STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910386	12/22/2015
NAME OF PROVIDER OR SUPPLIER **CITY WALK ACTIVE LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **534 DATURA STREET** **WEST PALM BEACH, FL 33401**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2015010810 was conducted on -, with a Limited Nursing Services Component, at City Walk Active Living. The facility had deficiencies found at the time of the visit.

0010 Admissions - Continued Residency

Based on observation, interview and record review, the facility failed to determine ongoing appropriateness for continued residency for 3 of 3 sample residents,(Residents #1, #2, and #3). This was evidenced by the facility's failure to meet the increased care needs, including supervision for residents experiencing a decline in health resulting in and injury.

The findings include:

1) A review of the facility's resident record revealed that Resident #2 was admitted to the facility on . Agency for Health Care Administration (AHCA) Health Assessment form 1823 dated revealed that the resident's diagnoses included , , , , and , . Physical limitations were identified as 'generalized .' The resident required the assistance of one person for ambulation, bathing, dressing, self-care, toileting and transferring, and was identified as 'not steady; uses wheelchair' for ambulation. She was further identified as needing observation ' more frequently than daily due to .' The resident was also identified as needing medication administration. No or other special precautions were identified.
A review of the facility records and hospital records from 2 local hospitals for the period of 2014- 2015 revealed that Resident # 2 11 times in the facility since admission. Of those 11 , 9 resulted in injury requiring medical treatment and/or hospitalization Six of those occurred from 2015 through 2015.
a) A review of the hospital records revealed that on , Resident #2 and was transported to the emergency ambulance, having acquired lacerations requiring staples to the head.
A review of the facility's resident record revealed that on / , a Medication Technician (Med Tech) informed a Certified Nursing Assistant (CNA) that Resident #2 had . The med tech found the resident lying on the ground in the Activities , from the back of the head. The CNA said that the resident was trying to get up from a chair when she stumbled back, hitting her head on another chair. Emergency Services was called and the resident was taken to the hospital. No actions or interventions to prevent additional after Resident #2's on was documented in the resident's record.
b) A review of the hospital records revealed that on , Resident #2 tripped and , acquiring an acute nasal with slight deviation to the left, and facial lacerations.

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A review of the facility's resident record revealed that on 6/27/15, a CNA stated that Resident #2 was coming down the hallway without her walker when she entered the dining room and stumbled over another resident's walker, falling and hitting the front of her face. No actions or interventions to prevent additional after Resident #2's on were documented in the resident record.
c) A review of the facility's resident record revealed that on / Resident #2 was found sitting on the floor in the hallway after having an unwitnessed . The Resident was examined by the staff and found to have no or discoloration, and she did not receive medical attention. No actions or interventions to prevent additional were documented in the resident record.
d) A review of the facility's resident record revealed that on / , a CNA heard a noise during rounds at 3:00 am and called for a Med Tech, who found Resident #2 on the floor. The resident said that she had lost her balance while trying to get up from the bed. The resident did not receive medical treatment. No actions or interventions to prevent additional were documented in the resident record.
e) A review of the hospital records revealed that on , Resident #2 and acquired a closed head injury, concussion, and subluxation.
A review of the facility's resident record revealed no documentation of Resident #2's on .
f) A review of the hospital records revealed that on , Resident #2 and required hospitalization for 3 days for a injury and normal pressure .
A review of the facility's resident record revealed no documentation of Resident #2's on / / .
On at 10:20 am, Employee A stated, she had not noticed that any residents had excessively since she started working at the facility on . She further stated, if a resident and had pain, cuts on the face, or if they couldn't bear weight, Emergency Services was called. She further stated, all were documented in the internal communication log, and the immediate supervisor was informed. She stated, the immediate supervisor decided on what steps needed to be taken next.

2) Review of Resident #1's medical file indicated that the resident was admitted to the memory care unit on with medical diagnoses of and visual , . Review of the Resident Health Assessment dated on / indicated Resident #1 was alert and , . She is documented as being independent for ambulation, but uses a walker. Further review indicated, she is independent for eating, toileting and transfers and requires supervision with bathing and self-care. No precautions were documented on the form.
a) Review of Resident #1's progress note dated on / at 6:19PM indicated the resident was found on the floor after a and she was transported to the hospital for evaluation of facial laceration and scalp .
b) Review of Resident #1's progress note dated / indicated the resident complaining of knee pain and she was ordered to see an orthopedic , on .
c) Review of Resident#1's progress note dated on indicated the resident lost her balance

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while ambulating and on her side. Review of the facility's documentation dated on 9/27/2015 revealed, there was no time documented. It was documented that Resident #1 was ambulating and stumbled, falling forward on her face. The resident was checked by the facility staff and stated that she had no injury, the resident refused to go to the hospital for evaluation. The report documented the physician and legal representative were notified of the . Further review indicated that the action taken to prevent recurrence as, " reminded to walk slowly, use environment for support."
Review of Resident #1's file dated on indicated that the physician ordered physical to be performed by the home health agency staff.
d) Review of Resident #1's progress note dated on indicated the resident complaining of knee pain and an appointment was scheduled for the orthopedic , on , then rescheduled for . Further review of Resident #1's progress note dated on indicated physical sessions began for the resident.
e) Review of Resident #1's progress note dated on indicated that the resident was found at 8:30PM in her on the floor between the two beds. The note indicated no or injuries and the floor staff were instructed to check the resident more frequently. Review of the facility's documentation dated on indicated that Resident #1 was found on the floor in her 2 staff. The report further indicated the staff were instructed to make regular rounds to ensure safety of the resident.
f) Review of Resident #1's progress note dated on / indicated that an aide found the resident on the floor in the 2nd floor dining 9:45 AM. The note indicated Resident #1 stated she was attempting to sit on the walker seat and forgot to lock the brakes, the walker slipped out from her and she . The note indicated that the resident had no apparent injury, and range of motion was intact. No additional facility incident report of the accident/ was available for review.
g) Further review of Resident#1's progress note on indicated the resident was not eating but pocketing her food in her mouth and refusing to drink fluids, and complaining of a throat. She was transferred to the hospital for evaluation and diagnosed with a ( ) and . The resident remained in the hospital rehabilitation unit at time of the survey.
h) Review of Resident #1's Home Health Nursing Assessment dated on / indicated the resident had medical diagnoses including difficulty walking, generalized muscle , incontinence, , , and major , . The form indicated Resident #1 was oriented to person and place, forgetful, having decision making skills, unable to perform activities of daily living (ADL) care and had jeopardized safety thru her actions. The resident was assessed to be a risk due to her diagnoses, prior history of , incontinence, visual , functional mobility, pain, and . The resident required the use of a walker for ambulation and to be "under the supervision and assistance of another person at all times."
Review of Resident #1's physical ( ) note dated indicated the resident had been receiving from . The resident's diagnoses included difficulty walking and . The resident was alert and oriented to person and place with complaints of knee

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pain. Her functional limitations included decreased stability, decreased transfer ability, decreased gait, poor endurance and poor safety awareness. She required moderate to with ambulation and transfers.
In an interview with Employee A on at 2:30PM, she stated that she was familiar with Resident #1 and the resident was able to independently ambulate with her walker around the memory care unit. Employee A stated, resident #1 was , forgetful and preferred to be by herself. Employee A stated, she was not aware that the resident had a history or required precautions.
In an interview with Employee D on at 8:30PM, she stated that she recalled the resident required the use of a walker at all times and had a . She stated that she routinely checks on the residents in the memory care unit every 2 hours, but she will increase the monitoring more frequently if she is aware of any history. She stated, at the beginning of her shift, she reviews the unit employee communication log for any incidents that occurred in the past 24 hours. She stated, that she had not been informed that Resident #1 was a risk or instructed to supervise the resident more frequently.

3) Review for Resident #3's medical record indicated the resident was admitted to the facility on with medical diagnoses including , with behavior, , controlled , abnormal gait, knee pain, , , , sleep , history and . Review of the Resident Health Assessment form dated // indicated that Resident #3 was alert and oriented, requiring the use of a walker for ambulation, medication management with home health nursing for administration. Further review indicated Resident #3 was independent for ambulation, uses walker, dressing, eating, self-care and required supervision with bathing, toileting and transfers. The resident's documented weight was 349 pounds. No precautions were documented on the form.
a) Review of Resident #3's progress note dated on indicated the resident out of bed in his 7:25 PM injuring his left knee. Review of the facility's internal documentation dated on indicated the that the resident off the bed while repositioning himself, his left knee and he refused to go to hospital for evaluation at that time. Further review of the report indicated interventions to be completed, such as "needs bigger bed with side rails."
b) Review of Resident #3's progress note dated on indicated the resident was found at 11:30PM on the floor in the resident's . The note indicated that Resident #3 out of bed while attempting to go to the . The resident complained of right shoulder pain and requested to go to the hospital for evaluation. Review of the facility's internal documentation dated on indicated the resident from bed attempting to go to the his right shoulder. The resident was transferred to the hospital and the physician notified. Facility interventions noted on the report included, obtain bed with ½ bed rails and instruct resident to ask for assistance to . Further review of the progress notes dated on indicated that the resident returned to the facility with a diagnosis of right shoulder injury/separation. Review of a progress note dated on indicated the physician visited the resident and ordered a hospital bed.

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c) Review of Resident #3's progress note dated on 10/13/2015 indicated the resident was found on the floor in his room at 10:20PM lying on his side. Review of the facility's internal incident report dated indicated the resident was found on floor, after falling while attempting to go to the . The resident complained of left shoulder pain and was transferred to the hospital for evaluation. Further review of report indicated facility interventions included, "needs hospital bed with side rails, educate the resident to call for assistance." The resident returned to the facility on / with no new discharge orders.
Review of a physician note dated on indicated the physician visited the resident. The note indicated no mention of a history, only that " persists."
d) Review of Resident #3's progress note dated on indicated the resident was found on the floor in his 12 AM. The note further indicated that the resident lost his balance rolling off his bed.
Review of the facility's internal documetation dated on indicated the resident was going to the rolled off his bed. He was assessed by the staff and had no complaint of injury or pain and refused to go to the hospital for evaluation. Further review of the report indicated facility interventions included, "educate the resident to call for assistance, and walk slower with walker."
e) Review of Resident #3's progress note dated on indicated the hospital bed was delivered.
f) Review of Resident #3 ' s progress note dated on 11/ indicated that physical services were ordered by the physician.
g) Review of Resident #3's progress note dated on indicated that the resident was found on the floor in his 12:50AM. The resident had complaints of pain in both knees and was transferred to the hospital for evaluation. No facility incident report was completed or available for review.
At the time of the survey on / and , Resident #3 remained out of the facility and admitted to a rehabilitation facility.
Review of Resident #3's discharge note dated on indicated, the resident's physical goals had been met and the resident had met his maximum potential. The note indicated that the resident's current status included that he still required assistance, had modified independence with basic transfer and ambulation inside the unit, but required supervision to be accompanied for safety to prevent since he remained high risk for . The note continues that Resident #3 was more functional to stand and perform self-care and basic mobility, but continued supervision and assistance is recommended as discussed with resident and staff on the floor.
In an interview with Employee C on / at 9:00PM she stated, Resident #3 was independent with ambulation with his walker. She stated, that he had a when he rolled off his bed and injured his shoulder, she was not sure which side. She stated, she had instructed him to get up slowly when getting out of bed. She was unaware if Resident #3 had numerous or required precautions.
In an interview with Employee B on at 8:30PM she stated, she recalled Resident #3 required the use of a walker at all times for ambulation, he was a large man and had off the bed while turning himself. She stated, as a result of his , he had been injured and required hospitalizations. She stated that since Resident #3 was a large man, the Emergency Medical Technicians (EMTs) had to

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be called to assist getting him off the floor. She stated, she had not been informed that Resident #3 was a risk or instructed to supervise the resident more frequently. She stated that she had informed the facility managers of Resident #3's need for a larger bed numerous times.
In an interview with Employee A, a manager on at 3:00PM, she stated that Resident #3 ambulated independently with a walker. She stated, that Resident #3 had recently been hospitalized after a , but could not recall if the resident had numerous or required precautions. She stated, the resident was moved to the east memory care unit since he required additional monitoring. She stated, that Resident #3 was receiving physical but she was unaware if the resident required supervision or assistance with ambulation or transfers.

In an interview with the Administrator on at 11:04 am, she stated that were managed on a case by case basis, and that the doctor and the family were always called. She further stated, for repeat , families are advised that the facility might not be the appropriate setting for the resident, and that they were given a chance to find a new setting for the resident. The Administrator also stated that the management team reviewed each that occurred in the facility, but said that she did not have documentation of these discussions. She stated, the staff had informed her of the resident but the facility did not have any policy/ procedure to track each resident history or a written response plan for the repeat .

Class II

0052 Medication - Assistance with Self-Admin

Based on observation, interview and record review, the facility failed to provide assistance with self-administration of medication according to the requirements identified in 429.256, F.S to three of nine sampled residents (Residents # 6, 7 and 8). Medications were not identified to Resident #6 before the resident took them; the resident was not observed taking the medications, and the Medication Observation Record (MOR) was signed before the resident took the medications. Residents #7 and 8 waited until after 10:20 pm to take medications prescribed to be taken at 8:00 pm or 9:00 pm.
Findings:
A review of the facility census report revealed that there were 160 residents in the facility on / .
On / at 6:54 pm, Employee # B stated that she was the Medication Technician for the 42 residents on the memory care unit and that Employee A was the Medication Technician for the rest of the residents in the facility (118 residents).
On / at 8:42 pm, Employee # A was observed giving 10 mg, 600 mg and 500 mg tablets to Resident #6 without informing the resident of what medications had been given. Employee # A then turned away from Resident #6 and signed the MOR while Resident #6 walked away with the medications in hand.

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On 12/17/15 at 10:22 pm, Residents #7 and 8 were observed sitting in the hallway outside of the medication room. On at 10:22 pm, Resident # 7 stated that he had been waiting for his medications since 8:30 or 9:00 p.m., and Resident #8 stated that he had been waiting for his medications since 8:30 pm.
A review of the MOR for Resident #7 revealed that 3 mg and 50 mg were listed to be taken at 8:00 pm.
A review of the MOR for resident #8 revealed that ProAir and CHL 5mg were listed to be taken at 8:00 pm and 9:00 pm respectively.
On at 10:25 pm, Employee B stated that she had been present in the medication around 4:00 pm, and acknowledged that it was difficult to ensure that all residents received their medication within one hour of the time identified on the MOR.
Class III

0053 Medication - Administration

Based on observation, interview, and record review the facility failed to ensure that unlicensed staff only provided assistance with self -administration of medications. The facility failed to have a licensed staff member administer medications to 2 out of 2 sampled residents (Residents # 9 and # 4).

The findings include:

a.) Review of Resident # 9 's medical record indicated the resident was admitted to hospice services on for diagnosis of s . Review of the current Resident Health Assessment form dated on indicated the resident had medical diagnoses including s, history of accident, , and lung . The form indicated the resident required assistance with all activities of daily living (ADL) care. The form indicated that Resident #9 required supervision with eating, food to be cut up to prevent choking and a dietary menu of pureed foods.

In an observation of Resident #9 on / at 6:45 PM during nightly ADL care performed by Employee D, Resident #9 was observed to be lying in her hospital bed. The resident ' s upper and lower extremities were thin and drawn up tight against her body during and after ADL care for incontinence. The resident was observed to yell out sounds but no words could be identified. Employee D stated that Resident #9 was on hospice services for and had recently been on 24- hour crisis care for a further decline in condition and increased agitation. Employee D stated that the resident required total care for all ADL care, including 2 person transfer to the wheelchair. She stated that the resident could no longer feed herself and required the staff to feed her a diet of pureed food. Employee D stated that the resident was able to move her arms and legs but had recently

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developed , more tremors and movements.

Review of Resident #9 ' s 2015 Medication Observation Record (MOR) indicated that the resident is prescribed the following medications by mouth daily during the 3-10 PM shift, 100mg, 1mg, , , and 50mg.

Review of the Hospice physician note for Resident #9 dated on indicated the resident had worsening cachexia, muscle wasting, severe , and pain management controlled by medications. The note further indicated that Resident #9 had lost verbal and motor abilities and was recently placed on 24- hour nursing monitoring for increased and functional decline from 20- , 2015.

Review of Resident #9 hospice Plan of Care review dated on indicated evidence of progression to include that the resident had a decreased level of activity and was dependent for 6 of 6 ADLs. Resident #9 had severe requiring pureed diet and thickened liquids, required precautions and facility staff to feed the resident.

Review of the Hospice nursing note dated on indicated the resident required total care for all ADL care, and a pureed diet and thickened liquids to reduce the risk of . Facility staff was to assist Resident #9 to eat her meals.

In an interview with the facility aide,(Med Tech) whose assignment was to assist the residents with self-administration of their medication on / at 9:00PM, she stated that Resident # 9 had difficulty swallowing and was ordered a pureed diet and thickened liquids to reduce the risk of . She stated that she crushed up the medications for Resident #9 and placed the crushed medications in applesauce then spoon fed the applesauce to the resident. The med tech stated that Resident #9 has had a decline in condition and is not able to feed herself or hold a spoon. The med tech stated that she was not aware that she should not be administering medication to Resident #9 as she is not licensed to perform this task.

b.) A review of AHCA form 1823 Health Assessment for Resident # 4 revealed that the resident needed assistance with self-administration of medications. Review of a medication order for Resident #4 dated / revealed that medications were to be crushed and liquids thickened.

A review of the Medication Observation Record (MOR) for Resident #4 revealed that 125 mg (2 tabs) was prescribed at 5:00 pm and Quetapine 50 mg was prescribed at 4:00 p.m.

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On 12/17/15 at 7:03 pm, observed Employee #B, who is not a nurse, crush medications for Resident #4 and place them in applesauce. On at 7:03 pm Employee B stated that the medications were the and Quetapine prescribed for the resident. On at 7:03 pm, observed Employee #B wake Resident # 4 and place the applesauce containing the crushed medications into the resident ' s mouth.

On at 7:04 pm, Employee #B acknowledged that she had placed the medications into Resident #4 ' s mouth, stating " He can ' t take them on his own so I have to put them in his mouth. "

Class III

0055 Medication - Storage and Disposal

Based on observation and interview, the facility failed to appropriately maintain medication. As evidenced of the facility failure to centrally store discontinued medications on the 2nd floor east memory care unit.

The findings include:

In an observation on at 6:52 PM of the 2nd floor east memory care unit nursing station, an open storage closet with resident prescription medications, sterile medical supplies and cylinders was observed. The ceiling inside the storage closet was observed to have numerous discolored wooden slats with missing sections, exposing open areas into the attic space above the ceiling. A soiled rag was observed draped around an exposed pipe coming into the closet. The floor of the closet was observed to be soiled with dust and debris and a wooden was observed covering the cracked dusty concrete flooring surface. Observed on the were dusty boxes of stored cans and containers of resident nutritional supplement items. Additional observation inside the closet included numerous brown paper bags with sterile resident supplies, these bags were piled on top of old dirty boxes of plastic storage containers. A large green plastic box was observed filled and overflowing with resident prescription medications in dispensing cards. 5 small cylinders were observed stored on the floor inside the closet and a large cardboard box was filled with resident medical records. Five prescription bottles, along with a pill box with pills inside, were observed top of the work desk located inside the nursing station. The desk top with medications was located directly under an open counter/ bar top which residents, staff and visitors had access to. See photographic evidence.

In an interview with Employee B, the facility staff responsible to assist the residents with medications, on

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12/17/2015 at 7 PM she stated that the 2nd floor nursing station had a door which should be locked at all times and she has the key. She stated that the medications observed on the desk belonged to a newly admitted resident and she had not had time to review the prescription bottles and properly store them. She stated that the storage closet was, not locked and it is used for storing medications and supplies for the residents. Employee B was questioned by the surveyor if the closet ' s open ceiling and dirty, dusty soiled floors was appropriate storage for medications and sterile care supplies. Employee B did not answer the question but shrugged her shoulders. When questioned further about the resident medical records stored in the cardboard box inside the closet, Employee B stated she was not sure why the resident records were stored there. Employee B stated that the medications in the green box were " discontinued " resident medications and needed to be sent back to the pharmacy. She stated she could not recall the date when the medications were picked up last. She stated that the storage of any medication and medical supplies should be in a clean, secured location, not in a dirty junk closet.

Class III

0165 Risk Mamt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file an adverse incident report with the Agency after two of nine sampled residents (Residents # 2 and 3) were hospitalized in a more acute care setting for injuries resulting from in the facility.
Findings:
a) A review of hospital records and the facility ' s resident record revealed that Resident # 2 and was hospitalized on , , and / .
A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed regarding Resident #2 ' s hospitalizations for on , , or / .
b) A review of hospital records and the facility ' s resident record revealed that Resident # 3 and was hospitalized on , and / .
A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed regarding Resident #3 ' s hospitalizations for at the facility on , or / .
On / at approximately 9:30 am, the Administrator confirmed that no Adverse Incident Reports had been filed for the above .
Refer to A 0010 for additional findings.
Class III

Z815 Backaround Screenina: Prohibited Offenses

Based on observation, interview and record review, the facility failed to ensure that 1 of 7 sampled staff

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(Employee E) who provided direct care to residents and had ongoing contact with residents and their property was free of disqualifying criminal offenses.
The findings include:
Review of the staffing schedule posted in the facility for indicated that Employee E was scheduled to work at the facility providing care and medications to the residents from 3PM to 10:30PM.
Review of the personnel file for Employee E conducted on indicated that Employee E's date of hire was / . The file contained an AHCA Level II background screen form for Employee E indicating the employee was " Not Eligible " .
The agency's background screen website was checked on and indicated that Employee E was screened and found "Not Eligible" on / .
In an interview with the agency ' s background screening unit staff on at 11:20AM, she confirmed that Employee E was not eligible due to the failure to provide requested background information to the screening unit to allow the processing of Employee's E application.
In an interview with the Administrator on at 2:00PM she stated that she was not aware that Employee E did not have a valid background screen and she would remove the employee from the work schedule until the screening was completed.

UNCLASSIFIED

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear . . Kaneti

This letter reports the findings of a licensure complaint survey (CCR#201510810) conducted on 17 through , 2015 by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

The inspection resulted in findings of non-compliance in the following areas:

1) St-A0010- Class II- Continued Residency

The facility failed to determine ongoing appropriateness for continued residency for 3 of 3 sampled residents, (Residents #1,#2, and #3) .This was evidenced by the facility 's failure to meet the increased care needs, including supervision, for residents experiencing a decline in health resulting in multiple with injury.

You are directed to complete the following tasks:

1) The facility must develop policies and procedures for promptly identifying and assessing residents who may no longer be appropriately placed at the facility as evidenced by one or more injuries incurred from , changing medical conditions or other factors. These policies and procedures must include the following elements:

- An identification of the parties responsible for conducting the assessment of resident appropriateness and needs upon a change of condition.
- A description of how these assessments and the resulting plans of action to prevent further injury to identified residents are documented and followed up.
- A description of how residents' medical concerns brought to any staff member's attention are shared with the management team and how the management team acts upon these reports from staff.
- Procedures for implementing precautions and interventions and who is responsible.

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Delray Beach, FL 33484
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- Implementation of a log and how will be documented.
- Procedures regarding ongoing documentation, including notification of family and health care providers regarding .

- The maximum timeframe for documenting the concern after it is first observed or reported.
- The required timeframe within which the follow up action must occur.

This task must be completed by .

2) The facility must have a complete record of each resident of the facility, including an updated complete health assessment for each resident (AHCA form 1823) completed by a medical provider. The resident record must also contain documentation of all significant changes in the resident's status and correspondence with all medical and service providers and responsible parties. **This task must be completed by .**

3) The facility must provide training to all staff, administrators and other managers. This training must include the policy and procedures above, and must guide staff about the scope of interventions that will be made on the residents' behalves. The training must also include recommendations about how to tailor such interventions to specific resident needs. The training must address plans for follow up on all identified needs. Staff must be instructed to ensure that the documentation of all interventions is placed in the resident record.

Documentation of this training, including the training agenda and staff signatures indicating attendance, must be kept on file at the facility and available for review by the Agency. **This training must be completed by .**

Any required documentation set forth above which is not to be maintained on site and/or in resident records, should be directed to the attention Mrs. Arlene Mayo-Davis, Field Office Manager and sent to:

Agency for Health Care Administration
Health Quality Assurance, Delray Beach Office
Attention: Arlene Mayo-Davis
5150 Linton Boulevard, Suite 500
Delray Beach, Florida 33484
Phone: (561) 381-5840
Fax: (561) 496-5924

Nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Arlene Mayo-Davis, Delray Beach Field Office, at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dmb

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

RE: CCR #2015010810

Dear Administrator:

This letter reports the findings of a state licensure survey that was concluded on , 2015 by representatives 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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 representatives. 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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