STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967828	07/23/2015
NAME OF PROVIDER OR SUPPLIER **NEW GREENVIEW II ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2650 NW 15TH AVENUE** **MIAMI, FL 33142**	

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

0000 Initial Comments

A Complaint Survey #2015007716 was conducted on / . New Greenview II Assisted Living Facility, Inc. with Limited Mental Health component had the following deficiency found at the time of the survey:

0160 Records - Facility

The facility failed to maintain an up to date admission and discharge log for two out of twelve (#2 and 3) sampled residents.

Findings Included:

Observation during the Facility tour on at 10:05 AM revealed, twelve residents identified as living at the Facility. Record review revealed, the Facility's Admission and Discharge log did not include Resident #2, who was admitted on / and Resident #3 who was admitted on / .

During an interview on at 7:00 AM, the Facility's manager stated, " resident #2 has been here since / and #3 since / / , we have a month to do the file.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
New Greenview II Alf, Inc
2650 NW 15th Avenue
Miami, FL 33142

RE: CCR #2015007716

Dear Administrator:

This letter reports the findings of a state licensure survey 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 attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.
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,

Arlene Mayo-Davis
Field Office Manager

amd
Enclosure
XG90

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