

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/17/2022
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NAME OF PROVIDER OR SUPPLIER COLONIAL ASSISTED LIVING AT PALM BEACH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2090 N. CONGRESS AVENUE WEST PALM BEACH, FL 33401
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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 AMENDED REPORT An unannounced revisit to Complaint survey (#2022006962) commenced on 06/09/2022 concluded on 06/17/2022 at Colonial Assisted Living At Palm Beach LLC. The previously cited deficiencies were 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