Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969299	A. BUILDING: _____ B. WING _____	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOSWELL MANOR, LLC	2185 HWY 173 BONIFAY, FL 32425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On April 10, 2023, an unannounced desk review revisit survey was completed for the abbreviated biennial survey ending January 31, 2023 at Boswell Manor, LLC. Based on interviews and supporting documentation, the deficiency was found to be corrected.	A 000		
CZ000	Initial Comments On April 10, 2023, an unannounced desk review revisit survey was completed for the abbreviated biennial survey ending January 31, 2023 at Boswell Manor, LLC. Based on interviews and supporting documentation, the deficiency was found to be corrected.	CZ000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE