STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911219	**11/14/2018**
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 biennial and extended congregate care survey was conducted through at King's Crown - Shell Point Village, an assisted living facility (license #6012) in Fort Myers, Florida.

The following is description of deficiences.

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

Based on record review and staff interview, the facility failed to obtain a complete Health Assessment for 1 (Resident #12) out of 2 residents reviewed.

The findings included:

Record review for Resident #12 found she was admitted to the facility on and her 1823 Health Assessment form was completed on .

The 1823 Health Assessment was incomplete since it did not include a medication list with dosage, direction for use and route. Furthermore, under medication section the question: "Does the individual need help with taking his or her medications" was left blank.

On at 3:00 p.m., the Administrator acknowledged the form was incomplete.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and staff interview, the facility failed to obtain a to medical examination by a health care provider at least every 3 years after the initial assessment for 1 (Resident #12) out of 2 residents reviewed. The results of the examination must be recorded on AHCA Form 1823 as is required. Failure to properly re-assess a resident has the potential of a resident that no longer meets admission criteria still be in the facility.

The findings included:

Record review for Resident #12 found she was admitted to the facility on and her 1823 Health

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Assessment form was completed on .

No other 1823 Health Assessment was found on record.

On at 3:00 p.m., the Administrator acknowledged the lack of re-assessment. Said she notified the Resident's physician and they will complete the form immediately.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and staff interview, the facility failed to provide care and services based on resident needs for 1 (Resident #12) out of 2 residents reviewed.

The findings included:

1. Record review for Resident #12 found she was admitted to the facility on and her 1823 Health Assessment form was completed on . Under nursing/treatment/ service requirements it said: medication administration. Under medication section it said: needs administration of medication. Under diagnosis section the resident had a diagnosis of .

Record review for Resident #12 found an order dated for 0.5 milligram (mg), take 2 tablets daily at bed time (P.O. QHS) for /sleep. Nurse to leave at bedside.

Interview with the Director of Pharmacy on at 3:00 p.m., confirmed they were not aware of the time the resident was taking the medication since they did not administer the medication to her.

A self-administration assessment for the Resident #12 was requested. On at 10:30 a.m., the Registered Nurse Manager (RNM) said they did not have a self administration assessment for Resident #12. She said they thought they conducted an assessment every six months, but she was unable to provide one. The RNM confirmed that the medication was left at bedside even though there was no self-administration assessment for Resident #12.

Class III

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

Based on record review and staff interview, the facility failed to ensure 1 (Staff D) out of 5 staff records

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reviewed included a pre-service orientation of at least 2 hours as required.

The findings included:

Record review for Staff D found she was hired on . Further review found that Staff D had a two hour pre-service orientation on record dated . The in-service orientation belonged to another assisted living facility where Staff D worked before she was transferred to the current facility. The certificate was signed by the employee and corresponding administrator; not the current facility's administrator.

On at 3:00 p.m., the Administrator confirmed the lack of pre-service orientation.

Class

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

Based on observation and staff interview, the food service designee failed to perform duties in a safe and sanitary manner. That puts at risk all residents that receive oral diet in the facility.

The findings included:

Observation during the initial kitchen tour with the dietary manager on at 8:00 a.m., found the following:

1. Black residue of unknown origin in the ice machine's interior. At time of observation the dietary manager placed gloves on his and proceed to wipe with his index part of the stain and looked at the black residue. He did not ask staff to remove ice and clean the ice machine. He continued touring the kitchen.
2. Accumulated dirt was found on the floor next to the ice machine and underneath the cooler next to the ice machine.
3. Food particles at all three stand up coolers.
4. Food particles at the standing freezer.

On at 8:14 a.m. the dietary manager brought a picture and said, "I took care of the issue with the ice machine. I wiped out." The ice was observed to be still in the ice machine. After observing the ice in the picture it was explained to the manager the ice cannot be utilized since it was already contaminated and presented an control issue. He said, "ok. I didn't know. I will take it out then."

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The Administrator acknowledged the findings on 11/14/18 at 3:00 p.m.

Class III