STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910258	07/01/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE NEW PORT RICHEY	6400 TROUBLE CREEK ROAD NEW PORT RICHEY, FL 34653	

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

0000 - Initial Comments

Assisted Living Facility

A complaint survey, CCR#2015003540, was conducted on .

The Brookdale New Port Richey Assisted Living Facility had one unrelated deficiency found at the time of the visit.

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview, the facility failed to provide a refund to the resident's responsible party within forty-five (45) days of discharge for 1 of 3 (#1) residents sampled for refund returns.

Findings include:

Record review on Resident #1's contract dated stated the facility shall provide a refund to the resident or the resident's responsible party within 45 days after the discharge, transfer or of a resident. Resident #1 was transferred on .

The refund check should have been issued by the facility by . The facility issued the refund check on . The facility was 7 days late in getting the refund check to the responsibile party.

When interviewed on at 10:00 a.m., the administrator stated this was about the time her company was taking over the management of the facility and the refund must have gotten overlooked during this process. She agreed the refund check was not received within 45 days after discharge as stated in the contract.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale New Port Richey
6400 Trouble Creek Road
New Port Richey, FL 34653

RE: CCR #2015003540

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 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 forward documentation of correction to the Field Office.** Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

PRC/clt
Enclosure: State (5000-3547) Form

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