AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965681	02/25/2016
NAME OF PROVIDER OR SUPPLIER **ROSEWOOD HOUSE II, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **3175 BELCHER ROAD** **DUNEDIN, FL 34698**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey (CCR 2016001647) conducted at Rosewood House Assisted Living Facility on . Rosewood House Assisted Living Facility had a deficiency at the time of visit.

0008 Admissions - Health Assessment

Based on record review and interview the facility failed to ensure the accuracy of an 1823 Health Assessment for 2 of 3 (#2,#3) sampled resident records reviewed.

Findings Include:

A review of resident's #2 (1823-health assessment) on dated , did not have documentation indicating whether resident #2 had any ,3 or 4 pressure sores. This section reads " Any ,3, or 4 pressures sores?" A review of page 2 section C, number 2 of resident #2 health assessment section was observed blank.

A review of resident's #3 (1823-health assessment) on dated , did not have documentation indicating whether resident #3 needs could be met in an Assisted Living Facility. A review of page 2 section D of resident #2 health assessment section was observed with an "X" marked in the "No" section.

During an interview with the facility Administrator on 12:32 P.M. The Administrator reviewed files with surveyor and confirmed findings.

No further documentation was provided to surveyor at this time.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Rosewood House II, Inc.
3175 Belcher Road
Dunedin, FL 34698

RE: CCR #2016001647

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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.

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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

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