STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	**05/31/2018**

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
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0000 - Initial Comments

An unannounced relicensure and limited nursing service (LNS) monitor survey was conducted through at Lamplight Inn, an assisted living facility (license # 5096) in Fort Myers, Florida.

The following is description of the deficiencies related to this survey.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure a resident had a new completed health assessment within a 3 year time frame for 1 (Resident #49) of 3 resident records reviewed.

The findings included:

Record review of Resident #49's chart revealed the last resident health assessment was dated . The resident's record did not have a complete up-to-date health assessment with a current medication list in the last 3 years.

On at 2:30 p.m., the Wellness Director acknowledged the resident's health assessment was past due and Resident #49 needed to be seen by a doctor or nurse practitioner and the medication list needed to be updated.

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to ensure the admission packet included all required information during the review of 1 of 1 admission packets. Lack of information in the admission packet may lead to expectations of services not available and inadequate knowledge of facility policies and procedures.

The finding included:

During admission packet review the following items were not found:

1. The contract did not contain accommodations, services, related services information, ancillary charges, refund for advance payment, religious affiliation, health assessment requirements,

medication assistance, informed consent, over-the-counter medication practices and Policy and Procedure. (refer to A167)

2. The facility handbook did not contain:
a. Exhibit I was titled Acknowledgment of Resident Rights and Elopement Policy, but Resident Rights were not present in the packet and the Elopement policy lacked information on the identification and assessment of each resident. The policy did not cover behavior which would put the resident at risk for elopement, how often the resident would be re-assessed, the requirement for a picture or personal identification on the resident, and the requirement to verify the identification, was present on the resident daily.
b. Grievance policy and procedure did not include the timeframe or method for the administration to address individual concerns nor did it contain the documentation requirement and process.
c. policy and procedure.
d. Reporting , Neglect and , policy and procedure and procedures to protect the residents when suspected , neglect or , has potentially occurred.
e. Administration and housekeeping schedules.
f. Control, Sanitation and Universal Precautions policy and procedures.
g. Third Party Coordination policy and procedures;
h. Advanced Directives and information and forms.
i. The "Company's Motorized Cart Policy" referred to in the handbook.
j. The "Medication Policy" referred to in the handbook.
k. The "HHA/Private Duty Attendant Policy".

On at 1:30 p.m., the Admission Staff Person verified the admission packet reviewed was complete and included all the required information.

On at 3:30 p.m., the Admission Staff Person again verified the reviewed admission packet was complete and contained all the information given out at the time of admission.

Class III

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

Based on record review and resident and staff interview, the facility failed to establish a grievance procedure for receiving and responding to resident complaints as described by 3 (Residents #12, #13, and #46) of 4 residents interviewed and documented in resident council minutes.

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The findings included:

On at 10:02 a.m., Resident #13 said he has had numerous complaints and concerns that he has brought forth to the Administrator and Wellness Director. Resident #13 said he has only verbally spoken to the management and has not put it in writing. He said the complaints and concerns have not been addressed and no one has come back to him on any of the concerns. Resident #13 said when he brought his concern over a medication tech giving him the wrong pills and not knowing his job, the Wellness Director answered back, "He knows what he is doing." Resident #13 said he goes to resident council, but he does not see resolution to many of the issues that are brought up there.

On at 11:10 a.m., Resident #12 said they have a resident council where they can bring up concerns, but a lot of times things don't change or the management doesn't get back to them on resolution.

On at 11:20 a.m., Resident #46 said she has spoken to the Administrator and Wellness Director about her concerns, about the way the staff speak to her and other residents. It seems nothing changes, or no one gets back to her on the issue.

Review of resident council minutes from , 2018 through 2018 showed multiple concerns residents have about their care, dining and food, and concerns over staff education and attitudes. There was no evidence of follow through on these concerns by management.

On at 10:30 a.m., the Administrator said when residents bring a complaint or concern to him verbally he does not record it as a grievance. He admitted the facility does not keep a grievance log. When asked if he could show evidence he addressed the concerns of residents from conversation or from resident council minutes, he said he could not.

Class III

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

Based on record review, observation and staff interview, the facility failed to ensure medications are provided as documented in the resident's record for 2 (Resident #50 and #52) of 7 residents observed for medication pass. Inaccurate medication management resulted in a Resident #50 to go without pain medication.

The findings included:

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1. Resident #50's Medication Observation Record (MOR) was reviewed on . The MOR showed 0.75 milligram (mg) was ordered (to decrease and reduce pain) to be taken 3 times a day for 1 week, then 2 times a day for 1 week, then 1 times a day for 1 week. The MOR showed the medication was not given multiple days & given wrong on multiple days. Resident #50 was not given the medication correctly since her admission.

Resident #50's MOR showed (to reduce stomach), (to reduce), (for sleep), (to reduce sugars), (to decrease), (a to reduce clots). Each one of these medications were written incorrectly on the medication administration record (MOR). The medications were written double the amount or 1½ times the amount to be taken for the 13 days the resident was in the facility.

Observation during med pass on at 8:35 a.m., found a bottle of (a medication) 5 mg daily. Review of the MOR failed to find ( ) listed as an ordered medication.

On at 8:35 a.m., Medication Technician Staff K acknowledged her error in giving Resident #50 the medication that was not written on the MOR. She also acknowledged that other medications above were not being given according to doctors' orders as written in the admission order.

On at 1:15 p.m., Licensed Practical Nurse (LPN) Staff N acknowledged that the medications written on the MOR were written incorrectly and she had written the above medication in error. She acknowledged that the doctor's orders were for twice a day or once a day and the medications were being given in error for 13 days that the resident was in the facility. She also acknowledged that some of the medications had missing signatures and appeared to not been given.

On at 1:15 p.m., the Wellness Director acknowledged the error Staff K had made in giving Resident #50 a medication that was not ordered and not written on the MOR. She also acknowledged that other medications were incorrectly written on the medication administration record and the resident appeared to been given double the amount or 1½ the amount ordered by the doctor.

On at 10:00 a.m., while speaking with Resident #50 she said that she had pain in her left hip and in her wrist and hands. She said that she had an operation on both of her wrists and she was having a lot of pain in her hands. She reported that her pain level was 6 on a scale of 1-10. She said because of the pain she has a hard time doing simple task such as picking things up, eating, using the reading a book and turning the pages. She was unaware of the medications that the facility

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is giving her.

On at 1:30 p.m., Nurse Practitioner was notified Resident #50 was not being given her medication for the pain & in her hands in the way it was ordered. The Nurse Practitioner acknowledged errors and ordered medication used for and pain to be given 2 times a day and ordered a new medication ( ) for pain.

2. Resident #52's MOR for 2018 was reviewed on . According to the MOR, the resident was to receive 40 milligrams (mg) twice a day for 7 days. There was no documentation the resident received the morning dose of on and . Resident #52 was to receive 500 mg 2 tablets twice a day. There was no documentation the resident received the morning dose of on , , and . The resident was to receive the medication 100 mg at bedtime. There was no documentation the resident received the medication on . The record indicated the resident may not have received multiple doses of several medications.

On at 10:09 a.m., the Wellness Director confirmed the missing documentation of Resident #52's medications.

Class II

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure 3 (Staff J, A, and I) of 6 staff records reviewed had a statement completed by healthcare provider that employee was free of communicable .

The findings included:

Employee personnel record review on revealed that Staff J, A, and I did not have a statement signed by a healthcare provider that they were free of communicable .

On at 10:30 a.m., in an interview the Business Office Manager said if documents were not in the employee file, then it was not available. She explained she just started 2 weeks ago and had not had a chance to review the files and address the missing items.

On at 1:30 p.m., the Wellness Director she said that she was unaware of missing items in the employees' files.

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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 education for 4 (Staff A, I, P, and Wellness Director) of 6 staff records reviewed.

The findings included:

1. Record review revealed Staff A was employed as a medication technician and resident aide on . Staff A's personnel record did not contain documentation of completed in-service training in the following areas: control, incident reporting, emergency procedures and evacuation, resident rights, recognizing and reporting / neglect/ , , resident behavior and needs, assistance with activities of daily living (ADLs), safe food handling, and elopement response.

2. Record review revealed Staff I was employed as a medication technician and resident aide on . Staff I's personnel record did not contain documentation of completed completed in-service training in the following areas: control, incident reporting, emergency procedures and evacuation, resident rights, recognizing and reporting / neglect/ , , resident behavior and needs, assistance with activities of daily living (ADLs), safe food handling, and elopement response.

3. Record review revealed Staff P was employed as a medication technician and resident aide on . Staff P's personnel record did not contain documentation of completed completed in-service training in the following areas: control, incident reporting, emergency procedures and evacuation, resident rights, recognizing and reporting / neglect/ , , resident behavior and needs, assistance with activities of daily living (ADLs), safe food handling, and elopement response.

4. Record review revealed the Wellness Director was employed on . The Wellness Director's personnel record did not contain documentation of completed completed in-service training in the following areas: control, incident reporting, emergency procedures and evacuation, resident rights, recognizing and reporting / neglect/ , , resident behavior and needs, assistance with activities of daily living (ADLs), safe food handling, and elopement response.

Employee record review showed 4 Staff (Staff A, I, P, and Wellness Director) had a checklist in their file of all mandatory education staff should have and in what period from hire. The checklists were not filled in for any education.

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8. On at 10:30 a.m., in an interview the Business Office Manager said if education was not in the employee file, it was not available. She said she just started 2 weeks ago and had not had a chance to get them in order.

9. On at 1:30 p.m., in an interview the Wellness Director said she was unaware of the missing in-service documentation in the employees' files.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and interview, the facility failed to ensure 5 (Staff A, I, P, Wellness Director and Administrator) of 6 staff records reviewed, contained no documentation of / training.

The findings included:

On Staff personnel records were reviewed. Records for Staff A, I, P, Wellness Director, and Administrator did not include / training. These 5 staff had been employed for more than 30 days.

On at 10:30 a.m., in an interview the Business Office Manager said that if education was not in the employee file, it was not available. She said she just started 2 weeks ago and had not had a chance to get them in order.

On at 1:30 p.m., in an interview the Wellness Director said she was unaware of the missing training in the employees' files.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on record review and interview, the facility's Food Service Designee (FSD) had not completed a minimum of 2 hours of continuing education in nutrition and food services related topics annually.

The findings included:

On the FSD's employee record was reviewed. The FSD was hired on but there was no

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evidence of any training or continuing education in food service or nutrition related topics.

On at 10:46 a.m., the Human Resources Designee confirmed she was unable to locate any training for the FSD.

On at 8:40 a.m., the Administrator said the FSD was held responsible for menu review, food preparation and supervising the employees in the dietary department. He confirmed there was no evidence of any continuing education. The Administrator said he thought the FSD had taken a 2-hour class in 2017 on food/sanitation but was unable to locate the documentation

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on record review and interview, the facility failed to ensure 2 (Staff I & P) of 6 staff records reviewed had the initial 4 hours of training, level 1 within 3 months of employment. One (Staff I) did not have the training, level 2 within 9 months of employment.

The findings included:

1. On review of personnel files revealed Staff I was hired on . Staff I's personnel record did not contain the initial 4 hours of training, level 1 within 3 months of employment.

2. Staff I's personnel record did not contain the 4 hours of training, level 2 within 9 months of employment.

3. On review of personnel files revealed Staff P was hired on . Staff P's personnel record did not contain the initial 4 hours of training, level 1 within 3 months of employment.

4. On at 10:30 a.m., in an interview the Business Office Manager said that if education was not in the employee fil,e it was not available. She said that she just started 2 weeks ago and had not had a chance to get them in order.

5. On at 1:30 p.m., while speaking with Wellness Director she said she was unaware of the missing education in the employees' files.

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

Based on record review and interview, the facility failed to ensure 5 (Staff A, I, P, and Wellness Director, and Administrator) of 6 staff records reviewed, had the mandatory 1 hour of training in ( ) within 30 days after employment.

The findings included:

1. On personnel record review revealed Staff A, I, P, Wellness Director, and Administrator had been hired more than 30 days prior to the survey. There was no documentation of completion of training within 30 days of hire. The records showed no documentation of the training at all.

2. On at 10:30 a.m., while interviewing the Business Office Manager, she said if education was not in the employee file it was not available. She stated that she just started 2 weeks ago and had not had a chance to get them in order.

3. On at 1:30 p.m., while speaking with Wellness Director, she said that she was unaware of the missing education in the employees' files.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Base on record review and interview, the facility failed to ensure 5 (Staff A, I, P, Wellness Director, and Administrator) of 6 staff records reviewed had proper documentation and monitoring of training as required.

The findings included:

1. On personnel record review revealed Staff A, I, P, Wellness Director, and Administrator did not have documentation of required in-services specified by regulation (see A081, A082, A086, and A090).

2. On at 10:30 a.m., while interviewing the Business Office Manager, she said that if education was not in the employee file it was not available. She said that she just started 2 weeks ago and had not had a chance to get them in order.

3. On at 1:30 p.m., while speaking with Wellness Director, she said she was unaware of the missing education in the employees' files.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on record review and interview. the facility's Food Service Designee (FSD) had not completed the food and nutrition services module of the core training course before assuming responsibility for the facility's food service.

The findings included:

On at 8:30 a.m., the FSD said he was hired as food service supervisor to oversee the the facility's dietary department on . He assumed the position immediately and did not receive any training. The FSD said he had worked in a kitchen prior to hire but was under the direction of a Certified Dietary Manager.

On at 8:40 a.m., the Administrator said the FSD was responsible for menu review, food preparation and supervising the employees in the dietary department. He confirmed there was no evidence of any training other than safe food handling a 1 hour online course given to all staff on hire.

Class III

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

Based on record review, resident and staff interview, the facility failed to provide residents an accurate accounting of their money being held in trust for 9 (Resident #14, #5, #33, #27, #59, #60, #66 #57, and #31) of 9 residents. Residents have an expectation for the facility to have their money in safekeeping and accounted for.

The findings included:

1. On at 10:20 a.m., Resident #5 said he had been here for several months and has never gotten his money. He said he used to receive a monthly allotment where he lived previously and but has received nothing since he moved here.

2. On at 11:22 a.m., the Business Office Manager (BOM) said the facility holds money in a trust

account for Resident #14, #5, #33, #27, #59, #60, #66, #57, and #31. The BOM said she was new and could not find any accounting for the trust accounts. She was aware Resident #33 had asked for money but had no method to give him any. She was aware Resident #33, #14, #33, #27, and #55 were to receive a stipend of $54.00 a month.

3. On at 12:46 p.m., the Administrator said the residents' stipend is put in the trust account and is only given out if the resident asks for it. He confirmed the facility has not been providing any quarterly statements to residents with an accounting of their trust and just found out they should be doing that. In regard to families who send in money or leave money for their family member, it is just put in an envelope with their name on it. He does not provide any receipt or accounting for the money when disbursed. The Administrator said in regard to Resident #33, he had not asked for his monthly stipend.

On at 1:15 p.m., Resident #33 confirmed he had requested money from the Administrator over a week ago. The Administrator gave him $10 and said he would have a check for him on Monday. Resident #33 said he had not received any check.

On at 1:34 p.m., the Administrator acknowledged Resident #33 had asked him for money and gave him $10 out of petty cash. The Administrator said he needs to notify the corporate financial officer of any request for money and they will send a check. Resident #33's trust was reviewed and indicated the facility was holding $324.00. There was no accounting for any withdrawal of $10.

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and staff interview, the facility failed to have a surety bond to cover twice the value of 5 (#5, #14, #33, #27, and #55) of 5 resident's monthly income when serving as representative payee and funds being held for 4 (#60, #66, #57, and #31) of 4 residents.

The findings included:

On at 11:22 a.m., the Business Office Manager (BOM) said the facility holds money in a trust account for Resident #14, #5, #33, #27, #59, #60, #66 #57, and #31. She said Resident's #33, #14, #33, #27, and #55 had a monthly income.

On the facility's surety bond was reviewed and provided coverage not to exceed $10,000. The total average income being being managed by the facility was 10,549.40. The resident funds deposited

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with the facility totaled $369.00 for a total of $10,918.40 being managed in the resident trust.

On at 2:30 p.m., the Administrator said he was not aware the surety bond needed to be twice the amount of the monthly income for residents and confirmed the surety bond did not cover the current amount being being received from Medicaid. The Administrator said he based the surety bond amount on the personal funds for all residents with money being held by facility. He verified the surety bond would need to be $21,836.80 to cover twice the amount of the average income and resident personal funds.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. These records include an adequate admission and discharge log, all fire safety inspection reports for the last 2 years, an approved emergency management plan, and all completed survey, inspection, and complaint investigation reports by the Agency within the last 5 years.

The findings included:

1. Per 58A-5.024(1) of the Florida Administrative code, the facility must maintain an up-to-date admission and discharge log listing the names of all residents and each resident's date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a pressure , date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged.

The Facilities Resident Move-In/Move-out log includes columns for Name, Admit date, Discharge Date, Reason discharged, discharged to and a space for comments.
, 2018 log showed 4 discharges. No admission dates or where admitted from was recorded for all 4. 1 discharge did not include reason discharged.
, 2018 log showed 1 admission. There was no indication where the resident was admitted from or if the resident had a pressure .
2018 log showed 1 admission. There was no indication where the resident was admitted from or if the resident had a pressure log also recorded 2 discharges. These discharges had no admission dates or where they had been admitted from.
2018 log showed 10 admissions. There was no indication where these residents were admitted

from or if they had a pressure . . . , log also indicated 2 discharges. These discharges indicated no admission date or where they were admitted from.
, 2018 log showed 9 admissions. There was no indication where these residents were admitted from or if they had a pressure . . . , 2018 log also showed 2 discharges. These discharges did not indicate where they had originally been admitted from.

On at 6:45 p.m., the Administrator expressed surprise that the log didn't meet the requirements.

2. On at 3:00 p.m., the Administrator said he did not have the fire safety inspection reports for 2017.

3. On at 12:53 p.m., the Administrator provided an Emergency Management Plan dated and said he had no approved plan beyond this.

4. A review of the survey inspection report kept in the front lobby revealed the last included report to be from of 2016. A review of The Agency's Facility /Provider Locater website (http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx) found the facility has had multiple surveys and complaint investigations beyond this date including surveys on for a complaint, on for a complaint, on for a revisit, complaint, and limited nursing service, on for a revisit, on for complaint survey, on for a revisit and complaint.

On at 6:45 p.m., the Administrator said nothing, but appeared to express surprise when this was pointed out.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and staff interviews, the facility failed to ensure 4 (Staff A, I, P, and the Wellness Director) of 6 employee personnel files were up to date with required documentation.

The findings included:

Review of personnel files for Staff A, I, P, and the Wellness Director revealed that there were no job descriptions given on hire.

On at 10:30 a.m., the Business Office Manager who handles all personnel files, said that the

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files were what they were and if the documentation was not in them, then it was not there.

Class III

0164 - Records - Inspection Availability - 58A-5.024(4) FAC

Based on record review and interview, the facility failed to ensure agency reports pertaining to Agency surveys, inspections or monitoring visits, is available to the residents and the public for 5 years from the date the reports are filed or issued.

The findings included:

A review of the survey inspection report kept in the front lobby revealed the last included report to be from of 2016. A review of The Agency's Facility /Provider Locater website (http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx) found the facility has had multiple surveys and complaint investigations beyond this date including surveys on for a complaint, on for a complaint, on for a revisit, complaint, and limited nursing service, on for a revisit, on for complaint survey, on for a revisit and complaint.

On at 6:45 p.m., the Administrator said nothing, but appeared to express surprise when this was discussed.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview, the facility failed to review its emergency management plan on an annual basis and submit to the local management agency for review and approval.

The findings included:

On at 12:53 p.m., the Administrator provided an Comprehensive Emergency Management Plan (CEMP) dated . Lee County Emergency Management requires an annual CEMP submission.

On at 12:53 p.m., the Administrator stated he searched everywhere and this is the only one he has. The Administrator admitted this is not current per regulation.

Class III

N276 - LNS - Nursing Services - 58A-5.031(1) FAC

Based on record review and interview, the facility failed to provide Limited Nursing Services (LNS) as an all-inclusive service per resident contract for 4 (Residents #8, #62, #63, and #51) of 4 residents receiving routine care. The facility also failed to provide LNS services on a regular basis as per order for 3 (Residents #9, #62, and #65) of 7 residents receiving services in the month of , 2018.

The findings included:

Per Florida Statute 429.255, a facility with a limited nursing services (LNS) license may apply and change routine dressings that do not require packing or irrigation, but are for , and closed surgical wounds.

1. Resident #8 had an order dated for a , performed on left . Refer to home health for care: cleanse site with , apply Xeroform and dressing, change dressing 3 times per week x 2 weeks, diagnosis .

On at 11:00 a.m., Resident #8 said he didn't choose to have home health do his dressing, the facility set it up. Resident #8 said you can't hardly get a -aid here. Resident #8 said he wasn't aware this was a service provided per contract.

2. Resident #63 had an order dated for skin removed at left cheek. Refer to home health for care: cleanse site with , apply Xeroform and dressing, change dressing 3 times per week for 2 weeks, diagnosis .
On at 10:45 a.m., Resident #63 appeared , was not able to say who does her care.

3. Residents #62 had an order dated stating Skilled Nursing to see patient for care for right ankle , diagnosis open to right ankle, pain. Another order dated for Skilled Nursing to see patient for care and to use adaptive non adhering , with medi honey, roll gauze to hold in place.

On at 10:20 a.m., Resident #62 said she didn't choose to have home health do her , the facility just set it up that way. Resident #62 said she did not know the facility nurses could do that as part of her contract.

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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 10:09 a.m., Licensed Practical Nurse (LPN) Staff N said she did not know why the facility did not provide care to the LNS residents.

On at 9:22 a.m., the administrator said the facility contract is all-inclusive. The administrator said the facility provided Limited Nursing Services (LNS) and there is no added charge for LNS services. The administrator said he could not explain why routine dressings are not being provided by the LNS and asked if that is covered under LNS services. The administrator said he would assume the Home Health agency is billing for the care.

4. Resident #9 has an order dated for geri sleeves for skin protection to arms. On at 11:16 a.m., Resident #9 was observed with no geri sleeve on. A review of documentation did not document any reason why. At 11:48 a.m., Resident #9 was seated at at table in the activity . The Administrator observed Resident #9 with the surveyor regarding a different issue. During this time, licensed practical nurse applied geri sleeves to Resident #9's arms. The Administrator agreed Resident #9 did not have geri sleeves on until this time.

5. Resident #62 has an order dated for LNS, wraps to legs daily at 7 a.m., remove at night. On at 1:18 p.m., Resident #62 was observed with both legs not wrapped. Resident #62 said she has an in her right ankle being treated by home health so the facility stopped wrapping her legs. Review of Resident #62's chart, does not show doctor was contacted regarding wraps, does not reveal an order to strop wrapping legs - or verification with MD was notified the wraps weren't being done.

On at 8:50 a.m., Resident #62 was observed on patio with no leg wraps on, only bandage to right ankle. Resident #62 said staff said they would put them on later. Resident #62 said she was left with the wraps on both legs all night. She did not know why the nurse did not take them off and said eventually her removed one of them for her because it was uncomfortable. At 9:22 a.m., the administrator entered the observed Resident #62 did not have wraps on her legs.

On at 9:40 a.m., Resident #64 who is Resident #62's verified she took her 's wrap off Residents #62's leg last night about 1 or 2 in the morning.

On at 9:45 a.m., LPN Staff N said she did not put Resident #62's wraps on this morning. Staff N said she was aware they were not taken off last night and that Resident #62's took one off in the middle of the night and she (Staff N) took the other one off this morning.

A review of the documentation for Resident #62's wraps revealed it was signed that the wraps had been

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taken off the previous evening at 6:00 p.m., and it was signed that wraps had been put on at 8:00 a.m. This was shown to the administrator at 9:50 a.m., and he was unable to explain why it was documented this way.

6. Resident #65 had an order dated stating: LNS apply left lower leg brace in AM, remove in PM. On at 1:46 p.m., Resident #65 said about once a week they don't put it on, they are rushed for time. Sometimes the administrator will notice it and put it on me at the dining . On at 2:29 p.m., this was discussed with the Administrator and he did not deny that he had placed Resident #65's braces on at times. The Administrator said he would look into the LNS services.
7. On at 4:12 p.m., Resident #51 was observed coming up the hallway in his power chair with his shirt off. A reddened area was noted on his stomach area just below his cage. The area of redness was approximately 3 inches wide by 4 inches long. The area had a hole in the center where the resident had a feeding tube prior. The area was red & . Secretions were coming out of the hole when resident talked and moved his stomach muscles. Resident indicated through gestures, writing and attempting to talk that the area was and he needed to have someone look at it. The medication technician said he would get the nurse.

On at 4:30 p.m., in an interview with Resident #51, he stated through gestures, writing and attempting to talk that he had his feeding tube removed about 4 weeks ago and it was not healing. He said that he was admitted to the facility on and he was caring for the site on his own since then. He said that he does not have the supplies such as dressing to care for it but uses paper towels to cover it and put paper tape around it that was given to him by the nurse. He said that the area was very and he has told many staff members about it.

On at 11:59 a.m., Resident #51 said that he was going to the doctor to have his feeding tube site looked at.

On at 12:15 p.m., while speaking with the Wellness Director about Resident #51's area on his stomach, she said that she did know about it and it had concerned her since his admission. She thought that it was something that the nurses should be monitoring, but when she brought it to the Administrator's attention, he reported to her that the nursing home that the resident was admitted from said that the resident could care for the site on his own. She was aware that the resident did not want added cost and said he would care for it on his own due to that point.

On at 12:20 p.m., while speaking to LPN Staff N, she stated that she was aware of Resident #51's feeding tube site, as he had come to her early last week. Staff N said that Resident #51 had asked her for dressing supplies so he could take care of his feeding tube site. She said at that time she

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had noted it to be red and and had asked the nurse practitioner to see the resident. Review of nurses notes on had no mention of feeding tube site or that the nurse practitioner had been notified.

Record review of admitting orders (1823) on , had no orders for dressing changes to feeding tube site but does record ointment to mid abdomen daily and at bedtime. The area for nursing/treatment/ service requirements: states "as needed." Nurses notes only record tube feeding site covered with no assessment of skin condition or if there is any sign of . No other facility progress notes on feeding tube site condition for 18 days, until .

Record review showed doctor saw Resident #51 on . Chief problem was recorded, as "[feeding] tube site won't heal." Order received for to be taken 3 times a day for for 7 days. Resident #51 then returned to doctor on after Resident #51 voiced concern on about his feeding tube site still being red and . The doctor now ordered again an to be taken twice a day times 10 days and the site to be cleaned twice a day with dressing change. The doctor also requested the nurse call with update on Resident #51's condition on Thursday and Friday and Monday of next week.

On at 4:00 p.m., while speaking to Resident #51 after the doctors appointment he said that he was worried about having to pay more money to have his feeding tube site on his stomach taken care of by the facility staff. He said that this is the reason he has been taking care of it on his own. He said that he does not have the supplies to take care of it and the facility is unable to provide him with them, so he uses paper towels and tape gotten from the nurse. He said that he changes the paper towel several times a day when it gets wet for the drainage coming out of the hole in his stomach. Resident #51 said again that he told the wellness director about his site several weeks ago as well as LPN Staff N and LPN Staff M. When Resident #51 was asked if he was aware that the facility had limited nursing services to take care of his with no extra charge to him, he stated that he was never told that. He agreed to let facility nurses take care of his if there was no additional charge to him.

Class II

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record review and interview, the facility failed to employ or contract with a nurse who must be available to provide Limited Nursing Services (LNS) and maintain documentation of the qualification of nurses providing LNS services in the facility's personnel file.

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The findings included:

Per Florida Statute 464, registered nurses (RN) conduct assessments. Licensed practical nurses (LPN) perform select acts under the direction of a registered nurse.

A review of the LNS monthly assessments for , 2018, 2018, 2018, and , 2018 showed these had been completed by LPN Staff N. There was no RN overseeing these or signing off on them as accurate.

On at 9:30 a.m., LPN Staff N said she works with the LNS residents. Staff N agreed that no one has been following along behind her monthly assessments as RN oversight, and said she just places them in the LNS folder. LPN Staff N said there was a RN who was supposed to come in and monitor the LNS, but she doesn't know if/when she does.

On at 1:01 p.m., the Wellness Director said she thought the last time the LNS RN was in the facility was 2018.

On at 3:11 p.m., the Administrator and Business Office Manager admitted the facility had no personnel file for the LNS supervisor, no contract with the LNS supervisor and no background screening for the LNS supervisor.

On 9:22 a.m., the Administrator said he thought the last time the LNS RN was in the facility was 2018. The Administrator said that the the LNS RN was owed about $2,000 and she said wanted to come in, but she also wanted to get paid for it.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on record review and interview, the facility failed to have monthly nursing assessments and nursing progress notes maintained for 9 (Residents #2, #9, #15, #62, #63, #64, #65, #66, and #72) of 9 residents receiving Limited Nursing Services (LNS).

The findings included:

A review of the LNS assessments for , 2018 showed the monthly nursing assessments for Residents #2, #9, #15, #62, #63, #64, #65, #66, and #72 were not signed by a Registered Nurse (RN).

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No progress notes were maintained for any of these residents regarding the LNS services they were receiving.

A review of the LNS assessments for 2018 showed the monthly nursing assessments for Residents #2, #9, #15, #62, #65, #66, and #72 were not signed by an RN. No progress notes were maintained for any of these residents regarding the LNS services they were receiving.

A review of the LNS assessments for , 2018 showed the monthly nursing assessments for Residents #2, #9, #15, #62, #65, #66, and #72 were not signed by an RN. No progress notes were maintained for any of these residents regarding the LNS services they were receiving.

A review of the LNS assessments for , 2018 showed the monthly nursing assessments for Residents #2, #9, #15, #62, #65, #66, and #72 were not signed by an RN. No progress notes were maintained for any of these residents regarding the LNS services they were receiving.

On at 9:30 a.m., Licensed Practical Nurse (LPN) Staff N said she works with the LNS residents. Staff N said they do not maintain progress notes regarding the LNS services. Staff N said she used to do that at her previous job, but they don't do that at this facility. LPN Staff N agreed that no one has been following along behind her monthly assessments for RN oversight; Staff N said she just places the assessments in the LNS folder. Staff N said there is a RN that is supposed to come in and monitor the LNS, but she didn't know if or when she does.

On at 3:11 p.m., the Administrator and Business Office Manager admitted the facility had no personnel file for the LNS supervisor RN and no formal contract with the LNS supervisor RN.

On 9:22 a.m., the Administrator said he thinks the last time the LNS RN was in the facility was 2018. The administrator said that the the LNS RN is owed about $2000 and said she wanted to come in but also wanted to get paid.

Class III