

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>AL11965516</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/24/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOMEWOOD RESIDENCE AT DELRAY B</b> |                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8020 W. ATLANTIC AVENUE<br/>DELRAY BEACH, FL 33446</b> |                                                                                                                          |                                                        |
| (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                                                                     | Initial Comments<br><br>Complaint Survey<br>CCR #2012008414<br><br>The allegation was not confirmed.<br>The Homewood Residence At Delray Beach<br>Assisted Living Facility had no deficiencies,<br>related to the allegation reviewed found at the<br>time of the visit on 08/24/2012. | A 000                                                                                              |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

OFZW11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

September 10, 2012

Administrator  
Homewood Residence At Delray Beach  
8020 W. Atlantic Avenue  
Delray Beach, FL 33446

RE: CCR#2012008414

Dear Administrator:

This letter reports findings of a complaint inspection survey that was conducted on August 24, 2012 by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey. **\*\*You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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: State Form 3020

65FO

