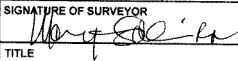


POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 105492	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/15/2016
NAME OF FACILITY CONSULATE HEALTH CARE OF WEST PALM BEACH	STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL 33406	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0248	Correction	ID Prefix F0278	Correction	ID Prefix F0280	Correction
Reg. # 483.15(f)(1)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	10/22/2016	LSC	10/22/2016	LSC	10/22/2016
ID Prefix F0309	Correction	ID Prefix F0311	Correction	ID Prefix F0325	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	10/22/2016	LSC	10/22/2016	LSC	10/22/2016
ID Prefix F0332	Correction	ID Prefix F0333	Correction	ID Prefix F0371	Correction
Reg. # 483.25(m)(1)	Completed	Reg. # 483.25(m)(2)	Completed	Reg. # 483.35(i)	Completed
LSC	10/22/2016	LSC	10/22/2016	LSC	10/22/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	10/22/2016	LSC	10/22/2016	LSC	10/22/2016
ID Prefix F0514	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(i)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/22/2016	LSC		LSC	
REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS)	DATE 11/16/16	SIGNATURE OF SURVEYOR 		DATE 11/16/16
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			<input type="checkbox"/> YES <input type="checkbox"/> NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 95032		Y1	MULTIPLE CONSTRUCTION A. Building B. Wing		Y2	DATE OF REVISIT 11/15/2016	Y3
NAME OF FACILITY CONSULATE HEALTH CARE OF WEST PALM BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1626 DAVIS RD WEST PALM BEACH, FL 33406				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix N0054	Correction	ID Prefix N0093	Correction	ID Prefix N0101	Correction
Reg. # 59A-4.107(5), FAC	Completed	Reg. # 59A-4.112(4), FAC	Completed	Reg. # 400.141(1)(j), FS; 59A-4.118(2), FAC	Completed
LSC	10/22/2016	LSC	10/22/2016	LSC	10/22/2016
ID Prefix N0201	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 400.022(1)(f), FS	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/22/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	<input checked="" type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	<input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			<input type="checkbox"/> YES <input type="checkbox"/> NO



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 16, 2016

Administrator
Consulate Health Care Of West Palm Beach
1626 Davis Rd
West Palm Beach, FL 33406

Dear Administrator:

This letter reports the findings of a federal certification and state licensure survey revisit conducted on November 15, 2016 by representatives of this office.

Attached are the provider's copies of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit.

You will not receive a copy of this report in the mail; you will only receive this electronic 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 representatives. Should you have any questions please call the field office at (561) 381-5840.

Sincerely,

Maryanne Salerni for

Arlene Mayo-Davis
Field Office Manager

AMD/ch
Enclosure

J5XD

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