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 follow-up to the biennial relicensure and limited nursing services (LNS) survey completed on . . . . .

This survey contains 6 uncorrected deficiencies including A123 at class II.

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

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

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

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, staff interview, and policy review the facility failed to read the medication label to the residents during the medication pass for 6 (Resident #1, #8, #10, #11, #20, and #32) of 6 residents observed for medication pass. Two (Residents #10 and #11) of 6 residents were given medications that were pre-poured and in unlabeled medication cups. Medications were not kept in proper locked storage during medication pass for 3 (Resident #1, #8, and #20) of 6 residents observed.
This was previously cited and remains an uncorrected deficiency.

The findings included:

Florida Statute 429.256(3) Assistance with self-administration of medication includes:
"(b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container." and
"(e) Returning the medication container to proper storage."

On . . . . a review of the policy titled "Medications" (no effective date) included:
"1. All medications centrally stored shall be kept in a locked cabinet and/or safe place." and
"B- In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container."

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1. On at 8:50 a.m., Medication Tech Staff N was observed for medication assistance. She removed Resident #8's medications from the cart and compared the labels to the medication observation record (MOR). She placed the MOR book in the bottom drawer of her cart. Staff N left the medication cart unlocked and entered Resident #8's the medication cup. The medication cart was out of her line of sight. She handed the resident the cup of medications and he took them. She did not read the medication label to Resident #8 of what was in the cup.

2. On at 9:07 a.m., Medication Tech Staff N was observed gathering medications for Resident #1. She compared the medication label to the MOR. The Medication Tech went to give Resident #1 his medications. She walked away from the medication cart in the hallway, leaving it unsecured and went outside the door at the end of the hall. The medication cart remained unlocked and out of her line of sight. She handed the resident the cup of medications and he took them. She did not read the medication label to Resident #1 of what was in the cup.

3. On at 9:30 a.m., Medication Tech Staff O was observed standing at her medication cart. There were 2 unlabeled medication cups with medications in them. She said they were for Residents #10 and #11.
At 9:45 a.m. Resident #11 came to the medication cart and the Staff N gave her a cup of medications from on top of the medication cart. Staff N did not read the medication label to the resident.

4. On at 9:30 a.m., Medication Tech Staff O said the 2 unlabeled medication cups were for Residents #10 and #11. Review of the MOR indicated Resident #10 should receive 10 pills, but there were only 8 pills in the cup. Medication Tech Staff O said she was not giving Resident #10 the , (for a ,) and , (for) because she was unable to locate them in her cart.
At 9:47 a.m., Medication Tech Staff N brought the medication cup to Resident #10's . She handed him the cup of medications and he took them. She did not read the medication label to Resident #10 of what he was getting.

5. On at 9:55 a.m., observed Medication Tech Staff O gathered medications for Resident #20. She compared each medication label to the MOR, including the Florastor (a probiotic). The directions on the Florastor label included, "Space 2 hours from ." Staff O said Resident #20 is getting an for a .
At 10:25 a.m., Staff O brought Resident #20's medications in a cup to the wellness station and placed the cup on the counter. Other residents were in the wellness . Leaving the medications on the counter, Staff O left to get the resident. She brought Resident #20 into the wellness was in

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the process of handing her the cup of medications. Staff O was asked to wait and after Licensed Practical Nurse (LPN) Staff F read the label on the Florastor (a probiotic). The was removed and the rest given to the resident. No one read the label to Resident #20 as to what medications she was taking.

6. On at 11:58 a.m., Medication Tech Staff P was observed gathering the medications for Resident #32. She turned to the MOR and retrieved pill package from the medication cart. She removed Resident #32's pill from package and placed (for pain) into the med cup. She handed Resident #32 her medication without reading the medication label to her of what was in the cup.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to ensure documentation of required staff in-service training within 30 days of employment for 1 (Staff Q) of 3 staff records reviewed. This was previously cited and remains an uncorrected deficiency.

The findings included:

Record review revealed Staff Q was employed as a medication tech and resident aide on to provide direct care to residents. Staff Q's personnel record did not contain documentation of completed in-service training in the following areas:
Incident reporting,
Emergency procedures and evacuation,
Recognizing and reporting /neglect/ ,
Behavior and needs training,
Activities of daily living (ADLs),
Safe food handling, and
Elopement response training.

On at 2:11 p.m., the Business Office Manager said she was unaware that Staff Q did not have this education in her file. The Business Office Manager manages all employee files.

On at 2:12 p.m., the Administrator said she was unaware that Staff Q did not have the training in her file.

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Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure 1 (Staff Q) of 3 staff records reviewed had the required 1 hour of training in ( ) within 30 days after employment.
This was previously cited and remains an uncorrected deficiency.

The findings included:

Review of Medication Tech Staff Q's personnel file showed that she was hired on . Staff Q's personnel record did not contain documentation of completion of ( ) policy and procedure training. The training should have been done within 30 days of hire.

On at 2:11 p.m., the Business Office Manager said she was unaware that Staff Q did not have policy and procedure training within 30 days of hire in her file. The Business Office Manager manages all employee files

On at 2:12 p.m., the Administrator said she was unaware that Staff Q did not have policy and procedure training within 30 days of hire.

Class III

0123 - Fiscal - Resident Trust Funds - 429.27(3-4) FS; 58A-5.021(2) FAC

Based on record review, resident family and staff interview, the facility failed to provide residents an accurate accounting of their money being held in trust for 6 (Resident #31, #2, #4, #7,#13, and #14) of 6 residents. Residents have an expectation that the facility will provide the safekeeping and appropriate accounting of their money. Withholding funds is harmful to residents' financial security.
This was previously cited and remains an uncorrected deficiency.

The findings included:

On at 10:00 a.m., the Business Office Manager (BOM) said Resident #31 had been there for several months and has never gotten his money. She said his trust account (resident spending account) is showing a zero balance. She reviewed his transaction history. The BOM said she can identify: Check #190 dated in the amount of $200.00,

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Check #195 dated in the amount of $200.00,
Check #200 dated in the amount of $250.00, and
Check #206 dated in the amount of $400.00 in the transaction history.
She said a total of what should have been put into Resident #31's trust account was $1,050.00. She said Resident #31 is no longer there, she will notify the responsible party and corporate will issue a check to him for $1,050.00.

On at 1:00 p.m., the BOM said the facility should have had money in a trust account for Residents #2, #4, #7, #13, #14, and #31. The BOM said she was new and could not find any accounting for the trust accounts. She was aware Resident #2, #7, #13, and #14 were to receive a stipend of $54.00 a month. She said she can see the money in their transaction history, but not recorded into their trust accounts.

On at 10:30 a.m., the daughter of Resident #31 said she has sent her father several checks designated "spending for [Resident #31]" as evidenced in the memo section of each of the checks. She confirmed she has not yet received a refund and has been told her father does not have any money in a trust account.

Class II

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on record reviews and staff interviews, the facility altered documentation on Medication Observation Records (MORs) for 7 (Residents #5, #21, #26, #27, #28, #29, and #32) of 7 residents sampled for medication assistance. Review of the MORs found medications that had not been initialed as given. Those MORs were scanned between 11:30 p.m. on and 12:20 a.m. on . Shortly after the scanning, the Director of Nursing (DON) provided photocopies of MORs that had initials in the boxes marked as given that were previously blank.

The findings included:

Florida Statute 429.256(3) Assistance with self-administration of medication includes:
"(f) Keeping a record of when a resident receives assistance with self-administration under this section."
Per Florida Administrative Code 58A-5.0185(5)(b), the MOR must be immediately updated each time the medication is offered or administered.
The facility's policy and procedure titled "Medications" (undated) included: "8- The Administrator will assure to provide an appropriate and accurate medication Record Keeping for each resident at [the

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facility name]."

1. On at 11:30 p.m., a scan copy was taken Resident #5's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #5's MOR included 20 milligrams (mg) twice daily (for) and Mycostatin three times daily (for a fungal).
The scanned copy of the MOR had no documentation to show the resident received and Mycostatin in the afternoon and evening on .
On shortly after 11:38 p.m., the DON provided a copy of Resident #5's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

2. On at 11:40 p.m., a scan copy was taken Resident #21's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #21's MOR included , 250 mg three times daily, , , ER 200 mg twice daily, Lamictal 150 mg twice daily, , 800 mg twice daily (anti- drugs), and 2 mg twice daily (for , ,).
The scanned copy of the MOR had no documentation to show the resident received the , the morning of and the evening of , the , , , , Lamictal, and in the evening of .
On shortly after 11:42 p.m., the DON provided a copy of Resident #21's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

3. On at 12:06 a.m., a scan copy was taken Resident #26's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #26's MOR included , , 40 mg once daily (for ,), 5 mg twice daily (for high ,), , 10 milliequivalents (MEQ) twice daily (for low ,), , , 25 mg twice daily (for ,), and ES 500 mg twice daily (for pain).
The scanned copy of the MOR had no documentation to show the resident received the above medications in the morning on .
On shortly after 12:30 a.m., the DON provided a copy of Resident #26's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

4. On at 12:13 a.m., a scan copy was taken Resident #27's MOR confirming the boxes

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without initials (that is, not initialed as given).
Review of Resident #27's MOR included , 81 mg (for maintenance), 10 mg once daily (for), , 10 mg once daily (for), , 5 mg every morning (for ,), and K-Tab for 10 MEQ every other day (for low ,).
The scanned copy of the MOR had no documentation to show the resident received the morning doses of the above medications on .
On shortly after 12:30 a.m., the DON provided a copy of Resident #27's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

5. On at 12:15 a.m., a scan copy was taken Resident #28's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #28's MOR included , 50 mg twice daily (for high ,) and to hold it if pulse is less than 60 beats per minute.
The scanned copy of the MOR had no documentation to show the resident received the , on , , , , , , , and the morning of .
On shortly after 12:30 a.m., the DON provided a copy of Resident #28's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

6. On at 12:17 a.m., a scan copy was taken Resident #29's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #29's MOR included 20 mg twice daily (for ,), , 10 mg three times a day (for), / , mg three times daily (for non-acute pain -) and Z 4% eye drop every night (for).
The scanned copy of the MOR had no documentation to show the resident received , in the afternoon of , the three doses of / , on , in the evening of , and the bedtime dose of Z on and .
On shortly after 12:30 a.m., the DON provided a copy of Resident #29's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

7. On at 12:19 a.m., a scan copy was taken Resident #32's MOR confirming the boxes without initials (that is, not initialed as given).
Review of Resident #32's MOR included Florastor 250 mg every other day (a probiotic), , 400 mg three times a day (for), , 20 MEQ twice daily (for low

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,), C 500 mg once daily (a supplement), and (iron) 325 mg once every other day.
The scanned copy of the MOR had no documentation to show the resident received the afternoon dose of Florastor on , the noon dose of on , C and on .

On shortly after 12:30 a.m., the DON provided a copy of Resident #32's MOR with initials in the previously blank boxes.
This showed the photocopied MOR had been altered.

8. On at 11:00 a.m., the Administrator reviewed the scanned copies of the MORs for Residents #5, #21 and acknowledged there were differences between the scanned and photocopied MORs. She confirmed there are now initials on the photocopied MORs as compared to the boxes without initials on the scanned MORs.

On at 2:15 p.m., Medication Techs Staff N and Staff O reviewed the photocopies of the MORs for the residents they were assigned to on . Staff N and Staff O confirmed they worked 6:00 a.m. to 2:00 p.m. on . Medication Techs confirmed the initials in the boxes for were not their initials. Staff N stated, "Those aren't mine, who did that?"

Class III