

Agency for Health Care Administration

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|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967819</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/12/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NUEVA VIDA ALF INC</b> |                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1901 W OKALOOSA AVENUE<br/>TAMPA, FL 33604</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                               | ID<br>PREFIX<br>TAG                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                         | Initial Comments<br><br>Assisted Living Facility<br><br>A complaint survey, CCR# 2013003900, was<br>conducted on 4/12/13.<br><br>The Nueva Vida ALF Inc., assisted living facility,<br>had no deficiencies found at the time of the visit. | A 000                                                                                      |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6500

9SHP11

If continuation sheet 1 of 1

RICK SCOTT  
GOVERNOR



ELIZABETH DUDEK  
SECRETARY

April 22, 2013

Administrator  
Nueva Vida Alf Inc  
1901 W Okaloosa Avenue  
Tampa, FL 33604

**Re: CCR# 2013003900**

Dear Administrator:

This letter reports the findings of a complaint survey completed on April 12, 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, indicating no deficiencies were identified during this 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 surveyor. Should you have any questions, please contact **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

For

Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

