STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 03/08/2019
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 was to the complaint survey completed on .

The following is description of the deficiencies:

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to ensure the documentation of legal power of attorney, legal health care surrogate or legal proxy were maintained in the resident's record for 2 (Residents #44 and #45) of 3 residents reviewed for advanced directives.

731.201 Florida Statute (F.S.) (21) defines , as, "a judicial determination that a person lacks the capacity to manage at least some of the person's property or to meet at least some of the person's essential health and safety requirements."

765.204(2) F.S. "If a principal 's capacity to make health care decisions for herself or himself or provide informed consent is in question, the primary or attending physician shall evaluate the principal 's capacity and if the evaluating physician concludes that the principal lacks capacity, enter that evaluation in the principal 's medical record. ..... If the principal has designated a health care surrogate or has delegated authority to make health care decisions to an attorney in fact under a durable power of attorney, the health care facility shall notify such surrogate or attorney in fact in writing that her or his authority under the instrument has commenced, as provided in chapter 709 or s. 765.203.

The findings included:

1. Record review revealed Resident #44 was admitted on . At the time of admission, Resident #44 was her own person and signed the admission paperwork.

The latest Agency for Healthcare Administration (AHCA) Resident Health Assessment (AHCA Form 1823) in the record was completed on and showed the resident was alert and oriented times 3 (that is alert and oriented to person, place, and time).

Record review revealed on a Healthcare Provider Communication Order about Resident #44

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which documented, "Resident was redirected several time to the facility need order to transfer her to m.c. [memory care] please." The order was signed by the Advance Registered Nurse Practitioner (ARNP). On at 6:30 p.m., the record documented the Resident was moved to the memory care unit, which is a locked unit.

Record review revealed a Designation of Health Care Surrogate form partially completed with names for a surrogate and alternative, dated but is not signed by Resident #44.
A Living Will including surrogate designation dated was also unsigned by Resident #44.

Record review also revealed the Advance Directive Policy and Procedure dated signed by Resident #44. The document showed the resident marked "No" beside the question "Does resident have an Advanced Directive?"

On at 1:30 p.m., regarding the legal decision maker for Resident #44, the Administrator said Resident #44's son lives in Japan was the surrogate they contact. She said the papers were in the chart. When shown the papers were unsigned by Resident #44 and therefore never legally executed, the Administrator denied unawareness of this.

2. Record review revealed Resident #45 was admitted on . The resident had diagnoses including major , generalized , and with behavioral disturbance, behavioral , and . She was admitted to the locked memory care unit.

A review of the admission packet and contract revealed all paperwork was signed by the Resident #45's spouse. Review of the medical chart and the business office charts lacked any advanced directives or court papers.

On at 1:30 p.m., the Administrator said Resident #45's husband was the legal decision maker and had to go to court to obtain the authority. The Administrator looked page by page in both the medical and business record and did not find any legal paperwork.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to ensure the contracts were signed by the resident or their legal representative for 2 (Residents #45 and #46) of 3 residents reviewed for legally executed contracts.

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731.201 Florida Statute (F.S.) (21) defines [redacted] as, "a judicial determination that a person lacks the capacity to manage at least some of the person's property or to meet at least some of the person's essential health and safety requirements."

765.204(2) F.S. "If a principal's capacity to make health care decisions for herself or himself or provide informed consent is in question, the primary or attending physician shall evaluate the principal's capacity and, if the evaluating physician concludes that the principal lacks capacity, enter that evaluation in the principal's medical record..... If the principal has designated a health care surrogate or has delegated authority to make health care decisions to an attorney in fact under a durable power of attorney, the health care facility shall notify such surrogate or attorney in fact in writing that her or his authority under the instrument has commenced, as provided in chapter 709 or s. 765.203".

The findings included:

1. Record review revealed Resident #46 was admitted on [redacted] with a diagnoses including [redacted] and [redacted]. The records included a Durable Power of Attorney (DPOA) dated and signed by the Resident giving her Canadian cousin her DPOA.

A review of the admission packet and contract revealed the contract paperwork was signed by the patient's DPOA.
Additional admission paperwork was signed by a friend of the resident on either [redacted] or [redacted], not by the Resident's cousin with DPOA. These documents included a Medical Release/Informed Consent/Assignment of Benefits (to allow the advanced registered nurse practitioner provide health care), Pharmaceuticals Purchase Agreement (agreement with the in-house pharmacy to provide medications and bill for payment), Request for and Informed Consent to Assistance with Medication by Unlicensed Personnel, Resident Choice Acknowledgement, Do No Order policy and procedure ( ), Elopement policy and procedure, Beneficiary Designation (making the friend her beneficiary not her Canadian relative), Medicaid Fraud Reporting Notification, Advanced Directives policy and procedure, Hurricane Evacuation Policy and Agreement, and Community Grievance Procedure

On at 1:30 p.m., the Administrator said Resident #46's cousin in Canada was the legal decision maker. The Administrator said the cousin had told them that they could speak to the friend and the friend could take the resident out. The Administrator reviewed the medical chart and the business file. She could not find any documentation the facility was allowed to release information, allow the Resident out with, or transfer the ability to sign on the resident's behalf to the friend.

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2. Record review revealed Resident #45 was admitted on . Her diagnoses included major , generalized , and with behavioral disturbance, behavioral , and . She was admitted to the locked memory care unit.

A review of the admission packet and contract revealed all paperwork was signed by the Resident #45's spouse. The medical chart and the business office charts lacked any advanced directives or court papers.

On at 1:30 p.m., the Administrator said Resident #45's husband was the legal decision maker and had to go to court to obtain the authority. The Administrator looked page by page in both the medical and business record and did not find any of Resident #45's legal paperwork giving the husband authority.

Class III