Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968004	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO AT WILLOUGHBY, LLC (THE)	3400 SE ASTER LN STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An Assisted Living Facility standard relicensure survey was conducted on . The Allegro at Willoughby, had licensure deficiencies found at the time of the visit.	A 000		
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable , including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable , he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter. (c) All staff must comply with the training	A 078		

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A 078	Continued From page 1 requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 1 out of 4 sampled staff (Staff #1) had freedom from documented on an annual basis . The findings include: The file for Staff #1 was reviewed for freedom from documented on an annual basis. There was no documentation of this dated within the previous year. The Administrator was interviewed at approximately 2:45 PM on and confirmed that the documentation was not present and available for review. Class III	A 078		
A 086 SS=D	58A-5.0191(9) FAC Training - ADRD (9) AND RELATED (" ADRD ") TRAINING REQUIREMENTS. Facilities which advertise that	A 086		

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A 086	Continued From page 2	A 086		

they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 434.4.6 of the Florida Building Code, as adopted in Rule 9N-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training.
(a) Facility staff who have regular contact with or provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , 1998 and , 2003 shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection will be considered as having met this requirement. " Staff who have regular contact " means staff who interact on a daily basis with residents but do not provide direct care to residents. Initial training, entitled " s and Related Level I Training, " must address the following subject areas:
1. Understanding s and related
2. Characteristics of
3. Communicating with residents with s
4. Family issues;
5. Resident environment; and
6. Ethical issues.
(b) Staff who have received both the initial one hour and continuing three hours of ADRD training pursuant to Sections 400.1755, 429.917, and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility 's and Related Level I Training.
(c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training, " within 9 months of employment. Facility staff who meet

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A 086	Continued From page 3	A 086		

the requirements for ADRD training providers under paragraph (g) of this subsection will be considered as having met this requirement. [illegible] and Related [illegible] Level II Training must address the following subject areas as they apply to these [illegible]:
1. Behavior management;
2. Assistance with ADLs;
3. Activities for residents;
4. Stress management for the care giver; and
5. Medical information.
(d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection can be found in the document " Training Guidelines for the Special Care of Persons with [illegible] and Related [illegible] " dated [illegible] 1999, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000.
(e) Direct care staff shall participate in 4 hours of continuing education annually as required under Section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by Section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule.
(f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under Section 429.178, F.S., within three (3) months of employment. " Incidental contact " means all staff who neither provide direct care nor are in regular contact with such residents.
(g) Persons who seek to provide ADRD training in accordance with this subsection must provide the

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A 086	Continued From page 4 department or its designee with documentation that they hold a Bachelor ' s degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with Alzheimer ' s disease and related disorders; 2. Three years of practical experience in a program providing care to persons with Alzheimer ' s disease and related disorders; 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with Alzheimer ' s disease and related disorders. With reference to requirements in paragraph (g), a Master ' s degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor ' s degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 1 out of 4 sampled staff (Staff#2) who had regular contact with or provided direct care to residents had obtained 4 hours of initial training (Alzhe 1) within 3 months of employment and 4 hours of additional training in Alzhe... Related Disorders II within 9 months of hire. The findings include: The personnel file for Staff #2 was reviewed for training in ADRD and did not contain	A 086		

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A 086	Continued From page 5 documentation of this training dated within the required timeframe. The following training was documented after the date of hire for this employee: Staff #2-Date of Hire 1 hour of training on 1 hour of training on These findings were reviewed and confirmed during interview with the Administrator at approximately 3 PM on Class III	A 086		
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was	A 092		

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A 092	Continued From page 6	A 092		

determined this facility did not ensure the person responsible for the total food services and the day to day operations of the food services staff ensured duties were performed in a safe and sanitary manner.

The findings include:

During initial tour of the kitchen conducted with the Chef (Acting Kitchen Manager), on beginning at approximately 9:50 AM, the following concerns were identified:
Walk-In Refrigerator:
a) A container labeled FT and dated was observed. The Chef was asked to identify this product. He stated that it was french toast batter. He was asked if it contained raw eggs in the batter. He confirmed that it did.
b) There was a container labeled cheese sauce that was dated . The plastic wrap that was covering this item had a 2" tear in the top and a "skin" was developing on the top of this product.
c) There was a large container of a brown liquid substance with bits and pieces in the bottom of this container and it was dated . The Chef was asked to identify this product. He stated that it was beef stock that was to be used to make soup.
d) There was a large pan on a storage cart that contained a pan with 2 large pieces of cooked meat that was uncovered. The plastic wrap was pulled 90% of the way off of this product. When the Chef attempted to unwrap this plastic wrap and cover the meat with the plastic wrap, the wrap was noted to have been labeled pork loin .

e) There was a pan of pink (what appeared to be cooked) shrimp that was very loosely covered with plastic wrap that was labeled . The Chef explained that this product was thawing out

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A 092	Continued From page 7 for the Independent Living residents. Walk-In Freezer: a) A case of Irish Bash was stored on the floor underneath of meat products. b) A case of Mint Cream Pie was stored on the floor underneath of meat products. c) A case of fries was stored on the floor. d) A case of assorted chicken pieces was stored on the floor. The Chef stated that this facility is short on storage and that he has counseled staff not to place items on the freezer floor in the past. Food Prep Area: a) The interior of the storage bin containing 1.5 - 50 pound bags of sugar contained a moderate amount of debris at the bottom of the bin. b) The interior of the storage bin containing bags of flour contained flour, and debris at the bottom of this bin. c) The interior of the bin containing a bags of rice had rice and debris in the bottom of this bin. The Chef stated these bins were due to be cleaned. d) The exterior of the standard size Kitchen Aid mixer was moderately splattered with debris of various colors and textures. e) The large mixer was moderately splattered with white debris. The Chef stated that it must be from the potatoes that had been prepared for lunch. The mixing utensil was clean and placed underneath of the large mixing unit that had not been cleaned. General kitchen observations: a) There were 2 sanitizing buckets that were in use during the time of this observation. The Chef tested the sanitizing solution in the first bucket (maintained in the food prep area) and it measured 50ppm (parts per million) and the	A 092		

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A 092	Continued From page 8 correct amount (as acknowledged by the Chef) is 200ppm. The second sanitizing bucket (from the food production area) that was tested by the Chef measured 400ppm. The Chef acknowledged that both buckets did not contain the proper concentration of sanitizing solution at this time. b) There were 7 garbage cans noted in the kitchen, none of which were covered. The Chef stated he was aware that they needed to be covered but that there are no lids for any of these garbage cans and it has been that way since he has worked there. Class III	A 092		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, . . . and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings;	A 093		

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A 093	Continued From page 9 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care	A 093		

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A 093	Continued From page 10	A 093		

provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and

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A 093	Continued From page 11	A 093		

shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
During observation, interview and record review, it was determined the facility failed to maintain an adequate amount of portable (drinking) water on site in order to meet regulatory requirements and their own CEMP (Comprehensive Emergency Management Plan), specifically related to being able to provide enough drinking water to meet the needs of their current census for the required 3 day period.
The findings include:
During observation of the emergency supplies in the resident storage area conducted with the Chef (Acting Dining Services Manager), on . beginning at approximately 10:20 AM, he stated all of the emergency drinking water is stored in this . . . . There was a mixture of empty and full 5 gallon jugs of water in these locked cages in this storage . . . . There were 62 - 5 gallon jugs that contained water that were located in this area. This to 310 gallons of drinking water available for emergency resident use. The requirement for a census of 95 residents is 427.5 gallons. The facility is lacking 117.5 gallons of drinkable (potable) water for their current census of 95 residents.
Upon review of the CEMP (Comprehensive

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A 093	Continued From page 12 Emergency Management Plan) that was approved on : conducted with the Community Director, on beginning at approximately 1:30 PM, this plan does not indicate the use of the 5 gallon jugs. Page 4 of 8 of this CEMP does indicate the use of 90 collapsible jugs to contain 450 gallons of portable (drinkable) water. During subsequent interview and observation of the emergency supply storage area conducted with the Community Director, on : at approximately 2:00 PM, she was unable to locate any collapsible jugs. Immediately following this observation, the Community Director and this surveyor, met with the Regional Supervisor and he stated that he had looked for the collapsible jugs on the other floors of this facility and he was not able to locate them either. They were informed that the 5 gallon jugs would be considered in the for the potable (drinkable) water but that the facility was still missing 117.5 gallons of drinkable water whether it was from pre-filled containers or the collapsible jugs. An email was received from the Community Director, on the evening of that indicated upon her further review of the CEMP that it indicated the use of the water that is maintained in the hot water heaters. This surveyor's reply to the above noted email reminded the Community Director that the facility's CEMP addresses the use of collapsible jugs to provide the portable (drinking) water. That page 4 of 8 of the CEMP does not indicate the water from the water heaters as portable (drinkable) water. Class III	A 093		
A 160 SS=D	58A-5.024(1) FAC Records - Facility	A 160		

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A 160	Continued From page 13	A 160		

Records.
The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.
(1) FACILITY RECORDS. Facility records shall include:
(a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s:
1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure ; and
2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of
Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968004	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO AT WILLOUGHBY, LLC (THE)	3400 SE ASTER LN STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 14	A 160		

recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.
(e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.
(f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.;
(g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.;
(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.
(j) If the facility advertises that it provides special care for persons with : or related a copy of all such facility advertisements as required by Section 429.177, F.S.
(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate.
(m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO AT WILLOUGHBY, LLC (THE)	3400 SE ASTER LN STUART, FL 34994

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A 160	Continued From page 15 69A-40, F.A.C., issued within the last two (2) years. (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility ' s resident elopement response policies and procedures. (r) The facility ' s documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined this facility failed to ensure all completed surveys (inspection and complaint investigation reports) issued by the agency were readily accessible and available for review by residents and visitors of the facility, specifically related to all units of this facility (assisted living and the memory care unit consisting of 3 distinct/separate neighborhoods). The findings include: During observation and interview with the receptionist, conducted on beginning at approximately 9:00 AM, she was asked where the survey results were posted. She obtained a binder from a shelf behind the reception desk. This binder contained most of the AHCA surveys	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO AT WILLOUGHBY, LLC (THE)	3400 SE ASTER LN STUART, FL 34994

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A 160	Continued From page 16 since the initial licensure, less the complaint survey conducted on [redacted] (with deficient practice cited). During subsequent interview with the Community Director, conducted on [redacted] beginning at approximately 9:15 AM, she was asked why the AHCA survey results binder was not readily accessible to residents and visitors. She stated it was supposed to be on the front of the reception desk ledge so it would be available. She could not provide an explanation as to why it was not accessible or why the [redacted] complaint survey was not enclosed in the binder. During observation of the memory care unit (three separate neighborhoods: Rhapsody; Melody; and Lyric) with the Community Director, conducted on [redacted] beginning at approximately 2:20 PM, she was asked where the AHCA survey report binders are located. She asked staff and the staff were not aware of these binders. These three separate memory care units require separate access and therefore are not required to enter through main front entrance (the location of the aforementioned binder). Class III	A 160		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Allegro At Willoughby, Llc (The)
3400 SE Aster Ln
Stuart, FL 34994

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by a representative from this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after , **2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

for Arlene Mayo - Davis
Field Office Manager
Division of Health Quality Assurance

AMD/jw
Enclosure

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

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
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Phone (561) 381-5840; Fax (561) 496-5924