STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910699	07/22/2015
NAME OF PROVIDER OR SUPPLIER **WILLOW BAY SENIOR RESORT**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 WEST HILLSBORO BLVD.** **DEERFIELD BEACH, FL 33442**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On 7/22/2015 a complaint investigation (CCR# 2015005928) was conducted at Willow Bay Senior Resort. At the time of the investigation deficiencies were found.

0006 Licensure - Rebates Prohibited: Penalties

Based on record review and interview, the facility failed to adhere to 429.195 FS and ensure that no referral service received payment for 1 of 6 sampled residents who were Medicaid recipients (Resident #3).
The findings are:
On at 11:10am an interview was conducted with the facility receptionist and Staff A. They presented invoice documentation showing that the facility has paid for marketing referral services that placed residents in the facility.
On Review of resident #3's record revealed that she was admitted to the facility on and was a Medicaid recipient upon admission. In addition, a review of the facility invoice dated on indicated that the facility paid $135.00 for services related to the referral of resident #3's admission to the facility. (See photographic evidence)
On a review of the facility records also revealed that they paid out $135 to a referral service company upon the admission of Resident #3 to the facility.
On 11:25 a.m., an interview was conducted with Resident #3's family member. The family member stated that Resident #3 was referred to the facility by an assisted living referral service. In addition, at the time of the referral Resident # 3 was a Medicaid recipient.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Willow Bay Senior Resort
4001 West Hillsboro Blvd.
Deerfield Beach, FL 33442

RE: CCR #2015005928

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative of 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite 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/dmb
XG90

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