

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/30/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968090	(X3) DATE SURVEY COMPLETED 03/17/2015
NAME OF PROVIDER OR SUPPLIER PARK PLACE ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8200 SW 43RD TERRACE MIAMI, FL 33155	

**SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)**

0000 - Initial Comments

A Limited Nursing Services Monitoring survey was conducted on March 17th, 2015. Park Place Assisted Living, Inc did not have deficiencies at time of the survey.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11968641

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
3/17/2015

Name of Facility

NEW AGE ADULTCARE INC

Street Address, City, State, Zip Code

1105 W 2ND AVENUE
HIALEAH, FL 33010

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0152	Correction Completed 03/17/2015	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # 58A-5.023(3) FAC LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
Reviewed By

Date:
Date:

Signature of Surveyor:
Signature of Surveyor:

Date:
Date:

Followup to Survey Completed on:

1/8/2015

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 30, 2015

Administrator
Park Place Assisted Living, Inc
8200 Sw 43rd Terrace
Miami, FL 33155

Dear Administrator:

This letter reports findings of a Limited Nursing Services Monitoring survey that was conducted on March 17, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

A handwritten signature in black ink, appearing to read "Arlene Mayo-Davis".

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

1GGN

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