| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968414 | 05/17/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**BRADFORD HOMELIVING LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2335 SOUTEL DR**<br>**JACKSONVILLE, FL 32208** | |

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

**0000 Initial Comments**

An unannounced complaint survey (CCR 2016002341) was conducted at Bradford Home Living, LLC on [redacted]. The complaint was not substantiated, however, Bradford Home Living, LLC had deficiencies at the time of the investigation.

**0025 Resident Care - Supervision**

Based on record review and staff interview, the facility failed to contact the residents' primary health care providers and responsible parties related to significant changes in health status for three (3) of three (3) sampled residents (Residents #1, #2, and #3).

The findings include:

During a complaint investigation conducted on [redacted], clinical record reviews were completed for Residents #1, #2, and #3. None of the three records contained observation notes documenting the residents' discharges to the hospital or notification of the responsible parties or the primary care providers. A review of the admission and discharge log indicated that Resident #2 was sent to the hospital on [redacted] related to "illness", and Resident #3 was sent to another facility "for rehab" on [redacted].

During a [redacted] interview with the co-owner of the facility (a registered nurse (RN) at 10:40 a.m., she confirmed that there were no observation notes available for any of the above-mentioned residents. She stated that she had not written any notes when the residents were sent to the hospital. She confirmed that she had no way to prove that she had notified each resident's responsible party or their physician of each resident's discharge or their change in health status..

Class III

**0160 Records - Facility**

Based on record review and staff interview, the facility failed to maintain a current, up-to-date Admission and Discharge Log with regard to Resident #1.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968414** | **05/17/2016** |
| NAME OF PROVIDER OR SUPPLIER **BRADFORD HOMELIVING LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE **2335 SOUTEL DR JACKSONVILLE, FL 32208** | |

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

The findings include:

During a complaint investigation conducted on , a review of the Admission and Discharge Log was completed. It revealed that all residents currently living in the facility were listed, and the forms were complete. Resident #1 was not listed on the log, however.

During an interview with the owners on at 10:40 a.m., the were unable to explain why Resident #1 was not on the Admission and Discharge Log. They stated they thought they may have rewritten the log and forgotten to include Resident #1's name.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Bradford Homeliving, LLC
2335 Soutel Drive
Jacksonville, FL 32208

**RE: CCR #2016002341**

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by a representative 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 , 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 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. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
for Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure
XG90

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com