

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11912132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/13/2020
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NAME OF PROVIDER OR SUPPLIER ATRIUM AT BOCA RATON (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A Generator Assessment Survey was conducted on 5/13/2020 at Atrium At Boca Raton (The). The facility had no deficiencies identified at the time of the survey. An infection control special survey was conducted in conjunction with the Generator Assessment survey on the same date. See separate report for findings.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE