

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 A second revisit survey was conducted on at New Horizon Assisted Living Inc. The provider had deficiencies at the time of the survey.	{A 000}		
A 125 SS=D	429.27(2) FS; 59A-36.013(3) FAC Fiscal - Surety Bonds 429.27 (2) A facility, or an owner, administrator, employee, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. An owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the consent of the resident. Any facility whose owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a	A 125		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 125	Continued From page 1 result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection. 59A-36.013 (3) SURETY BONDS. Pursuant to the requirements of section 429.27(2), F.S.: (a) For entities that own more than one facility in the state, one surety bond may be purchased to cover the needs of all residents served by the entities. (b) The following additional bonding requirements apply to facilities serving residents receiving : 1. If serving as representative payee for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include any supplemental security income or social security , income plus the payments, including the personal needs allowance. 2. If holding a power of attorney for a resident receiving , the minimum bond proceeds must equal twice the value of the resident's monthly aggregate income, which must include	A 125			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 125	Continued From page 2 any supplemental security income or social security income; the payments, including the personal allowance; plus the value of any property belonging to a resident held at the facility. (c) Upon the annual issuance of a new bond or continuation bond, the facility must file a copy of the bond with the Agency Central Office. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Administrator who served as representative payee for several residents filed for a surety bond with the agency in an amount equal to twice the average monthly aggregated income or personal funds due to residents, or expendable for their account, which are received by a facility. Findings: A review of the facility's records found the surety bond expired. Interviewed on _____ at 11:47 when asked if he had a surety bond, the Administrator stated, "I do have it (Surety Bond), but it was expired. When asked how many residents received _____ (), the Administrator stated, "five residents." When asked if he was a payee for any of the five residents, the Administrator did not provide an answer. Class III	A 125			
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 152	Continued From page 3 (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable _____ to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, _____ or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be _____. This Statute or Rule is not met as evidenced by:	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 152	Continued From page 4 Based on observation and interview, the facility failed to provide a safe living environment free of hazards. Additionally, the facility failed to ensure architectural and structural appurtenances were maintained. Findings: An observation on _____ at 10:43AM showed Resident # 2 holding in his _____ a screwdriver and a pair of pliers walking out from the facility to the front porch area. An observation on _____ at 10:54AM showed a hammer in a plastic container in the backyard. (photographic evidence obtained). An observation on _____ at 10:56AM showed a 25- _____ gym _____ lying beside 4 propane cylinders. (photographic evidence obtained). In an interview on _____ at 10:55AM, Staff C was asked why there was hammer in the backyard, Staff C stated, "that hammer belongs to Resident # 3". In an interview on _____ at 10:57AM, Staff C was asked why a 25- _____ gym _____ in the backyard was by the propane cylinders, Staff C stated, "That _____ belongs to a resident, I am not sure which one". In an interview on _____ at 12:20PM, the Administrator was asked why Resident # 2 had a screwdriver and flat _____ pliers, the Administrator stated, "Resident # 2 is a mechanic and was fixing the water pump in the _____ of the house". Class III	A 152		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033	
(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)
{A 162} SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to	{A 162}	
			(X5) COMPLETE DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 162}	Continued From page 6 residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required	{A 162}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 162}	Continued From page 7 documentation from the Department of Children and Families. (m) Documentation of the . . . of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain complete health records for one out of six sampled residents. (#1).	{A 162}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 162}	Continued From page 8 Findings: Reviewed Resident #1's record showed another person's health assessment from a different facility. (photographic evidence obtained) In an interview on _____ at 12:19PM, The Administrator was asked why there was another person's health assessment in Resident # 1's files, The Administrator stated, "Oh yes, this health assessment is from another person. This person does not belong to this facility. Let me call to see if they have Resident # 1's health assessment in the other facility's file. I messed up". An observation on _____ at 12:25PM showed the Administrator calling the other ALF to find the correct health assessment. Class III	{A 162}		
A 180 SS=D	59A-36.019(1) FAC Emergency Management (1) EMERGENCY PLAN COMPONENTS. Pursuant to Section 429.41, F.S., each facility must prepare a written comprehensive emergency management plan using "Minimum Emergency Management Planning Criteria for Assisted Living Facilities," AHCA Form 3180-5006, _____, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-15964 . The form is also available at: https://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml . The emergency management plan must, at a minimum, address the following: (a) Provision for all hazards;	A 180		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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 180	Continued From page 9 (b) Provision for the care of residents remaining in the facility during an emergency, including pre-disaster or emergency preparation; protecting the facility; supplies; emergency power; food and water; staffing; and emergency equipment; (c) Provision for the care of residents who must be evacuated from the facility during an emergency including identification of such residents and transfer of resident records; evacuation transportation; sheltering arrangements; supplies; staffing; emergency equipment; and medications; (d) Provision for the care of additional residents who may be evacuated to the facility during an emergency including the identification of such residents, staffing, and supplies; (e) Identification of residents with _____'s or related _____, and residents with mobility limitations who may need specialized assistance either at the facility or in case of evacuation; (f) Identification of and coordination with the county emergency management agency; (g) Arrangement for post-disaster activities including responding to family inquiries, obtaining medical intervention for residents, transportation, and reporting to the county emergency management agency the number of residents who have been relocated, and the place of relocation; and, (h) The identification of staff responsible for implementing each part of the plan. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide documentation of an approved Comprehensive Emergency Management Plan (CEMP), including a mutual aid agreement in the event of an	A 180			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/23/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NEW HORIZON ASSISTED LIVING INC

**30110 SW 145 CT
HOMESTEAD, FL 33033**

(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 180	Continued From page 10 evacuation. The facility failed to provide an approved updated emergency power plan (EPP) with substantive changes. Findings: A review of the facility's records showed an approved on _____ for the 2024 renewal and a renewal for 2025 submitted on _____. However, there were no receipts to show it was paid, including the mutual aid agreements documents attached were found. A review of the facility's records found no approved letter from the emergency management agency for the emergency power plan for a fixed generator for 2024 or 2025 with any changes from a portable to a fixed generator. Interviewed on _____ 2025 at 11:50 AM the Administrator accused the agency staff of just wanting to give a citation and requested the supervisor's number. The Administrator stated further that it was a one-time submission for the emergency power plan and he did not have to make any new submissions. The Administrator stated that he submitted the CEMP and that he made the payment, but he did not have the documents in the facility and that once it was approved, he would have the agreements in the facility. A review of an email from the emergency management agency states: "Please note, your facility's CEMP is not considered as submitted, nor will it be reviewed, until the required CEMP review fee is successfully paid." Class III	A 180		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/23/2025
NAME OF PROVIDER OR SUPPLIER NEW HORIZON ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 30110 SW 145 CT HOMESTEAD, FL 33033		
(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