

Agency for Health Care Administration

|                                                                             |                                                                                                                                                                                                                                                         |                                                                                           |                                                                                                                          |  |                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969602</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/24/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ROSARIO ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2616 22ND ST W<br/>LEHIGH ACRES, FL 33971</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                                                                       | <p>Initial Comments</p> <p>An unannounced focused infection control survey was conducted on 3/24/21 at Rosario Assisted Living Facility, an assisted living facility in Lehigh Acres, Florida.</p> <p>No deficiencies were found at time of survey.</p> | A 000                                                                                     |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE