if she could not get to a phone. She said the staff check on her twice a day. She thinks they check on everyone.

On at 1:26 p.m., Resident #8 said staffing is bad at night. If you need someone you have to go look, but can't ever find anyone. During the day the staff are pretty good because the bosses are here. Sometimes you have to look for 5 to 10 minutes to find someone. Staff are usually found sitting in the activity library area. They sleep in the library most every night. They all work two jobs and get tired and sleep. If she needed someone at night, she would call 911. She said she had lived there for 3 months and there is no system to call staff.

On at 1:50 p.m., Resident #11 said she had difficulty walking. At night she would have to yell or use a phone to get assistance. She said the administrators kept telling residents they were going to get a call system, but have not. She said has lived here 3 years. When she first moved in, the facility had a system. Residents used to have a bracelet that looked like a watch. However they broke down and the facility said it cost too much to fix. Resident #11 said the staff don't check on people. She said she heard that someone and could not get help right away. Even if you use a cell phone, the front desk is not manned.

On at 2:30 p.m., Resident #13 said there is not enough staff in the evenings or at night. Said if you do not have a phone and you , you have to yell. Resident #13 said she a month ago at night. She had to "holler" for help. It took a while for help to come and if they could not hear her, it would have been a longer time. She said she tried to get up, but was unable. She said they need more help on

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evenings and nights. She said she has lived here more than 1 year. She said they speak about getting a call system, but they are not getting it any time soon.

Class I

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, record review and interview, the facility failed to ensure prescriptions are filled/refilled in a timely manner for 1 (Resident #12) of 2 residents reviewed for medication refills. Failure to ensure timely refill caused Resident #12 to suffer a pain level of 9 to 10 on a scale of 0-10 for 3 days without relief.

The findings included:

On at 2:00 p.m., Resident #12 talked about his pain medication, saying he had not received it in 3 days. His pain was described as a 9 to a 10 on a 0-10 scale. The resident said when he gets the medication, his pain lessens to a 3 or 4. Resident #12 said he had spinal damage and ( ) of the spine. Although the was treated and spinal damage was operated on, he still had severe pain. The resident said he had not slept much due to the severe pain and he just wants relief. The resident said he had lived in the facility for over a month, and he did not understand how they could let him run out of pain medication.

On at 2:30 p.m., record review revealed Resident #12 was prescribed / , ( ) 5-325 milligrams (mg), 1 tablet by mouth every 8 hours as needed for complaints of pain. The Medication Observation Record (MOR) showed the pain medication was initialed 32 times from to . The medication was last initialed as given on at 8:00 a.m.

On at 2:30 p.m., Observation of the medication cart revealed no / 5-325 tablets for Resident #12 in the locked drawer or with his other medications.

On at 2:36 p.m., the Executive Director (ED) said the medication was brought to the facility last night, but since they did not have an original written prescription to give to the pharmacy, the pharmacy could not leave the medication and took the drug back. The ED said she did not know Resident #12 had been without pain medication for days.

On at 2:40 p.m., Licensed Practical Nurse (LPN) Staff A said the process is to peel the reorder

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sticker (bar code) from the medication pack and place it on a Refill Reorder Form and fax it to the pharmacy. The facility had no copy of the form being sent for Resident #12's / 5-325 mg.

The pharmacy faxed back a copy of a Refill Reorder Form showing the order was received and noted, "Attn: Lamplight ** sending Hydroco/ tonight, but refill requests received after 1:00 p.m., will be delivered next day..." and "Faxed Dr [doctor] for new original prescription, Please fax copy of new original C-II if you have one..." (C-II refers to schedule II controlled substance; the pharmacy will require an original script.)

The LPN Staff A said the facility had no process to keep the faxed copies and track the medication requests, or compare the requests to the medications when they arrive. They just check the delivery slip against the medications delivered. She acknowledged the medication had been requested on and was not provided by .

On at 2:50 p.m., the LPN Director of Nurses (DON) said she spoke to the doctor who said they needed to get a pain management doctor. (An assisted living facility is responsible to assist with arranging medical appointments.) She said she did not know he would need an original written prescription to get the medication. She said the pain management appointment was now set for . The LPN DON said looking at the 32 times he took the pain medication from to he should have a routine pain medication besides the breakthrough, as needed medication.

Class II

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

Based on record review and interviews, the facility failed to file 1 day or 15 day adverse incident reports as required for 1 (Resident #3) of 2 residents reviewed for adverse incidents. The facility failed to complete the day 1 adverse incident report accurately for 1 (Resident #1) of 2 residents reviewed for adverse incidents. Failure to recognize elopements of non-exit seeking residents may lead to further episodes of elopements and harm to the eloping residents.

The findings included:

1. Record review revealed Resident #1 was admitted with diagnoses including with rapid rate, II and due to protein and calorie deficiency. The resident ambulated with a rolling walker.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**09/25/2018**
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)

On at 9:00 a.m., the Executive Director (ED) said Resident #1 left the facility on Wednesday night after supper ( ). The resident was not here for breakfast and did not sign out. On at 7:00 a.m. to 8:00 a.m. the ED was told she did not come down for breakfast. The resident was independent, keeps her door locked and will not let people in her . The ED said the resident went to church next door that night, did not return and went to a hotel.
The ED verified it was not normal for the resident to spend time at a hotel. The resident would take the bus down town and go to the mall, but always returned at night.
The ED said the resident was last seen by Licensed Practical Nurse (LPN) Staff A, who works the 2:00 p.m. to 10:00 p.m. shift. Supper is 5:00 p.m. to 6:00 p.m. and medications are at 8:00 p.m.
The ED said the incident was not an elopement since the resident was not exit seeking, although she left against facility policy and was gone for 3 and 1/2 days.

A review of the Adverse Incident Reporting data base showed the facility completed a 1 day report for this incident but marked it only as an event reported to law enforcement. The state reviewer flagged the report back to the facility to mark it as an elopement with a note to "please check every applicable outcome. (Elopement; if the elopement places the resident at risk of harm or injury)."

A review of the policy Elopement Policies and Procedures revised 11/2013, revealed "Resident Elopement is defined as when a dependent resident in a licensed facility leaves that facility without staff observation or knowledge of their departure."

Elopement refers to exit seeking behavior demonstrated by residents who are typically . These residents are constantly looking for a way out of the building. They may be searching for a specific place, Although it is common that a individual may not know what or who they are searching for and are just searching."

The facility has a history of citations for elopement in 2018, 2018, and 2018 with 2 prior resident elopements.

2. Record review showed Resident #3 was admitted with and .

Review of the Service Notes dated at 6:00 a.m., documented the resident had in his .
The MT was smelling an odor in the hallway and went she found Resident #3 on the floor. He was noted to be from both elbows, and left knee. 911 was called and the resident was taken to a local hospital.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**09/25/2018**
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)

On at 5:37 p.m., MT Staff B said on around 4:00 a.m. to 5:00 a.m., she smelled a strong odor in the hallway on B wing and began going door to door until she found Resident #1 on the floor in the 's hallway. She said he was covered with feces, and . She yelled to the other MT who called 911 while she cleaned him up and put a pillow under his head. She said Resident #3 said he had been laying on the floor for 5 hours. Staff B said he had hit his head and there was a lot of mixed in with the feces and .

A review of the Adverse Incident Reporting data base showed the facility failed to complete a day 1 or day 15 report for this incident with Resident #3.

Class III