RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Visionary Living, Inc
923 North 77th Avenue
Pensacola, FL 32506

Dear Administrator:

This letter reports the findings of a state licensure revisit survey that was conducted on 30, 2016 by representative(s) of this office. Attached is the revisit report, indicting which deficiencies were noted as corrected. Also attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified as uncorrected 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 the uncorrected deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than , 2016.**

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 surveyor(s). Should you have any questions please call me at 850-412-4540.

Sincerely,

Deriah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911156	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONARY LIVING, INC	923 NORTH 77TH AVENUE PENSACOLA, FL 32506

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

0000 Initial Comments

An unannounced follow-up to biennial survey was conducted at Visionary Living assisted living facility on / . Deficient practice was found at the time of the survey.

0054 Medication - Records

Based on staff interview and clinical record review the facility failed to maintain an up to date daily medication observation record (MOR) for 1 of 3 residents (#3).

The findings are:
A review of resident #3's file revealed an order for medication 10 gram/15 milligrams (mg) give 15 milliliters (ml) ammonia level control dated fro / written as a verbal order by the administrator who is also a registered nurse (RN). A review of resident #3 MOR (medication observation record) indicated that the medication 10 gram/15 ml take 15 ml by mouth if no bowel movement for 3 days.
On at 9:17 am an interview was conducted with the administrator/RN. She was asked to explain the discrepancy. She stated it was an as needed order because the doctor has not signed off on the order she wrote in . She said the doctor never got back with me. She then stated, "I give that to her every day . The resident will ask for it if you do not give it to her. " She was asked about the MOR which does not indicate it has been given for the month of . She confirmed the MOR does not indicate the had been given and stated, "I have no excuse".
Employee A came into the also said that he gives the to the resident every day. He says he gave it this am and used up the bottle. He then said he forgot to sign he had given it.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11911156 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONARY LIVING, INC	923 NORTH 77TH AVENUE PENSACOLA, FL 32506

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0078	Correction	ID Prefix A0084	Correction	ID Prefix A0152	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0161	Correction	ID Prefix AL243	Correction	ID Prefix AZ815	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 429.075(1) FS; 58A-5.0191(8) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			[signature]	9/1/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/12/2016	☐ YES ☐ NO

STATE FORM: REVISIT REPORT ( ) EVENT ID: CMG312