

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

Reviewed By

Reviewed By

Date:

Signature of Surveyor:

Date:

State Agency

Reviewed By

Date:

Signature of Surveyor:

Date:

CMS RO

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES

NO

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/15/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910846	(X3) DATE SURVEY COMPLETED 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)		
0000 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

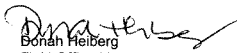
Dear Administrator:

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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