

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/04/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968543	(X3) DATE SURVEY COMPLETED 10/27/2015
NAME OF PROVIDER OR SUPPLIER NEW BEGINNING ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 418 NW 21ST TERRACE CAPE CORAL, FL 33993	

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

0000 Initial Comments

An unannounced Monitoring visit was conducted on / at New Beginning Assisted Living, Inc., an assisted living facility in Cape Coral, Florida.

The following is a description of the cited deficiency:

0162 Records - Resident

Based on record review and interview, the facility failed to have available for review a current Resident Contract for 1 (Resident #1) out of 2 residents sampled.

The findings included:

Review of Resident #1's record revealed no contract with the facility was available in the file or on the premises.

During an interview with Staff A on at 12:35 p.m., he agreed that there was no contract available. Staff A reported that the Administrator texted him to inform the surveyor that a faxed copy of the resident's contract was faxed to the Agency for Health Care Administration (AHCA) Area 08 office in , 2015.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 15, 2015

Administrator
New Beginning Assisted Living, Inc
418 Nw 21st Terrace
Cape Coral, FL 33993

Dear Administrator:

This letter reports the findings of a state licensure monitoring visit that was conducted on January 15, 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for the deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than January 30, 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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