STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967239	11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHANNA'S ASSISTED LIVING INC	**1958 DORADO LN PORT SAINT LUCIE, FL 34953**

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

0000 Initial Comments

A Limited Nursing Services survey was conducted at Johanna's Assisted Living Inc., on 11/17/2015. The facility had a deficiency found at the time of the visit.

0152 Phvsical Plant - Safe Living Environ/Other

Based on observation and interviews, the facility failed to maintain a clean and functional environment in 3 out of 3 (# 1, # 2 and #3).

The findings include:

An observation tour of the facility was conducted upon entrance with Staff A on / / at 11:24 AM. The following was observed:

1) In # 1 the toilet riser had rust like substance on both legs extending from the floor to the top of the front legs and on the back legs as well as the supporting rame. The wall behind the toilet had a large area of bubbling paint that was wet to the touch and missing drywall,. A 5 x 2 inch area next to the closet was missing drywall and had visible gray metal.
2) The used by Resident # 2 had missing grout at the base of the wall to the floor approximately 6 inches .
3) The wall behind the toilet in Resident # 1's private a large area of bubbling paint, which was peeling and damp to the touch .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Johanna's Assisted Living Inc
1958 Dorado Lane
Port Saint Lucie, FL 34953

RE: Limited Nursing Services Monitoring Survey

Dear Administrator:

This letter reports the findings of Monitoring survey that was conducted on , 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com