

Agency for Health Care Administration

|                                                                       |                                                                                                                                                                                 |                                                                                                         |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968413</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/01/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ROSE GARDEN OF ORLANDO</b> |                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9309 S ORANGE BLOSSOM TRAIL</b><br><b>ORLANDO, FL 32837</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                    | ID<br>PREFIX<br>TAG                                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                               | Initial Comments<br><br>A desk review to Complaint Investigation<br>#2020007023 was conducted. The Rose Garden<br>Assisted Living Facility is in compliance as of<br>9/23/2020. | {A 000}                                                                                                 |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE