STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911219	**05/07/2018**
NAME OF PROVIDER OR SUPPLIER **KING'S CROWN-SHELL POINT VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3699 KINGS CROWN COURT** **FORT MYERS, FL 33908**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2018002297 was conducted on at King's Crown Shell Point Village, an assisted living facility (license #6012) in Fort Myers, Florida.

The following is description of the deficiency.

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

Based on observation, record review, and staff interview the facility failed to ensure accuracy of the medication administration record (MAR) for 3 (Resident #9, #10 and #11) of 3 residents observed for accuracy of records.

The findings included:

On at 12:15 p.m., observations and reviewed 3 residents' records with as needed pain medication revealed that are supposed to be signed out by the nurse with date and time that it was administered to the resident. In the three residents' records reviewed for medication administration record, the medication administration record (MAR) did not match the sign out sheet. This causes a danger to the resident of being given too much medication because the nurse giving the next dose does not know the proper time frame.

Resident #9 had 8 doses of that were administered in the month of , that were not properly documented in the MAR. Staff B, Licensed Practial Nurse (LPN), acknowledged that the doses were not recorded in the resident's medication record.

Resident #10 had 3 doses of that were administered in the month of , that were not properly documented in the MAR. Staff B, LPN, acknowledged that the doses were not recorded in the resident's medication record.

Resident #11 had 1 dose of pain medication that was administered in the month of , that was not properly documented in the MAR. Staff B, LPN, acknowledged that the dose was not recorded in the resident's medication record

On at 12:35 p.m., in an interview with Registered Nurse (RN) manager, she said that the nurse should be recording in the medication administration record any as needed medication given to the

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resident and signed out in the . . . book. She acknowledged that if a nurse did not document the medication given it could result in another nurse giving the medication too soon.

Review of facility's Policy and Procedure on administration of medication record revealed that an accurate up-to-date medication record shall be maintained.

Class III