

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11943102</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>R<br><b>03/27/2024</b> |
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|                                                                                       |                                                                                                       |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL ASSISTED LIVING AT PALM BEACH LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2090 N. CONGRESS AVENUE<br/>WEST PALM BEACH, FL 33401</b> |
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| (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}                  | <p>Initial Comments</p> <p>An unannounced revisit to the Six Month Relicensure survey was conducted on 03/27/2024 at Colonial Assisted Living at Palm Beach LLC. The previously cited deficiencies were found corrected at the time of the survey.</p> | {A 000}             |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE