State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11910846

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
7/10/2015

Name of Facility
DOGWOOD INN

Street Address, City, State, Zip Code
108 WAGNER ROAD
BONIFAY, FL 32425

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0081** Reg. # **58A-5.0191(2) FAC** LSC		ID Prefix **A0152** Reg. # **58A-5.023(3) FAC** LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:**

Reviewed By CMS RO | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910846	R
NAME OF PROVIDER OR SUPPLIER **DOGWOOD INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **108 WAGNER ROAD** **BONIFAY, FL 32425**	

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

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An unannounced follow up survey was conducted at Dogwood Inn in Bonifay. Deficiencies were cited.

0078

Based on employee record review and staff interview the facility failed ensure 3 out of 3 (1,4,5) employees reviewed had a written statement from a health care provider that the individual was free of communicable .

The findings are:

A review of the employee records revealed:

1. Employee# 1 had a ..... test form that included the communicable ..... statement dated ..... This statement was signed by a Registered Nurse (RN) and not an approved healthcare provider.

2. Employee #4 date of hire ..... had a communicable ..... statement signed by an RN. This was the only communicable ..... statement on file for the employee.

3 . Employee #5 date of hire ..... had a communicable ..... statement signed on ..... by an RN. This was the only communicable statement on file for the employee.

An interview with the Administrator on ..... at approximately 10:45 AM was conducted. She was not aware that an RN could not sign the communicable ..... statement.
Class III- uncorrected

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Dogwood Inn
108 Wagner Road
Bonifay, FL 32425

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the uncorrected deficiency identified 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 your corrective action and any additional documentation to support correction of identified deficiencies to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit. Also attached is the Revisit Report indicating which citations were found corrected.

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,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure

XG90

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