STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967061	08/26/2016
NAME OF PROVIDER OR SUPPLIER **MY NEW HOME ALF I, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7151 SW 42ND STREET** **MIAMI, FL 33155**	

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

0000 Initial Comments

A Licensure Monitoring Survey to check on the residents was conducted on at My New Home ALF, Inc with Limited Mental Health component. There were deficiencies found at time of the survey. (Lic #11164)

0189 ADCCs in ALF

Based on record review and interview the facility failed to have one out of the six sampled residents/participants (#6) completed contract for daycare services.

Findings included:

Record interview revealed Participant #6 was admitted to the facility for daycare services. Participant #6 did not have the monthly rate listed on the contract signed on . Record review also found the participant was not listed on the day care log.

Interviewed the Administrator on at 2:00 PM, with the help of her daughter as an interpreter, the Administrator stated that she had forgotten to put the monthly amount on the contract and will take of that as soon as possible.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
My New Home Alf I, Inc
7151 Sw 42nd Street
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a Licensure Monitoring Survey that was conducted on 26, 2016 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** 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, RN
Field Office Manager

AMD:ve
Enclosure

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