

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2012
NAME OF PROVIDER OR SUPPLIER CITY WALK ACTIVE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 534 DATURA STREET WEST PALM BEACH, FL 33401		
(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 Complaint Inspections CCR #2012008996, CCR #2012007933 and CCR #2012008372 were conducted on August 28, 2012. City Walk Active Living had no licensure deficiencies found at the time of the visit.		A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

8880

MD2F11

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 24, 2012

Administrator
City Walk Active Living
534 Datura Street
West Palm Beach, FL 33401

**Re: CCR #2012007933, #2012008372 &
#2012008966**

Dear Administrator:

This letter reports the findings of a complaint surveys completed on August 28, 2012 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions, please contact Arlene Mayo-Davis at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis, HFO Supervisor
for Arlene Mayo-Davis
Field Office Manager

AMD/dlt
Enclosure

