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| STATEMENT OF DEFICIENCIES                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11968799</b>         | (X3) DATE SURVEY COMPLETED<br><br><b>03/01/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOSEFA'S ALF CORP</b>                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3567 BALI DR<br/>SARASOTA, FL 34232</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION) |                                                                                     |                                                     |

**0000 - Initial Comments**

An unannounced relicensure survey was conducted on \_\_\_\_\_ at Josefa Alf Corp, an assisted living facility (license #12682) in Sarasota, Florida.

The following is a description of the deficiencies.

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation and interview facility, Staff B failed to follow appropriate procedures when assisting 2 (Residents #2 and #3) out of 2 residents with their medications.

The findings included:

Observation on \_\_\_\_\_ at 12:00 noon found that Staff B (certified nursing assistant) marked the Medication Observation record prior of assisting Residents # 2 and #3 with their self administration of their medications.

Staff B did not verbally prompt the residents to take medications as prescribed nor observe neither resident taking their medications.

Both residents were sitting in the dining \_\_\_\_\_ lunch. Staff went close to them placed the pills next to them on the table and walked away.

During an interview on \_\_\_\_\_ at 2:00 p.m., the administrator acknowledged that Staff B did not follow appropriate procedure when assisted Residents #2 and # 3 with their medications.

Class III

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

Based on observation and interview facility failed to update the medication observation record (MOR) immediately each time the medication is offered or administered for 2 (Residents #2 and # 3) out of 2 sampled residents .

The findings included:

Observation on \_\_\_\_\_ at 12:00 noon found that Staff B (certified nursing assistant) marked the Medication Observation record prior of assisting Residents # 2 and #3 with their self administration of

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

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FORM APPROVED

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| <p>their medications.</p> <p>During an interview conducted on . . . at 2:00 p.m., the Administrator acknowledged the error. The Administrator said Staff B should had waited and marked the MOR after assisting residents. She stated "this is a mistake, she does not know if the resident refuses medications. She shouldn't have marked the book before."</p> <p>Class III</p> |                                                                                     |                                                     |