STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**
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 for CCR #2017012364, 2017014385, 2017014636, 2017014960, and 2017015782 was conducted through at Lamplight Inn, an assisted living facility (license #5096) in Fort Myers, Florida.

Complaint CCR #2017012364 contained 1 allegation which was substantiated.
Complaint CCR #2017014385 contained 3 allegations, of which 2 were unsubstantiated and 1 was substantiated.
Complaint CCR #2017014636 contained 2 allegations which were unsubstantiated.
Complaint CCR #2017014960 contained 4 allegations, of which 1 was unsubstantiated and 3 were substantiated.
Complaint CCR #2017015782 contained 1 allegation which was substantiated.

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, interview, and observation, the facility failed to provide supervision in the prevention of and elopement for 1 resident (Resident #14) causing the resident to be hospitalized on 4 occasions. The facility also failed to supervise memory care residents, allowing them to walk unsupervised near an open section in the damaged fence, this placed residents at risk for elopement. The facility failed to ensure 2 residents (Resident #18, and #20) were wearing shoes or nonskid socks, having a potential to cause the residents to .

The findings included:

1. During an interview on at 1:53 p.m., the Administrator said Resident #14's father, who was his Power of Attorney, in of 2017. The Administrator said in of 2017 the resident's stepmother refused to act as the resident's guardian and had turned the resident's phone off because the resident was no longer able to communicate on the phone due to his . The Administrator verified Resident #14 was not able to make his medical decisions for himself due to having injuries from playing football. The Administrator said the resident was allowed to continue to sign himself out of the facility and leave the building until he was placed in memory care on .

Documentation on the sign-out sheets showed Resident #14 did not sign himself out from until . There are six lines of scribbled illegible writing from to on the sign out

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

sheets identified by the administrator as Resident #14's signing himself out of the facility. There is no notation as to when Resident #14 left the building or returned to the building on those dates.

The Healthcare Provider Communication Form noted Resident #14 "is becoming more /busy acting-on the go more. Monday there was feces on his floor, wall, outside back (his) door. He is collecting garbage (empty bottles, cereal boxes, coffee) more than usual & it's all outside his back door. His hygiene is slacking. Only medication is ."

On Resident #14 was placed on , 4 capsules by mouth twice daily.
The Healthcare Provider Communication Form noted, "Concerned that resident not eating since , started. Evening Nurse stated Resident won't eat."

Review of the monthly weights for Resident #14 showed the resident's weight on was 198 lbs.
On Resident #14's weight was 168 lbs. The documentation showed a loss of 30 pounds in a four month period.

The Healthcare Provider Communication Form noted, "Behaviors have not changed with , , , and ."

On the Advanced Registered Nurse Practitioner (ARNP) ordered , (an anti-, medication) 0.5 milligrams (mg) twice daily for 5 days then increased to 1 mg twice daily thereafter. According to the Food and Drug Administration (FDA) one of the side effects of , is . The FDA website reads, "Somnolence, , , motor and sensory instability have been reported with the use of , , , including , ®, which may lead to and, consequently, or other -related injuries. For patients, , , the elderly, with , conditions, or medications that could exacerbate these effects, assess the risk of when initiating , , treatment and recurrently for patients on long-term , , ."

A Service Note dated at 10:00 a.m., documented Resident #14 was walking outside the building and became overheated. At 10:30 a.m., staff documented, "reeducated on not to walk when the temperature outside is so warm and to go on shorter walks."

A Service Note dated at 2:00 p.m., documented the resident in the facility parking lot twice and was sent to the hospital.

The Healthcare Provider Communication Form noted, "send to ER for eval for and x 2."

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

The Health Assessment (Form 1823) dated showed Resident #14 was diagnosed with , concussions, , and , . The 1823 documented Resident #14 as nonverbal and a risk.

On at 2:00 p.m., a service note documented, "Resident out walking had incident and went to ER with for evaluation."

In the triage note from the hospital dated at 1:54 p.m., the registered nurse (RN) documented, " [patient] to ED via . Bystander called 911 bc [because] , was walking down the road with all over him; , lives at [facility name] memory care; per staff patient is allowed to leave the facility but states he usually signs himself out and today he didn't sign out; , was found about 6 blocks away from the facility ... a&o [alert and oriented] to name and dob [date of birth] only."

Nine days later, on , the triage nurse from the hospital documented, "arrives via after an unwitnessed outside the facility. HX [history] of head injury and is non-verbal. Per , diaphoretic and noted to left shoulder, palms and knees. unable to report complaints and does not respond to palpating ."

Six days later, on , the triage nurse from the hospital documented Resident #14 was transferred to the hospital after he was found in the bushes. The nurse noted the resident was not able to communicate verbally and he had at various stages of healing throughout his body.

Documentation from the hospital showed Resident #14 was discharged from the hospital to another assisted living facility on .

During an interview on at 1:23 p.m., the Administrator said Resident #14 was found in hurricane debris on , several blocks away from the facility. The Administrator said the resident was sent to a sister facility after being discharged from the hospital because there was no space in the memory care unit at the facility.

On at 9:54 a.m., the triage nurse documented, "Per , has hx of , , . has hx of . lives at [sister facility] a nursing facility where he escaped. was spotted by a bystander that saw him on his head. is nonverbal, responds to voice."

On at 12:38 p.m., the Case Manager at the hospital documented that she called the sister facility and was told they had transferred the resident back to the facility after one day. The Case

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

Manager documents speaking with the Administrator at Lamplight, who said the patient has always had walking behaviors but there have been more lately and patient has become non directional. The Administrator said he had reached out to other facilities that had not been able to meet the resident's needs.

During an interview on at 9:30 a.m., the Administrator verified Resident #14 was sent to the hospital after falling outside the facility on , , , and . The Administrator verified that Resident #14 was placed in the locked unit of memory care on , after returning from the hospital. On , the resident in the memory care unit and was hospitalized. The Administrator said Resident #14 has not returned to the facility and remains in a skilled nursing facility.

During an interview on at 1:03 p.m., the ARNP said Resident #14 was , , , due to , , , (altered mental state), caused from , . The ARNP verified Resident #14 should have been assessed as an elopement risk on , when he outside the facility. The ARNP said he felt the reason the resident was not assessed is because there were staffing issues and there was no director of nursing at the time.

2. On at 9:40 a.m., a fence was observed to be in disrepair around the memory care unit. There was a hole observed in the fence large enough for a resident to get through. Several of the memory care residents were observed unsupervised in the area of the damaged fence.

On at 10:30 a.m., 3 residents were observed going out of the rear door of the memory care unit unsupervised. The residents were ambulating near the area of the damaged fence. The staff remained inside of the memory care unit.

During an interview on at 3:45 p.m., the Administrator verified the fence had been damaged since , of 2017. The Administrator acknowledged residents in the memory care unit were allowed out of the memory care and near the damaged fence without supervision.
The following day, on at 9:30 a.m., the Administrator said the hole in the fence had been repaired. He said there were still repairs to be completed on the fence.
(photo on file)

3. On at 9:30 a.m., Resident #18 was observed ambulating in the hallway. Resident #18 was observed wearing only socks and no shoes.

On at 9:35 a.m., Resident #20 was observed ambulating with a walker. He was observed to have no shoes and regular white socks on his feet. Several other residents on the memory care unit were

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

observed at this time without shoes and wearing regular socks.

During an interview on at 1:00 p.m., Resident Aide Staff C said several of the memory care residents were not wearing shoes was because one of the residents keeps taking the other residents shoes and putting them in her closet.

During an interview on at 1:23 p.m., the Administrator verified that a memory care resident was taking other residents' shoes. The Administrator verified it was a risk for residents to ambulate in socks without shoes. The Administrator acknowledged that he has had staffing issues. He said staff will come to work but no one wants to do their job.

During an interview on at 2:00 p.m., Resident #18's wife said Resident #18 never has shoes on when she comes to see him. She said she has been complaining for 6 months about her husband not having his shoes on. Resident #18's wife said she was never told why Resident #18 was not wearing shoes.

Class II

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on record review, interview, and observation, the facility failed to provide assistance and supervision in activities of daily living for 3 (Resident #17, #18, and #20) of 4 residents surveyed.

The findings included:

1. On at 9:30 a.m., Resident #18 was observed ambulating in the hall of the memory care unit. The resident's hair was disheveled, greasy, and unwashed. There was a copious amount of dandruff observed on his shoulders and extending down the back of his dark colored sweater. The resident was wearing socks that were not non-skid and no shoes.

During an interview on at 11:30 a.m., Medication Aide Staff A and Resident Aide Staff C said there was a schedule for showering residents. Both staff said the policy of the facility was to fill out a "shower sheet" when the resident was showered and then the shower sheet was to be signed by a supervisor. Staff A said she had showered Resident #18 on . She provided documentation that the resident was showered on . Staff A was unable to provide any further documentation that the resident had been showered over the last three months.

On at 1:00 p.m., one shoe was observed in resident #18's closet. Resident Aide Staff C said the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

resident did not have shoes because one of the female residents had been gathering resident's shoes and putting them in her closet.

Review of the shower schedule of the memory care unit showed Resident #18 was scheduled to be showered on Mondays and Thursdays on the 2 p.m. to 10 p.m. shift.

Review of the Health Assessment (Form 1823) dated , showed Resident #18 needs assistance with bathing, dressing, and .

During an interview on at 2:00 p.m., Resident #18's wife said she visits her husband weekly and over the last few months his appearance has been unkempt. She said he appears as though he has not been bathed and his hair is not washed. She said he suffers from dandruff and she has provided shampoo for staff to use to decrease the dandruff. Resident #18's wife said staff are not using the shampoo. She said staff have lost two pairs of the resident's glasses. She has complained for the last 6 months because the resident never has shoes on. Resident #18's wife said she would prefer her husband was shaved regularly.

2. On at 12:55 p.m., Resident #17 was observed in the memory care hallway being assisted to the . The resident was wearing dark colored sweat pants soaked through in .

Review if the Health Assessment (Form 1823), dated , showed Resident #17 needs assistance with bathing, dressing, and toileting.

During an interview on /18 at 10:44 a.m., the Administrator admitted he could not find any documentation that Resident #17 was receiving showers as scheduled. The Administrator verified that the policy of the facility was for the aides to document showers on a shower sheet.

3. On at 9:35 a.m., Resident #20 was observed in the activity with a walker. He had no shoes on and was wearing socks that were not non-skid. He was unshaven and he had fingernails that were long and jagged.

During an interview on at 12:19 p.m., Resident #20's son said he was the resident's guardian and he felt the resident should be shaved regularly and he should always be wearing shoes. Resident #20's son said he had seen the resident on several occasion wearing clothing that was not his.

There was documentation that Resident #20 received a shower on . There was no further documentation provided that the resident had been showered over the past three months.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

During an interview on at 11:08 a.m., the Wellness Director said 3 months ago she had implemented that either she or the nurse would sign the shower sheets to ensure residents were receiving showers. The Wellness Director verified she had not signed any of the residents shower sheets over the last three months. The Wellness Director said staff do not cut any of resident's fingernails but that staff could file the resident's fingernails.

Class III

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

Based on record review, interview, and observation, the facility failed to ensure 6 (Resident #14, #15, #16, #17, #18, and #20) of 6 residents sampled as at risk for elopement were identified as an elopement risk, had photo identification in their chart, and identification on their person. After an elopment, Resident# 14 was not identified as being from the facility and went to the hospital.

The findings included:

1. During an interview on at 1:53 p.m., the Administrator said Resident #14 was and had a history of from multiple concussions from playing football in college. The Administrator verified Resident #14 was not capable to make his own medical decisions. The Administrator said Resident #14's father, who was his guardian, in of 2017. Starting in of 2017, Resident #14's stepmother had refused to make decisions for him. The Administrator said Resident #14's stepmother had turned off Resident 14's phone at that time because the resident was no longer capable of communicating on the telephone due to a decline in mental capabilities.

Documentation showed starting in of 2018 Resident #14 was declining mentally. Resident #14's monthly weight record showed from to the resident lost 30 pounds.

A Healthcare Provider Communication Form showed on , Resident #14 "is becoming more /busy acting-on the go more. Monday there was feces on his floor, wall, outside back (his) door. He is collecting garbage (empty bottles, cereal boxes, coffee) more than usual and it's all outside his back door. His hygiene is slacking. Only medication is ."

On , the resident was placed on , (a medication used for certain conditions) twice daily.

A Healthcare Provider Communication Form dated reads, "Behaviors have not changed with

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

, , , and ."

A service note dated at 10:00 a.m., showed Resident #14 was walking outside the building and became overheated. At 10:30 a.m., staff documented, "reeducated on not to walk when the temperature outside is so warm and to go on shorter walks."

On at 2:00 p.m., the service note documented the resident in the facility parking lot twice and was sent to the hospital.

A Healthcare Provider Communication Form dated reads, "send to ER for eval for and X 2."

The 1823 dated , showed Resident #14 was diagnosed with , concussions, , and , . The 1823 documents Resident #14 as nonverbal and a risk.

On at 2:00 p.m., a service note documented, "Resident out walking had incident and went to ER with for evaluation".

In a triage note from the hospital dated at 1:54 p.m., the registered nurse (RN) documented, " (patient) to ED via . Bystander called 911 bc (because) , was walking down the road with all over him; , lives at (facility) memory care; per staff patient is allowed to leave the facility but states he usually signs himself out and today he didn't sign out; , was found about 6 blocks away from the facility ... a&o (alert and oriented) to name and DOB (date of birth) only."

Nine days later, on , a triage nurse from the hospital documented, "arrives via after an unwitnessed outside the facility. HX (history) of head injury and is non-verbal. Per , diaphoretic and noted to left shoulder, palms, and knees. . unable to report complaints and does not respond to palpating ."

Six days later, on , a triage nurse from the hospital documented that Resident #14 was transferred to the hospital after he was found in the bushes. The nurse documented the resident was not able to communicate verbally and he had at various stages of healing throughout his body.
Documentation from the hospital showd the resident was discharged from the hospital to another assisted living facility on .

During an interview on at 1:23 p.m., the Administrator said Resident #14 was found in hurricane

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

debris on , several blocks away from the facility. The Administrator said the resident was sent to a sister facility after being discharged from the hospital because there was no space in the memory care unit at the facility.

On at 9:54 a.m., the triage nurse documented, "Per , , has hx of , , . has hx of . . lives at (sister facility) a nursing facility where he escaped. was spotted by a bystander that saw him on his head. is nonverbal, responds to voice."
On at 12:38 p.m., the Case Manager at the hospital documented that she called the sister facility and was told they had transferred the resident back to the facility after one day. The Case Manager documented speaking with the Administrator at facility, who said the patient has always had walking behaviors but there have been more lately and patient has become non-directional. The Administrator said he had reached out to other facilities that had not been able to meet the resident's needs.

During an interview on at 9:30 a.m., the Administrator verified Resident #14 was sent to the hospital after falling outside the facility on , , , and . The Administrator verified Resident #14 was placed in the locked unit of memory care on , after returning from the hospital. The Administrator said the facility uses whatever is documented on the most recent Health Assessment (Form 1823) to identify at risk residents for elopement. He said there is a new assessment tool, that will be implemented within a few days, that will include questions regarding history of elopement. The Administrator verified Resident #14 was not assessed as an elopement risk by the facility until he was placed in the memory care unit on . The Administrator said the resident was allowed to leave the facility on his own until that time. The Administrator said any person in the locked memory care unit would be considered an elopement risk. He said he was currently updating all the photos of the residents in the memory care unit. The Administrator said he had identification bracelets that he had ordered to be placed on residents at risk for elopement. The identification bracelets were currently on his desk.

2. During an interview on at 2:00 p.m., Medication Aide Staff B said she felt Resident #15 would be at risk for eloping from the facility. She said the resident had not been the same mentally since she had and hit her head about a week ago. Staff B said Medication Aide Staff D had reported to her that Resident #15 was walking out the door saying she was going to see a person and had to be brought back into the facility.

During an interview on at 3:45 p.m., the Administrator said he had not been made aware Resident #15 had been attempting to leave the facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

Resident #15 does not reside in the memory care unit. Review of Resident #15's Form 1823 dated did not show an assessment as to the resident's risk for elopement. The Form 1823 showed Resident #15 has , is , forgetful, and unable to use a call light to call for assistance.

During an observations on at 4:00 p.m., Resident #15 did not have a photo in her record and no identification on either of her wrists.

During an interview on at 12:31 p.m., Medication Aide Staff D said she has stoped several residents from attempting to leave the facility. Staff D said this morning Resident #16 was stopped from attempting to leave the facility. Staff D said Resident #16 has tried on more than one occasion to go out and get into cars in the parking lot.

During a review of Resident #16's 1823 dated , it showed the resident is not at risk for elopement. The residents behavioral status is documented as "intermittent ."

During an interview on at 1:00 p.m., the Administrator said he had not been made aware of the resident's attempts to leave the building and get into cars in the parking lot. The Administrator verified, if the resident was having these actions, he was at risk for elopement.

3. On at 9:35 a.m. Resident #17 was observed on the memory care unit. No identification was observed on the resident.

Review of Resident #17's record showed no photo identification. The Form 1823 dated showed Resident #17 was at risk for elopement.

4. On at 9:30 a.m., Resident #18 was observed ambulating in the hall of the memory care unit. The resident walked up to an open door as a staff member was leaving the facility. The staff member shut the door to prevent the resident from leaving the memory care unit. No identification was on the resident.

During a review of Resident #18's Form 1823 dated showed Resident #18 has a history of . The form documents Resident #18 is not a risk for elopement. No photo was observed in Resident 18's medical record.

5. On at 9:35 a.m., Resident #20 was observed on the memory care unit. The resident was not observed with any identification on his person.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

Review of the chart of the resident showed no photo available for the resident.

During a review of Resident #20's 1823 dated , it showed Resident #20 has a history of and is alert an oriented times two. The resident is not assessed on the Form 1823 as being an elopement risk.

During an interview on at 12:21 p.m., Resident #20's son said the resident was admitted to the facility because he was attempting to elope from the previous facility. Resident #20's son verified he had been admitted to the facility in 2015.

Class II

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

Based on record review and interview, the facility failed to immediately document medications given for 9 (Resident #1, #2, #3, #5, #6, #7, #9, #21, and #29) of 29 residents sampled.

The findings included:

During an interview on at 2:45 p.m., Resident #13 reported he does not get his medications on time, sometime the medications can be an hour or two late. He said this past week he got his medications an hour late on the evening shift. He said because he has mild , he sometimes swears at the Med Tech who is late giving medications and she will reply to him that he will get his medication when he calms down.

During a record review on at 2:00 p.m., 1 of 2 medication books for residents revealed blank squares on the Medication Observation Record (MOR) sheets where Medication Aides should have charted their initials as medications were given to residents.
In interview at this time, both Medication Aide Staff I and Medication Aide Staff J said they forgot to chart the medications.

During a review of the MORs and the following was found for each resident:

Resident #13 did not have charting by Medication Aide for (medication) on at 4:00 p.m. The health care provider order was for ( ) 1 tab twice daily.

Resident #7 had blank charting by Medication Aide on for 6:00 a.m., (medication). The health care provider order was for ( ) 1 tab every morning.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**
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)

-Acet (pain medication) not charted by Medication Aide on at 6:00 a.m. The health care provider order was for one tab by mouth three times daily. Scheduled by pharmacy to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m., daily.

Resident #1 had blank charting by Medication Aides on , and at 8:00 a.m. for , . The health care provider order was for one tablet by mouth once daily.

Resident #2 had blank charting by Medication Aides on at 8:00 a.m., 12:00 p.m., and 4:00 p.m., and at 8:00 a.m. for , . The health care provider order was for , 3 times daily. There was blank charting Medication Aide on at 8:00 a.m., for , . The health care provider order for medication was for (,) twice daily. There were circled initials meaning medication not given by Medication Aides on dates through and no reason documented by Medication Aides why medication was not given. MOR had blank charting at 8:00 a.m. on and through .

Resident #21 had a health care provider order for , (, medication) 1 tablet every morning upon arising. There was blank charting by Medication Aide on at 6:00 a.m.
The health care provider order was for (for ,) 1 tablet twice daily. There was blank charting for 8:00 a.m. on through .
The health care provider order for (an medication) 1 tab every day. There was blank charting by Medication Aide on at 6:00 a.m.

Resident #9 had a health care provider order for medication , for , (, medication) 1 tablet once daily. There was blank charting by Medication Aide on at 6:00 a.m..

Resident #5 had a health care provider order for , for , (, medication) 1 tablet every morning. There was blank charting by Medication Aide on at 6:00 a.m..

Resident #6 had a health care provider order for , (an inhaler) inhale 2 puffs by mouth twice daily. There was blank charting by Medication Aides on through for 8:00 a.m..

Resident #29 had a health care provider order for , (, medication) 1 tab three times daily with food. There was blank charting by Medication Aide on at 6:00 a.m.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**01/05/2018**
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)

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

The findings included:

1. On at 9:40 a.m., a fence was observed in disrepair around the memory care unit. There was a hole observed in the fence large enough for a resident to get through. Other areas of the fence were leaning over and propped up by pieces of wood on both sides of the fence. Several of the memory care residents were unsupervised in the area of the damaged fence.

On at 10:30 a.m., 3 residents were observed going out the rear door of the memory care unit unsupervised. The residents were ambulating near the area of the damaged fence. The staff remained inside of the memory care unit.

During an interview on at 1:16 p.m., the Administrator verified the fence had been damaged since the hurricane in , 2017. The Administrator said the fence was scheduled to be fixed on , but was unable to show a contract with the fencing company to verify this. The Administrator said when it first happened, the staff was texting him hourly, with checks on head counts, but that had slipped through the cracks lately. The Administrator said hourly head counts should have been put on paper but he couldn't tell us where the documentation would be. The Administrator admitted residents in the memory care unit were allowed out of the memory care, in the fenced area without supervision.

2. During an interview on at 1:16 p.m., the Administrator admitted the hurricane of , 2017 affected the heating and cooling system in the building. He explained the facility has 4 units and the air conditioning (AC) company said it would be better to replace the unit as a whole. The Administrator said they have replaced 2 compressors at this time. The Administrator said portable AC units are throughout the facility. The Administrator said he has received 2 quotes since the first of , but the facility is in the process of sale. The Real Estate Investment Trust (REIT) is working with the old owners to figure what is covered by them and what is covered by the new owners. The Administrator said there was nothing in as to when the repairs will occur. The Administrator said the last 4-5 on each wing are still affected by the lack of heating and cooling systems. He said some have portable AC and he asked staff to keep doors open to those so the cool and/or heat will migrate into the from the areas where the system does work. The Administrator said he also asked staff to appropriately dress the residents according to the weather.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

Florida Building Code regarding temperatures in an assisted living facility (ALF) states: When outside temperatures are 65° Fahrenheit (F) or below, an indoor temperature of at least 72°F shall be maintained in all areas used by residents during hours when residents are normally awake. During night hours when residents are asleep, an indoor temperature of at least 68°F shall be maintained.

On at 10:23 a.m., Resident #23 and Resident #24 were observed in the hallway outside of the dining . Both residents were seated in chairs wrapped in blankets. When asked if they were , Resident #23 said "Oh its terrible, its freezing." Resident #24 said "I was until I got this blanket."

On beginning at 10:26 a.m., a random temperature check was conducted throughout the building with the Maintenance Director using the facilities thermometer. The following temperatures were recorded:
Memory Care hallway was 68 degrees F.
Memory Care was 60 degrees F. Resident #28, who resides in this , was observed to be wearing long pants, a hoodie with the hood pulled up on his head and baseball cap on top of that, pacing, wringing his hands together. When asked if he was , he said, "Yes its ."
Memory Care was 62 degrees F.
Memory Care activity 70 degrees F.
was 70 degrees F. Resident #25, who resides in this , was observed to be wearing a jacket and said to the Maintenance Director at 10:45 a.m., "I'd like it warmer in here."
was 73 degree F. At 10:50 a.m., Resident #12, who resides in this , was observed to be wearing a jacket and said "the sun is coming through my window now and helps, but it gets enough I keep my jacket on all the time. To be quite honest, something should be done about it. It's been 3 months and it's ridiculous. About a month ago, my son talked to the Administrator and wanted to get me a portable heater. The Administrator said no, we are waiting on a part, it will be fixed shortly - now it's a month later, it's still not fixed. It's ridiculous paying the kind of money I do here and no heat and no air."
was 68 degrees F. At 10:50 a.m., Resident #26, who resides in this , said "It's in here, I just had to put on an extra sweater."
was 70 degrees F. At 10:55 a.m., Resident #27, who resides in this her husband, said "It's , that's why I have my jacket on". Residents #27's husband was observed to be lying in bed with the covers on.
was 72 degrees F.
was 70 degrees F.

During an interview on at 10:26 a.m., the Maintenance Director said the heat was completely on in building and the areas are because residents open the doors to the outside. During the random

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMPLIGHT INN	**1896 PARK MEADOW DRIVE FORT MYERS, FL 33907**

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

temperature check throughout the building, no resident were observed to have the door to the outside open. The outdoor temperature in Fort Myers at 11:30 a.m. was 50 degrees.

During an interview on at 2:40 p.m., Medication Aide Staff H said the building has been cool since the weather came. Staff H said residents are being dressed with extra clothing and there are extra blankets available. Staff H said when the weather is hot outside, it's hot in the building and residents do complain when it's hot. Staff H said they give them water and bring the fan over towards them. Staff H said they had been working for the facility a little less than a year and felt the temperature problems had been going on that long.

3. The following observations were also made during the course of the survey on and :
The Memory Care dining , table was scuffed, the walls had scratches and were missing paint, and the door was scuffed and had dirt built up.
There was a soiled diaper on lawn outside memory care fence.
The Memory Care fence Emergency Exit with a punch code not working and padlocked shut.
The Memory Care patio had rubbish strewn about; McDonalds bags, soiled chair padding, and downed palm trees.
The outdoor entry to Memory Care dining was dirty.
The Memory Care hallway and dining frames were gouged and walls were missing paint throughout.
The Memory Care # had floor tiles that were missing and peeling.
The Memory Care # had no toilet paper holder.
The Memory Care # had the towel holder missing.
The Memory Care # had missing floor tile, the corner of the wall was marred with plastic piece that was falling off.
The Memory Care # had broken blinds.
had floor tile that was peeling at entry door.
had stained caulking around toilet and holes in the floor tile.
had cracked and stained flooring.
had a hole in wall behind bed, a hole in floor tile, and there was soiled garbage left on floor.
had staining on the floor.
's was missing a large piece of wood.
The hallway outside had a large plaster patch and the carpeting had water stain There was a large pile of debris outside of building near .
The door at the entry to the kitchen had tape holding together the bottom and was dirty, along with the floor with built up dirt.
had a recliner with soiled choux, and fluid (?) on floor in front of recliner.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	01/05/2018
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)

had cracked floor tile.
had no toilet paper holder.
had multiple holes in tile floor.
had peeling on the , and the frame was heavily marred.
had a loud , the closet door was broken, there was peeling on the , and the frame was heavily marred.
had floor tile with holes and discolored.
had holes in the floor tile and caulk was peeling around toilet.
had cracked caulk around toilet, the door to outside did not have the proper seal (able to see outside) and the back of entry door was dirty.

On at 1:13 p.m., the Administrator admitted he was aware of the problems with the floors. The Administrator said he had been dealing with that but only getting small amounts of money at a time for repairs. The Administrator said he was told he could do two floors a month, but then something seems to come up and it gets delayed. He admitted, "I don't have control of the purse strings."

On at 4:15 p.m., the Administrator confirmed he was aware of the issues with the maintenance of the building, debris around the building, the heating/cooling system, and the fence. The Administrator said the Maintenance Director had put some temporary boards over the holes in the memory care fence that day, so residents will not be injured or be able to get through the fence. The Administrator said his hands are tied as far as getting money released for repairs and he said he has told the owners he needs people out here to fix these issues. The Administrator said he feels hopeful that the new company taking over will be more proactive with this.

Class II

photos on file