AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965487	**09/11/2015**
NAME OF PROVIDER OR SUPPLIER **BLOOMFIELD MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **2774 WESLEYAN DR PALM HARBOR, FL 34684**	

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

0000 Initial Comments

Assisted Living Facility

Bloomfield Manor, assisted living facility, had a deficiency at the time of the visit.

An unannounced change of ownership (CHOW) state licensure survey was conducted on / .

0008 Admissions - Health Assessment

Based on record review and staff interviews, the facility failed to provide a completed Health Assessment (AHCA form 1823) signed by a health care provider for 2 of 3 sampled residents (Resident #1,#2).

Findings include:

Review of resident #1 records revealed an admission date of / . Resident #1 records had no completed Health Assessment on file.
A record review of resident #2 records revealed an admission date of . Resident #2 records had no completed Health Assessment on file.
During an interview with the facility administrator on / at 2:10 P.M.. The administrator reviewed resident #1 and #2 records with surveyor and confirmed findings. The administrator stated, " I know there are a few residents in which I haven't had a chance to get them completed, the doctor take their time with these things.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 21, 2015

Administrator
Bloomfield Manor
2774 Wesleyan Dr
Palm Harbor, FL 34684

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than October 21, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

Patricia Reid Caufman RN
fy Patricia Reid Caufman
Field Office Manager

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

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