

Agency for Health Care Administration

|                                                         |                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION     |                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953207</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>11/13/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FOUNTAINVIEW</b> |                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>145 EXECUTIVE CENTER DRIVE</b><br><b>WEST PALM BEACH, FL 33401</b>           |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 000}                                                 | Initial Comments<br><br>An unannounced revisit to licensure complaint survey, #2019009060, was conducted on 11/06/19 and 11/13/19 at Fountainview Assisted Living Facility. The previously cited deficiencies were found to be corrected at the time of the survey. | {A 000}                                                                        |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE