

Agency for Health Care Administration

|                                                                            |                                                                                                                                                                                   |                                                                                             |                                                                                                                          |  |                                                        |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11970501</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/23/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BLUE FOUNTAIN IV HOME CARE, LLC</b> |                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>211 SILVER OAK RD NE<br/>PALM BAY, FL 32907</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                      | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                      | Initial Comments<br><br>An initial survey was conducted on 7/23/24 at Blue Fountain IV Assisted Living Facility. There were no deficiencies identified at the time of the survey. | A 000                                                                                       |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE