

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910386</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/18/2019</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COLONIAL ASSISTED LIVING AT WEST PALM BEACH</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>534 DATURA STREET<br/>WEST PALM BEACH, FL 33401</b> |
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| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | <p>Initial Comments</p> <p>An unannounced Licensure complaint survey, #2019013144 and #2019017496, was conducted on 11/18/19 at Colonial Assisted Living At West Palm Beach Fl. The facility had no deficiencies at the time of the survey.</p> | A 000               |                                                                                                                          |                          |

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE