

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 07/22/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953473	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER VILLA ROSE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 6753 CARPEL DRIVE NEW PORT RICHEY, FL 34653	

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

0000 Initial Comments

Assisted Living Facility

A revisit to the complaint survey, CCR# 2016001757, in conjunction with a complaint investigation (CCR 2016005406), was conducted at Villa Rose Assisted Living Facility on . Villa Rose Assisted Living Facility had an uncorrected deficiency at the time of the visit.

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe living environment, free of hazards.

Findings included:

A tour of the facility conducted on revealed the following observations: a can of paint and paint brushes sitting in a liquid on the ground in the front porch common area, accessible to the residents; cans of paint on the floor in the facility 's living /common area on the floor by a piano; metal chairs on the outside porch without cushions-one resident was observed sitting on the bare metal of one of the chairs while smoking.

At 10:35 AM on the administrator was interviewed and acknowledged the paint on the floor in the facility 's living /common area. At 10:49 AM on / the administrator acknowledged the painting supplies on the front porch.

Additionally, the facility 's back porch/screened-in patio was observed with Staff A in the afternoon and showed an approximate 4-inch hole in the ceiling near the inside entrance to the .

Staff A was interviewed at 12:32 PM on and he stated that the ceiling needed to be repaired.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11953473	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY VILLA ROSE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 6753 CARPEL DRIVE NEW PORT RICHEY, FL 34653

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0028	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.0182(4) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE 7/22/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/11/2016			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO	



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Villa Rose Assisted Living Facility
6753 Carpel Drive
New Port Richey, FL 34653

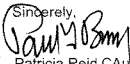
Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016, by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiency identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **The deficiency shall be corrected no later than , 2016.**

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. Should you have any questions please call **Paul Brown**, HFES, of this office at (727) 552-2000.

Sincerely,

for Patricia Reid CAufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547 & Revisit Report

BBT7

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida