STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912132	07/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Atrium At Boca Raton (the)	1080 Northwest 15th Street Boca Raton, FL 33486	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014005218, was conducted on thru and at The Atrium At Boca Raton. The facility had a deficiency found at the time of the visit.

This survey was conducted in conjunction with the Relicensure survey on the same date. Please refer to separate report for findings.

0167-Resident Contracts 58A-5.025 FAC
Based on record review and interview, the facility failed to provide a refund within 45 days of discharge, for 1 of 3 (Resident #3) sampled discharged residents' records reviewed.

The findings include:

Review of Resident #3 ' s record revealed that she was admitted to the facility on on that date the facility was paid for the monthly services fees for 2014, 2014 and a community fee in the amount of $3000.

Review of the facility ' s " Issues that Require Documentation " notes revealed an entry made on that Resident #3 moved out of the facility with daughter at her side on that date. Review of the Medication Observation Record (MOR) for Resident #3 revealed that the last date medication was documented as observed was

Review of Resident #3 ' s Residency Agreement item #3 related to the Community Fee revealed the following: "if You terminate this agreement at any time or for any reason within (30) days from Your move in date, You shall receive a refund of a pro- rated percentage of the Community Fee equal to the amount by subtracting the number of days since Your move in date from thirty (30) and then placing the number obtained over thirty (30). For example, if you terminate this Agreement ten (10) days

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11912132	07/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Atrium At Boca Raton (the)	1080 Northwest 15th Street Boca Raton, FL 33486	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

following Your move in date, You would receive a refund equal to [redacted] multiplied by the community fee). If you terminate this agreement at any time for any reason on or after the 30th day following Your move in date, the community shall retain the entire amount of the community fee "

In an interview conducted with the Executive Director on [redacted] at 12:50 PM, he confirmed that he did speak to the family of Resident #3 on [redacted] and told her he would speak to the Business Office Manager about the refund. He also confirmed that Resident #3 was entitled to a refund of the prorated amount of the community fee and that a check for $1500 had not been mailed out; but would ensure it gets mailed to the Resident immediately. Further record review of the resident's record and facility records revealed Resident #3 was at the facility for 15 days, from [redacted] to [redacted]. Therefore, she would be entitled to a prorated refund of $1500 of the Community Fee [redacted] at [redacted] multiplied by $3000).

In an interview conducted on [redacted] at 4:50 PM with the family representative of Resident #3, she stated she hand delivered the notice that she was moving Resident #1 on [redacted]. She also stated that she spoke to the Executive Director who assured her she would be receiving a refund. She further stated as of the date of the survey, no refund had been received.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Atrium At Boca Raton (The)
1080 Northwest 15th Street
Boca Raton, FL 33486

RE: CCR #2014005218

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2014 by a representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com