STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968596	**03/17/2016**
NAME OF PROVIDER OR SUPPLIER **REGAL PARK ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET** **BOYNTON BEACH, FL 33435**	

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

0000 Initial Comments

A complaint investigation survey (CCR# 2015013020, CCR# 2016000008, CCR# 2016000315, and CCR# 2016000799) was conducted at Regal Park Assisted Living, Inc. on and . Regal Park Assisted Living, Inc. had a deficiency at the time of the survey.

0031 Resident Care - Third Party Services

Based on interview, and record review, it was determined that the facility failed to develop policies and procedures regarding the coordination of services by third party service providers for residents.

The findings included:

During a review of the facility's documents, the surveyor was unable to locate written policies or procedures for the coordination of services provided to residents by third party service providers. During an interview with the Administrator on at 11 AM, a request was made to obtain the facilities policies and procedures regarding third party providers and coordination of care and services. The Administrator confirmed that the facility had no such policy or procedure. The Administrator confirmed that the facility should have written procedures to assure timely and accurate communication with home health agencies and hospice agencies providing care and services to residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Regal Park Assisted Living, Inc
1708 NE 4th Street
Boynton Beach, FL 33435

RE: CCR #2015013020, CCR #2016000008, CCR #2010000315 & CCR #2016000799

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016 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 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

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