

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/07/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964130	(X3) DATE SURVEY COMPLETED 03/25/2016
NAME OF PROVIDER OR SUPPLIER BROOKDALE CLEARWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 2750 DREW STREET CLEARWATER, FL 33759	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, (CCR# 2015013366) was conducted at Brookdale Clearwater on Brookdale Clearwater, Assisted Living Facility, had a deficiency at the time of the visit.

0160 Records - Facility

Based on interview and record review, the facility failed to maintain a fully completed admission and discharge log.

Findings included:

A review of the facility's admission and discharge log was conducted on . The admission/discharge log showed no reasons for discharges or where residents were discharged to for 46 residents that were discharged between and .

At approximately 5:00 PM on , an interview was conducted with the administrator and the missing information from the admission/discharge log was discussed.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 15, 2016

Administrator
Brookdale Clearwater
2750 Drew Street
Clearwater, FL 33759

RE: CCR# 2015013366

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on January 15, 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 January 15, 2016.** 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 deficiency 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.

St. Petersburg Field Office
625 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com



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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 Kaufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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