STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967239 Y1	A. Building B. Wing Y2	Y3

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

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 A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC	Correction Completed
ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed	ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC	Correction Completed	ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed
ID Prefix A0085 Reg. # 58A-5.0191(6) FAC LSC	Correction Completed	ID Prefix AZ814 Reg. # 435.12(2)(b-d), FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
		7/8/10		7/11/10
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/22/		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967239	R 06/29/2016

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

An unannounced revisit to the licensure survey was conducted on at Johanna's Assisted Living Inc., License #11332. The facility had uncorrected deficiencies at the time of the revisit.

0052 Medication - Assistance with Self-Admin

Based on observation, staff interview and resident record review, facility staff failed to assist residents with self-administered medications in accordance with proper procedures outlined in state-mandated annual 2 hour Assistance with Self-Administered Medication Training for 4 of 4 residents who were observed receiving assistance with self-administered medications (Residents #1 - #4).

The findings include:

On at 5:00 PM, Staff A was observed preparing to assist 4 residents with self-administration of their 5 PM medications.
The following procedure was followed for all 4 residents:
a) Staff A washed her hands using proper handwashing technique before handling each resident's medication package/container;
b) She removed the residents' 5 PM medication(s) from the locked medication cabinet;
c) She checked medication labels with residents' Medication Observation Record (MOR)
d) While standing in the kitchen, at the counter, not observed by residents, Staff A removed the medications from the labeled medication containers and placed pills into small medication cups. She did not approach the resident(s) with the medication container and read the medication label to the alert resident and confirm understanding. Staff A did not open the medication container in front of the resident and place medication into the medication cup.
When removing Resident #1's medication from bubble-packed medication card, the pill flew out of package and landed on the counter. Staff A picked up the pill with her ungloved hand and placed it into the medication cup.
e) Staff A initialed MOR after placing each medication into the med cups, instead of immediately after observing resident take their medication(s);
f) She set each medication cup aside on the counter until all 4 residents' cups had been filled with the 5 PM medications.
g) When all residents had their medications placed in their small medication cups, Staff A took the cups and placed each one on the table in front of the resident.
Staff did not inform the residents of the medication being provided at this time, either.

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h) Staff observed each resident take their medication.

During interview with Staff A and Administrator on at 5:10 PM, they stated they were not aware the proper procedure for assisting with self-administered medications were not being followed. Staff A was asked how she can assure medications do not get mixed up when all medications are prepared at the same time and then passed out to the residents; she responded that she knew the resident's medications. Proper procedure for unlicensed staff providing assistance with oral medications was share with staff and administrator.

Class III

0054 Medication - Records

Based on resident record review and staff interview, staff failed to immediately update each time a resident's medication is offered or administered for 6 of 6 residents.

The findings include:

On at 8:20 AM, Staff A stated that all residents had received their 8:00 AM medications. A review of 2016 Medication Observation Record for each of the 6 residents revealed the following issues:
1) Residents'(#1-#6) 5:00 PM, 8:00 PM and 10:00 PM medication boxes for are not initialed by staff
2) Residents'(#1-#6) 8:00 AM medication boxes for are not initialed by staff.
3) Resident #1 did not have staff initials for 25 mg 5:00 PM dose on and 8:00 AM dose on ;
4) Trutrack Test for sugar monitoring for Resident #1 was not initialed by staff on at 8:00 AM
5) Resident #1's 6 mg is not initialed by staff on at 9:00 PM
6) Resident #3 and #5's once a month dosage is not initialed by staff on
7) Resident #6's 2:00 PM dose of is not initialed by staff on and

On at 8:30 AM, Staff A was asked why the MOR had not been initialed since morning medications had been given, she stated, "I was just getting ready to initial it before you came." This did not explain why there were also missing staff initials on , , and / .

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

SUMMARY STATEMENT OF DEFICIENCIES
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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 29, 2016 by a representative of this office. Attached is the provider's copy of the State Revisit Report Form, which indicates the deficiencies corrected during the visit, and State Form 5000-3547 form, which indicates uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosures: State 5000-3547 and State Revisit Report

YOSF

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