Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953392	A. BUILDING: _____ B. WING _____	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE RESIDENCE	6260 GUN CLUB ROAD WEST PALM BEACH, FL 33415

(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 An unannounced Wellness Monitoring and Generator Monitoring survey was conducted on at Lee Residence. The facility had a deficiency identified related to the Wellness Monitoring at the time of the survey.	A 000		
A 300	429.31 Facility Closure 429.31 Closing of facility; notice; penalty.- (1) In addition to the requirements of part II of chapter 408, the facility shall inform, in writing, the agency and each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the fact and the proposed time of discontinuance of operation, following the notification requirements provided in s. 429.28(1)(k). In the event a resident has no person to represent him or her, the facility shall be responsible for referral to an appropriate social service agency for placement. (2) Immediately upon the notice by the agency of the voluntary or involuntary termination of such operation, the agency shall inform the State Long-Term Care Ombudsman Program and monitor the transfer of residents to other facilities and ensure that residents' rights are being protected. The agency, in consultation with the Department of Children and Families, shall specify procedures for ensuring that all residents who receive services are appropriately relocated. (3) All charges shall be prorated as of the date on which the facility discontinues operation, and if any payments have been made in advance, the payments for services not received shall be refunded to the resident or the resident's guardian within 10 working days of voluntary or involuntary closure of the facility, whether or not such refund is requested by the resident or guardian.	A 300		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953392	A. BUILDING: _____ B. WING _____	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE RESIDENCE	6260 GUN CLUB ROAD WEST PALM BEACH, FL 33415

(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 300	Continued From page 1	A 300		

(4) The agency may levy a fine in an amount no greater than $5,000 upon each person or business entity that owns any interest in a facility that terminates operation without providing notice to the agency and the residents of the facility at least 30 days before operation ceases. This fine shall not be levied against any facility involuntarily closed at the initiation of the agency. The agency shall use the proceeds of the fines to operate the facility until all residents of the facility are relocated.

This Statute or Rule is not met as evidenced by:
Based on observation the facility failed to notify the Agency for Health Care Administration of its closure as required as evidenced by the facility was observed to be vacant at the time of the survey.

The findings included:

On this surveyor arrived at the facility at 9:30 AM. Upon arriving, this surveyor rang the doorbell and knocked on the door multiple times within a 30-minute period, neither of which yielded a response.

A view of the inside of the facility through three of the front windows of the facility (house) revealed no persons or activity. The windows had sheer drapes that were closed, except for the window to the left (east) of the double front doors. No resident activity in that room inside was observed during this surveyor's visit and observation of the facility.

Observation was made of front lights mounted atop two columns by the double front door revealing they were still on. (Photographic evidence obtained.) A view of the west-side of the

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953392	A. BUILDING: _____ B. WING _____	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE RESIDENCE	6260 GUN CLUB ROAD WEST PALM BEACH, FL 33415

(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 300	Continued From page 2 facility by the garage revealed no sound that is produced when an air conditioner is running. . On at 9:51 AM, 10:03 AM and 4:37 PM, telephone calls were made to the facility at the number listed as the facility's telephone. On each occasion this surveyor received a recorded message informing callers they have reached a number that has been disconnected or is no longer in service. Prior to exiting the facility's grounds, this surveyor left a business card along with a note on the . . . requesting the Administrator call the Agency for Health Care Administration. No return call was forthcoming. Class III	A 300		