State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11965708

(Y2) **Multiple Construction**
A. Building
B. Wing

(Y3) **Date of Revisit**
3/30/2015

Name of Facility
ABBEY DELRAY HEALTH CENTER

Street Address, City, State, Zip Code
2105 SW 11 COURT
DELRAY BEACH, FL 33445

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0008** Reg. # **58A-5.0181(2) FAC** LSC	**03/30/2015**	ID Prefix **A0053** Reg. # **58A-5.0185(4) FAC** LSC	**03/30/2015**	ID Prefix **A0056** Reg. # **58A-5.0185(7) FAC** LSC	**03/30/2015**
ID Prefix **A0081** Reg. # **58A-5.0191(2) FAC** LSC	**03/30/2015**	ID Prefix **A0082** Reg. # **58A-5.0191(3) FAC** LSC	**03/30/2015**	ID Prefix **A0090** Reg. # **58A-5.0191(11) FAC** LSC	**03/30/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By TWP **Reviewed By** TWP **State Agency** **Date:** 4/14/15 **Signature of Surveyor:** T. Wade Ybers for H. Largent **Date:** 4/14/15

Reviewed By CMS RO **Reviewed By** **Date:** **Signature of Surveyor:** **Date:**

Followup to Survey Completed on:
1/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 14, 2015

Administrator
Abbey Delray Health Center
2105 SW 11 Court
Delray Beach, FL 33445

Re: Revisit to Relicensure and Extended Congregate Care

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on March 30, 2015 by a representative from this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit.

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

DT9D

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Delray Beach, FL 33484
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