

Agency for Health Care Administration

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|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967394</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>10/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BLUE FOUNTAIN HOME CARE, LLC</b> |                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2440 EMERSON DRIVE SE</b><br><b>PALM BAY, FL 32909</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>A revisit to generator monitoring was conducted on 10/27/2025 at Blue Fountain Home Care, LLC, Palm Bay. No deficiency was found at the time of the survey. | {A 000}                                                                                            |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X8) DATE