

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/18/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968543	(X3) DATE SURVEY COMPLETED R 11/03/2016
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 revisit was conducted on 11/3/16 at New Beginnings Assisted Living Inc. (license #12436) an Assisted Living facility in Cape Coral, Florida. This was the second follow-up to the Biennial and Limited Nursing Services survey completed

The following is description of deficiency found at the time of this visit.

Z815 Background Screening: Prohibited Offenses

Based on record review and interview, the facility failed to have a required current background screening for 1 (Staff C) out of 4 staff records reviewed.

The findings included:

Record review for Staff C, a resident aide hired , revealed a background screening dated with the following wording on the form "Screening in Process."

Record review of the Agency website on // found the same wording: Screening in Process. Agency review required.

No further information found on record.

During an interview with Staff B on // at 10:39 a.m., she acknowledged that Staff C actively works in the facility. She said she works Mondays, Wednesdays and Fridays from 9:00 p.m. to 9:00 a.m.

Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968543	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
NAME OF FACILITY NEW BEGINNING ASSISTED LIVING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 418 NW 21ST TERRACE CAPE CORAL, FL 33993	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0007 Reg. # 429.26(11) FS; 58A-5.0181(1) FAC LSC	Correction Completed	ID Prefix A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed
ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed	ID Prefix A0082 Reg. # 58A-5.0191(3) FAC LSC	Correction Completed	ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC	Correction Completed
ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed	ID Prefix A0091 Reg. # 58A-5.0191(12) FAC LSC	Correction Completed	ID Prefix A0152 Reg. # 58A-5.023(3) FAC LSC	Correction Completed
ID Prefix A0161 Reg. # 429.275(2) FS; 58A-5.024(2) FAC LSC	Correction Completed	ID Prefix AN276 Reg. # 58A-5.031(1) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) <i>SD</i>	DATE 11-18-16	SIGNATURE OF SURVEYOR <i>Aurora White for Stephanie S. S. S.</i>	DATE 11-18-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 3, 2016 by representative(s) of this office.

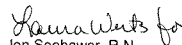
Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 this office at (239) 335-1315.

Sincerely,


Jon Seehawer, R.N.
Filed Office Manager

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Enclosure: State Form and Revisit Report

YOSF

