DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105609	A. BUILDING _____ B. WING _____	C 11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF TAMARAC	5901 NW 79TH AVENUE TAMARAC, FL 33321

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey, CCR# 2015011763, was conducted on and at Heartland of Tamarac. The allegations were substantiated. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide an admission packet, which should have included a notice of the rights to refuse treatment or participate in experimental	F 155	It is the practice of the facility to provide admission packets which include notice of right to refuse treatment, to refuse to participate in experimental research, and to formulate an advanced directive. The responsible party for Resident #1 was provided an admission packet. The Admission Director and the Admission Coordinator were educated on completing the admission packet. 12-28-2015	

LATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Denise Summers	Administrator	12/28/15

ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days g the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued n participation.

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F 155	Continued From page 1 research and the right formulate advance directives, to 1 of 5 sampled residents/representatives, (Resident #1) upon admission to the facility. The findings include: Resident #1 was first admitted to the facility on ../.. Since Resident #1 could not make his own medical or financial decisions, a family member acted as his representative. An interview was conducted with the Admissions Director on at 10:44 AM. She referred to the Business Manager when asked to view an admission packet for Resident #1. An interview was conducted on at 10:54 AM with the Business Manager. The Business Manager reported Resident #1 was admitted under hospice and no admission packet was signed. Upon further inquiry, the Business Manager stated an admission packet should have been provided and signed for by Resident #1's representative. The Business Manager also explained when a resident leaves the facility for more than 15 days a new admission packet must be completed by the resident/representative. Although she reported Resident #1 was out of the facility from to , the Business Manager confirmed no admission packet was provided or signed upon his readmission on During an interview with the Nursing Home Administrator on at 4:34 PM, she also confirmed there was no admission packet for Resident #1, who had resided in the facility since ../..	F 155	An audit was completed on current residents and patients, and admission packets were provided if indicated. The Admission Director or designee will complete random audits of admission packets weekly x 4 weeks then monthly x 3 months thereafter. Findings will be reported to the QA Committee by the Administrator or Designee x 3 months for review and follow up as needed. Date of Correction: / /	

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F 155	Continued From page 2 During a further interview with the Nursing Home Administrator on at 4:55 PM she reported when she started working at the facility she found a stack of incomplete admission packets and had to recruit staff from other facilities to help get them completed. The Nursing Home Administrator denied awareness of any attempt to get Resident #1's representative to sign an admission packet because she said Resident #1 did not leave the facility long enough to require a new packet to be signed. She acknowledged that no admission packet was ever provided to Resident #1's representative. Review of the facility's admission packet revealed it contained information on advance directives and the right to refuse treatment as well as the facility policies to implement advance directives.	F 155		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the	F 156	It is the practice of the facility to provide admission packets which include the admission agreement with notification of charges, the resident's bill of rights, facility admission and discharge policies, and information on advanced directives. The responsible party for Resident #1 was provided an admission packet.	

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F 156	Continued From page 3 resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification	F 156	The Admission Director and the Admission Coordinator were educated on completing the admission packet. An audit was completed on current residents and patients, and admission packets were provided if indicated. The Admission Director or designee will complete random audits of admission packets weekly x 4 weeks then monthly x 3 months thereafter. Findings will be reported to the QA Committee by the Administrator or Designee x 3 months for review and follow up as needed. Date of Correction: / /	

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F 156	Continued From page 4 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident , neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide an admission agreement with notification of charges, the resident's bill of rights, facility admission and discharge policies, and information on advance directives for 1 of 5 sampled residents (Resident #1) resident's representative upon admission. This failure to disclose the charges and conditions of Resident #1's stay upon admission prevented the family from managing his income properly to cover his expenses. The findings include:	F 156		

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F 156	Continued From page 5	F 156		

Record review revealed Resident #1 was first admitted to the facility on 11/ . Resident #1 was unable to make his own medical or financial decisions, a family member acted as his representative.

An interview was conducted with the Admissions Director on 11/ at 10:44 AM. The Admissions Director explained residents or their representatives are informed upon admission of their copays and deductibles when they sign the admission packet. She referred to the Business Manager when asked to view an admission packet for Resident #1.

An interview was conducted on at 10:54 AM with the Business Manager, who reported she had been at the facility for 9 years. The Business Manager reported Resident #1 was admitted under hospice and no admission packet was signed. Upon further inquiry the Business Manager stated an admission packet should have provided and signed for but persons who no longer worked there did not get this done. The Business Manager also explained when a resident leaves the facility for more than 15 days a new admission packet must be completed by the resident/representative. Although she reported Resident #1 was out of the facility from to , the Business Manager admitted no admission packet was provided or signed upon his readmission on . The Business Manager confirmed Resident #1's charges were not discussed with his representative when he came off of hospice on because she said there was no patient responsibility at that time and she didn't know there would be a patient responsibility. The

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F 156	Continued From page 6	F 156		

Business Manager stated Medicaid sends a letter directly to the responsible party and the facility, letting them know of the patient responsibility and she herself also tells the responsible party of the patient responsibility after she sees the letter. The Business Manager was unable to provide documentation of this discussion. The Business Manager denied providing Resident #1's representative a written notification of his charges when his payor source changed to Medicaid again on .

During an interview with the Nursing Home Administrator on at 4:34 PM, she also confirmed there was no admission packet for Resident #1, who had resided in the facility since . The Nursing Home Administrator stated there was nothing signed by Resident #1's representative until the facility refused to readmit Resident #1 from the hospital for nonpayment of charges and the representative signed for his payment arrangements.

During another interview with the Business Manager on at 4:54 PM, she stated she did not have a letter of approval for Medicaid for Resident #1, therefore she did not receive one and did not know he had a patient responsibility until they started seeing the bills.

During a further interview with the Nursing Home Administrator on at 4:55 PM, she reported when she started working at the facility she found a stack of incomplete admission packets and had to recruit staff from other facilities to help get them completed. The Nursing Home Administrator denied awareness of any attempt to get Resident #1's representative to sign an admission packet because she said

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F 156	Continued From page 7 Resident #1 did not leave the facility long enough to require a new packet be signed. She acknowledged that no admission packet was ever provided to Resident #1's representative. Review of facility admission packet revealed it contained an admission agreement, resident's bill of rights, advance directive information, the facility's admission and discharge policies, state resources such as advocacy groups, board rates, and a list, but not the standard charges, of covered and noncovered services and supplies.	F 156		

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N 000	INITIAL COMMENTS An unannounced licensure complaint survey, CCR# 2015011763, was conducted on 11/23/15 and 11/25/15 at Heartland of Tamarac. The allegations were substantiated. The facility had deficiencies at the time of the investigation.	N 000	The statements made on this plan of correction are not an admisson to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
N 030 SS=D	59A-4.106(1)(a) FAC Resident Notice of Policies Each resident will receive, at the time of admission and as changes are being made and upon request, in a language the resident or his representative understands: 1. A copy of the resident's bill of rights conforming to the requirements in Section 400.022, F.S.; 2. A copy of the facility's admission and discharge policies; and 3. Information regarding advance directives. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to have an admission packet signed upon admission for 1 of 5 sampled residents (Resident #1) or to provide the required information to the resident's representative including the resident's bill of rights, facility admission and discharge policies, and information on advance directives. The findings include: Record review revealed Resident #1 was first	N 030	It is the practice of the facility to provide admission packets which include notice of right to refuse treatment, to refuse to participate in experimental research, and to formulate an advanced directive. The responsible party for Resident #1 was provided an admission packet. The Admission Director and the Admission Coordinator were educated on completing the admission packet. An audit was completed on current residents and patients, and admission packets were provided if indicated.	

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N 030	Continued From page 1	N 030		

admitted to the facility on . Resident #1 was not able to make his own medical or financial decisions, a family member acted as his representative.

During an interview with the Business Manager on 11/25/15 at 10:54 AM she reported Resident #1 was admitted under and no admission packet was signed. Upon further questioning the Business Manager stated an admission packet should have been provided and signed for but the prior admissions personnel did not get this done. The Business Manager also explained if a resident leaves the facility for more than 15 days a new admission packet must be completed by the resident/representative. Although she reported Resident #1 was out of the facility from to ., the Business Manager admitted no admission packet was provided or signed upon his readmission on .

During an interview with the Nursing Home Administrator on 11/25/15 at 4:34 PM, she also confirmed there was no admission packet for Resident #1, who had resided in the facility since .

During a further interview with the Nursing Home Administrator on 11/25/15 at 4:55 PM< she reported when she started working at the facility there was a stack of admission packets that had not been completed and she recruited staff from other facilities to help get them completed. The Nursing Home Administrator denied awareness of any attempt to get Resident #1's representative to sign an admission packet because she said Resident #1 did not leave the facility long enough to require a new packet be signed. She acknowledged that no packet was ever provided to Resident #1's representative.

The Admission Director or designee will complete random audits of admission packets weekly x 4 weeks then monthly x 3 months thereafter.

Findings will be reported to the QA Committee by the Administrator or Designee x 3 months for review and follow up as needed.

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N 030	Continued From page 2 Review of the admission packet revealed it contains the resident's bill of rights, facility's admission and discharge policies, and advance directive information. Class III	N 030		
N 031 SS=D	400.151(1-2) FS; 59A-4.106(1)(b) FAC Resident Contracts 400.151, FS (1) The presence of each resident in a facility shall be covered by a contract, executed by the licensee and the resident or his or her designee or legal representative at the time of admission or prior thereto and at the expiration of the term of a previous contract, and modified by the licensee and the resident or his or her designee or legal representative at the time the source of payment for the resident's care changes. Each party to the contract is entitled to a duplicate original thereof, printed in boldfaced type, and the licensee shall keep on file all contracts which it has with residents. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration or such longer period as may be provided in the rules of the agency. Microfilmed records or records reproduced by a similar process of duplication may be kept in lieu of the original records. (2) Each contract to which this section applies shall contain express provisions specifically setting forth the services and accommodations to be provided by the licensee, the rates or charges therefor, bed reservation and refund policies, and any other matters which the parties deem	N 031	It is the practice of the facility to provide admission packets which include the admission agreement with notification of charges, the resident's bill of rights, facility admission and discharge policies, and information on advanced directives. The responsible party for Resident #1 was provided an admission packet. The Admission Director and the Admission Coordinator were educated on completing the admission packet. An audit was completed on current residents and patients, and admission packets were provided if indicated.	

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N 031	Continued From page 3 appropriate. The licensee shall attach to the contract a list of services and supplies available but not covered by the per diem rate of the facility or by Titles XVIII and XIX of the Social Security Act and the standard charge to the resident for each item. The licensee shall provide written notification to each party to the contract of any changes in any attachment thereto, no fewer than 14 days in advance of the effective date of those changes. The agency shall specify by rule an alternative method for notification of changes in the cost of supplies. If the resident is a party to the contract, the licensee shall provide him or her with a written and oral notification of the changes. 59A-4.106(1)(b), FAC Each resident admitted to the facility shall have a contract in accordance with Section 400.151, F.S. which covers: 1. A list of services and supplies, complete with a list of standard charges, available to the resident, but not covered by the facility's per diem or by Title XVIII and Title XIX of the Social Security Act and the bed reservation and refund policies of the facility. 2. When a resident is in a facility offering continuing care, and is transferred from independent living or assisted living to the nursing home section, a new contract need not be executed; an addendum shall be attached to describe any additional services, supplies or costs not included in the most recent contract that is in effect.	N 031	The Admission Director or designee will complete random audits of admission packets weekly x 4 weeks then monthly x 3 months thereafter. Findings will be reported to the QA Committee by the Administrator or Designee x 3 months for review and follow up as needed. Date of Correction: 12/25/2015	

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N 031	Continued From page 4	N 031		

This Statute or Rule is not met as evidenced by:
Based on interview and record review the facility failed to have an admission agreement/contract signed upon admission, upon the subsequent changes of payor source, or upon readmission for 1 of 5 sampled residents (Resident #1). This failure to communicate up front charges for his stay prevented the family from making an informed decision about his placement and resulted in unexpected charges against his funds after the funds had already been dispursed.

The findings include:

Record review revealed Resident #1 was first admitted to the facility on . Resident #1 was unable to make his own medical or financial decisions and a family member acted as his representative.

An interview was conducted with the Admissions Director on 11/25/15 at 10:44 am. The Admissions Director explained residents or their representatives are informed upon admission of their copays and deductibles when they sign the admission packet. She referred to the Business Manager when asked to view an admission packet for Resident #1.

An interview was conducted on 11/25/15 at 10:54 am with the Business Manager, who reported she had been at the facility for 9 years. The Business Manager reported Resident #1 was admitted under and no admission packet was signed. Upon further questioning the Business

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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
	100626	A. BUILDING: _____ B. WING _____	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF TAMARAC	5901 NW 79TH AVENUE TAMARAC, FL 33321

(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
N 031	Continued From page 5 Manager stated an admission packet should have been provided and signed for but she did not know why the prior admissions team, who no longer worked there, did not get this done. The Business Manager also explained when a resident leaves the facility for more than 15 days a new admission packet must be completed by the resident/representative. Although she reported Resident #1 was out of the facility from to , the Business Manager admitted no admission packet was provided or signed upon his readmission on . Further, the Business Manager admitted Resident #1's charges were not discussed with his representative when he came off of on because she said there was no patient responsibility at that time and she didn't know there would be a patient responsibility. The Business Manager stated Medicaid sends a letter directly to the responsible party and the facility letting them know of the patient responsibility and she herself also tells the responsible party of the patient responsibility after she sees the letter. The Business Manager was unable to provide documentation of this discussion. The Business Manager denied providing Resident #1's representative a written notification of his charges when his payor source changed to again on . During an interview with the Nursing Home Administrator on 11/25/15 at 4:34 pm, she also confirmed there was no admission packet for Resident #1, who had resided in the facility since . The Nursing Home Administrator stated there was nothing signed by Resident #1's representative until the facility refused to readmit Resident #1 from the hospital for nonpayment of charges and his represnetative signed for payment arrangements.	N 031		

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N 031	Continued From page 6 During another interview with the Business Manager on 11/25/15 at 4:54 pm she stated she did not have a letter of approval for for Resident #1, therefore she did not receive one and did not know he had a patient responsibility until they started seeing the bills. During further interview with the Nursing Home Administrator on 11/25/15 at 04:55 pm she reported when she started working at the facility there was a stack of admission packets that had not been completed and she recruited staff from other facilities to help get them completed. The Nursing Home Administrator denied awareness of any attempt to get Resident #1's representative to sign an admission packet because she said Resident #1 did not leave the facility long enough, since she had been there, to require a new packet be signed. She acknowledged that no admission packet was ever provided to Resident #1's representative. Review of the facility admission packet revealed it contains the admission agreement, room and board rates, and a list of covered and noncovered services and supplies. It was also noted that the provided list of noncovered supplies and services did not include the required listing of standard charges. Class III	N 031		

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Heartland Of Tamarac
5901 NW 79th Avenue
Tamarac, FL 33321

RE: CCR #2015011763

Dear Administrator:

On , 2015 and , 2015, a complaint survey was conducted in your facility by a representative of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit. **You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed report.**

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than , 2015.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed **, 2016** if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **, 2016** if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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 cons application of the survey process.

Thank you for the assistance provided to the representative. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

R6WB