STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966320	**06/18/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
NEW ERA ASSISTED LIVING	**815 WEST DAUGHTERY RD LAKELAND, FL 33809**	

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

0000 - Initial Comments

Assisted Living Facility

A Biennial state licensure survey with Limited Nursing Services (LNS) and Limited Mental Health services (LMH) was conducted on .

The New Era Assisted Living facility had one deficiency at the time of the visit.

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to maintain required documentation concerning power of attorney for 1 (#12) of 2 residents sampled for contracts.

Findings Include:

Record review on of Resident #12's financial record revealed that Resident #12's facility contract was signed by another person. A further review of Resident #12's contract revealed a lack of required documentation of an appointment of guardianship or power of attorney for the person that did sign the contract.

The Assistant Administrator was interviewed on , at approximately 12:30 P.M. and asked for documentation concerning the legal status of the individual who signed the contract for the Resident. The Assistant Administrator stated that the individual is the Resident's power of attorney. The Assistant Administrator reviewed the file and stated that the documentation was not there.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
New Era Assisted Living
815 West Daughtery Rd
Lakeland, FL 33809

Dear Administrator:

This letter reports the findings of a Biennial state licensure survey with Limited Nursing Services (LNS) and Limited Mental Health Services (LMH) that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Paul Brown

FOR Patricia Reid Caufman
Field Office Manager

PRC/src
Enclosure: State (5000-3547) Form

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