STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 10/10/2018
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 conducted on . . . . through . . . . at Lamplight Inn, an assisted living facility (license # 5096) in Fort Myers, Florida.

This was a third follow-up to the complaint survey. The complaint survey was completed on . . ; the first revisit was completed . . . . ; and the second revisit was completed . . . . .

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

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

Note: This citation was not reviewed on this . . . . . follow-up because it was cited on the . . . . complaint survey (NRXV11) and the facility was still in their correction period.

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

Based on record and policy review and staff interview, the facility failed to maintain an accurate Medication Observation Record (MOR) for 17 (Resident #1, #5, #9, #10, #11, #12, #13, #16, #18, #21, #26, #27, #28, #29, #32, #33, and #34) of 66 residents sampled. The MOR must be immediately updated each time the medication is offered or administered (per 58A-5.0185(5)(b) Florida Administrative Code).
This was previously cited and remains an uncorrected deficiency.

The findings included:

Review on . . . . . of the facility's "Medications" (undated) policy and procedure included:
"8- The Administrator will assure to provide an appropriate and accurate medication Record Keeping for each resident at [the facility]."

1. Resident #18's . . . . . MOR was reviewed on . . . . . According to the MOR, the resident was to receive . . . . . 37.5 milligrams (mg) three times a day for pain. The MOR failed to show . . . . . was given twice on . . . . . Mycostatin was ordered (for a fungal . . . . .) twice daily until resolved. The MOR failed to show the Mycostatin was given in the morning on . . . . . .

2. Resident #29's . . . . . MOR was reviewed on . . . . . . According to the MOR, the resident was to receive . . . . . 10 mg three times a day for . . . . . . The MOR failed to show the resident received

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the afternoon dose of on . The resident was to receive / mg three times daily for non-acute pain, . The MOR failed to show the resident received the afternoon and evening doses of / , on . The resident was to receive Z 0.004% eye drops every night for . The MOR failed to show the resident received the bedtime dose of Z on and .

3. Resident #32's MOR was reviewed on . According to the MOR, the resident was to receive Florastor 250 mg (a probiotic) every other day. The MOR failed to show the resident received the afternoon dose of Florastor on . The resident was to receive , 400 mg three times a day for . The MOR failed to show the resident received the noon dose of on . The resident was to receive , 20 milliequivalents (MEQ) twice daily (for low ,). The MOR failed to show the resident received the , the evening of . The resident was to receive , 2.5 micrograms (mcg) once daily for . The MOR failed to show the resident received , on . The resident was to receive C 500 mg once daily as a supplement. The MOR failed to show the resident received C on . The resident was to receive (iron) 325 mg once every other day. The MOR failed to show the resident received iron on .

4. Resident #28's MOR for was reviewed on . According to the MOR, the resident was to receive 50 mg for high , twice daily and to hold it if pulse is less than 60 beats per minute. The MOR failed to show the resident's pulse when given the , on , , , , , , , (evening dose only) and . The MOR failed to show the resident received , in the morning on .

5. Resident #26's MOR was reviewed on . According to the MOR, the resident was to receive , 40 mg once daily for ; 5 mg twice daily for ; ; 10 MEQ twice daily for low level; , 25 mg twice daily for , ; ES 500 mg twice daily for pain. The MOR failed to show the resident received the above 5 medications in the morning on

6. Resident #27's MOR was reviewed on . According to the MOR, the resident was to receive , 81 mg for maintenance; 10 mg once daily for high ; , 10 mg once daily for ; , 5 mg every morning for , ; 10 mg twice daily for ; K-Tab for , 10 MEQ every other day. The MOR failed to show the resident received the morning dose of the above 6 medications on .

7. Resident #21's MOR was reviewed on . According to the MOR, the resident was to

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receive 250 mg three times daily; ER 200 mg twice daily; Lamictal 150 mg twice daily; 800 mg twice daily for ; and 2 mg twice daily for . The MOR failed to show the resident received the the morning of and on the evening of . The MOR failed to show the resident received and , Lamictal, and in the evening on .

8. Resident #1's MOR was reviewed on . According to the MOR, the resident was to receive 500 mg every 8 hours for pain relief and/or ; 80 mg ½ tablet every night at bedtime for high ; 100 mg every night at bedtime for mood and 25 mg 1 ½ tab twice daily. The MOR failed to show the resident received and evening doses on .

9. Resident #5's MOR was reviewed on . According to the MOR, the resident was to receive 20 mg twice daily for high and Mycostatin three times daily for a fungal . The MOR failed to show the resident received and Mycostatin afternoon and evening on .

10. Resident #10's MOR was reviewed on . According to the MOR, the resident was to receive 100 mg daily for ; ER 25 mg once daily for ; and cream twice daily. There was no documentation to show the resident received the morning doses on . The resident was to receive 600 mg three times daily; 75 mg three times daily for nerve pain; and 400 mg four times daily. The MOR failed to show the resident received the afternoon doses of and on . The MOR failed to show the resident received the afternoon doses of and on .

11. Resident #11's MOR was reviewed on . According to the MOR, the resident was to receive 300 mg three times daily for / 10 mg every night at bedtime for and 50 mg every night at bedtime for . The MOR failed to show the resident received and evening/nighttime doses on .

12. Resident #12's MOR was reviewed on . According to the MOR, the resident was to receive 20 mg once daily and 5 mg once daily for high ; 0.25 mg half hour before for , and 500 mg twice daily for pain. The MOR failed to show the resident received , and morning doses on .

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13. Resident #13's MOR was reviewed on . According to the MOR, the resident was to receive 40 mg once daily for ; 150 mg once daily for , ; , 40 mg twice daily for , , 100 mg twice daily, and 50 mg twice daily for pain. The MOR failed to show the resident received the morning dose of on , the morning doses of , , , , and the afternoon dose of on .

14. Resident #16's MOR was reviewed on . According to the MOR, the resident was to receive , 50 mcg every 72 hours for pain; 100 mg twice daily for , , and recurrent ; , 0.5 mg four times daily for ; Xtampza ER 8 mg every 8 hours for pain; 50 mg nightly; prazosin 1 mg every night used to treat high , , , , gel 1% four times daily for pain. The MOR failed to show the resident received , morning dose on and , levetiraceta, , Xtampza, , prazosin and gel evening doses on and .

15. Resident #33's MOR was reviewed on . According to the MOR, the resident was to receive , 25 mg twice daily (for high ,) and twice daily (for digestion); 60 mg (take with 30 mg for total of 90 mg) daily (for ,). The MOR failed to show the resident received morning dose, , and afternoon doses on .

16. Resident #34's MOR was reviewed on . According to the MOR, the resident was to receive , 1 mg twice daily and , 5 mg three times daily for , . The MOR failed to show the resident received , and , afternoon doses on .

17. Resident #9's MOR was reviewed on . According to the MOR, the resident was to receive cream twice daily for skin irritation, , , 10 mg three times daily for , , , 5 mg at bedtime for , , and 20 mg at bedtime. The MOR failed to show the resident received cream morning dose and bedtime dose on . The MOR failed to show the resident received , evening dose on . The MOR failed to show the resident received , evening dose on .

18. On at 11:00 a.m., the Administrator reviewed the scanned copies of the MORs for Residents #5 and #21 and acknowledged there were boxes without initials on the scanned copies of the MORs.

Class III

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

Based on observation and staff and resident interviews, the facility failed to maintain a safe living environment free from hazards for residents. Failure to maintain furnishings and systems or inadequate housekeeping was identified in 14 resident and several common areas.
This was previously cited and remains an uncorrected deficiency.

The findings included:

During the assisted living facility tour with the Memory Care Coordinator on at 10:30 a.m., the following was observed:
- Multiple black stains on the floor.
- Strong odor of , open trash container in resident soaked brief.
On at 11:00 a.m., the Memory Care Coordinator said the resident assistants must remove wet briefs from trash can immediately and dispose of them by tying the plastic trash bag and disposing it.
- Broken window on the upper right side.
- The bedrail was not fixed to the bed, posing a safety hazard to the resident.
On at 10:30 a.m., the Director of Nursing (DON) said the resident's family must have brought the bedrail and placed it on the resident's bed. The DON reported she informed the family the bed rail was removed by her from the resident's , and they could place the bedrail back onto the bed, only if it could be fixed to the bed frame.
- Entire floor in the resident's wet. Air conditioning ceiling vent was leaking water continuously onto the floor of the resident's .
On at 11:15 a.m., the Memory Care Coordinator said the air conditioning vent leaks water because the resident leaves the door to his , to the outside.
- was peeling.
- Caulking was loose around the toilet.
- The door frame of the entryway to the gouged ; the closet door was missing.
- Slats were missing from the window .
- The window was broken; the closet door was missing and found resting on the wall inside the closet.
- There were multiple large black stains on the floor.
On at 11:40 a.m., Resident #22 said he has complained to administration numerous times to replace black, stained floor tiles.
- There was a strong odor of in the ; There was , wood along the lower side of the vanity.
- A drainage bag was found hanging from a towel rack with the end of the tubing lying

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on the .
- The closet door was missing; a floor tile was broken.
Public Hall D - The window facing the street was broken; The had massive scuff marks.
Hall D hallway - The carpet had large back stains.
On at 11:55 a.m., Housekeeper Staff X confirmed Hall D carpet had large back stains. She said the hallway carpet are to be cleaned on the night shift, but she does not know when they were cleaned.

During an interview on at 2:40 p.m., the Administrator reported there were 2 housekeepers at the facility for 92 residents on 8th due to a staff call out and a staff firing. The Administrator said the usual number of housekeepers is 4 and their assignments include:
Staff U cleans memory care and A hallway ,
Staff V cleans memory care and B hallway ,
Staff X cleans memory care and D hallway ,
Staff V cleans laundry and common areas,
The Administrator admitted if there is a call out, there is no replacement.

On at 2:45 p.m., Housekeeper Staff V said 2 housekeepers are not able to keep the facility clean.

Class III

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

Note: This citation was not reviewed on this follow-up because it was cited on the complaint survey (NRXV11) and the facility was still in their correction period.