

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
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 Complaint Survey (CCR #20130046120) was conducted in your Assisted Living Facility on . . . New Horizon Assisted Living Inc, had deficiencies found at the time of the survey.	A 000			
AZ806 SS=D	59A-35.040, FAC Change of Address (2) Any request to amend a license must be received by the Agency in advance of the requested effective date as detailed below. Requests to amend a license are not authorized until the license is issued. (a) Requests to change the address of record must be received by the Agency 60 to 120 days in advance of the requested effective date for the following provider types: 1. Birth Centers, as provided under Chapter 383, F.S.; 2. Abortion Clinics, as provided under Chapter 390, F.S.; 3. Crisis Stabilization Units, as provided under Parts I and of Chapter 394, F.S.; 4. Short Term Residential Treatment Units, as provided under Parts I and of Chapter 394, F.S.; 5. Residential Treatment Facilities, as provided under Part of Chapter 394, F.S.; 6. Residential Treatment Centers for Children and Adolescents, as provided under Part of Chapter 394, F.S.; 7. Hospitals, as provided under Part I of Chapter 395, F.S.; 8. Ambulatory Surgical Centers, as provided under Part I of Chapter 395, F.S.; 9. Nursing Homes, as provided under Part II of Chapter 400, F.S.; 10. Hospices, as provided under Part of Chapter 400, F.S.; 11. Homes for Special Services as provided	AZ806			

AHCA Form 3020-0001

TITLE

(X8) DATE

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

STATE FORM

5899

IDKZ11

If continuation sheet 1 of 4

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AZ806	Continued From page 1 under Part V of Chapter 400, F.S.; 12. Transitional Living Facilities, as provided under Part V of Chapter 400, F.S.; 13. Prescribed Extended Care Centers, as provided under Part VI of Chapter 400, F.S.; 14. Intermediate Care Facilities for the as provided under Part VIII of Chapter 400, F.S.; 15. Assisted Living Facilities, as provided under Part I of Chapter 429, F.S.; 16. Adult Family-Care Homes, as provided under Part II of Chapter 429, F.S.; 17. Adult Day Care Centers, as provided under Part III of Chapter 429, F.S. (b) Requests to change the address of record must be received by the Agency 21 to 120 days in advance of the requested effective date for the following provider types: 1. Drug Free Workplace Laboratories as provided under Sections 112.0455 and 440.102, F.S.; 2. Mobile Surgical Facilities, as provided under Part I of Chapter 395, F.S.; 3. Health Care Risk Managers, as provided under Part I of Chapter 395, F.S.; 4. Home Health Agencies, as provided under Part III of Chapter 400, F.S.; 5. Nurse Registries, as provided under Part III of Chapter 400, F.S.; 6. Companion Services or Homemaker Services Providers, as provided under Part III of Chapter 400, F.S.; 7. Home Medical Equipment Providers, as provided under Part VII of Chapter 400, F.S.; 8. Health Care Services Pools, as provided under Part IX of Chapter 400, F.S.; 9. Health Care Clinics, as provided under Part X of Chapter 400, F.S., including certificate of exemption; 10. Clinical Laboratories, as provided under Part I of Chapter 483, F.S.;	AZ806			

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AZ806	Continued From page 2 11. Health Testing Centers, as provided under Part II of Chapter 483, F.S.; 12. Organ and Tissue Procurement Agencies, as provided under Chapter 381, F.S. (c) All other requests to amend a license including but not limited to services, licensed capacity, and other specifications which are required to be displayed on the license by authorizing statutes or applicable rules must be received by the Agency 60 to 120 days in advance of the requested effective date. This deadline does not apply to a request to amend hospital emergency services defined in Section 395.1041(2), F.S. (3) Failure to submit a timely request shall result in a \$500 fine. (4) A licensee is not authorized to operate in a new location until a license is obtained which specifies the new location. Failure to amend a license prior to a change of the address of record constitutes unlicensed activity. (5) The licensee shall return the license certificate to the Agency upon the rendition of a final order revoking, cancelling or denying a license, and upon the voluntary discontinuance of operation. This Statute or Rule is not met as evidenced by: Based on record review and interview facility exceeded its license capacity of 6 residents without prior approval from the AGENCY. Findings include: Facility's admission log review revealed that resident #3 admitted to the facility on _____ and was discharged on _____. Resident occupied _____.	AZ806			

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AZ806	Continued From page 3 # . Resident #6 occupied # . and was admitted on Resident #8 occupied # . and was admitted on and discharged on Resident #5 occupied # . and was admitted on Resident #4 was admitted on and occupied # . Resident #1 admitted on and occupied # . Resident #2 was admitted on and occupied # . Facility exceeded its license capacity of 6 residents from to Administrator acknowledged the findings on at 2:00 pm Class III	AZ806			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
New Horizon Assisted Living Inc
30110 Sw 145 Ct
Homestead, FL 33033

CCR# 2013004612

Dear Administrator:

This letter reports the findings of a state complaint survey that was conducted on , 2013 by representative(s) of 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 6/22/2013 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 surveyor(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

