STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969248	**08/15/2017**
NAME OF PROVIDER OR SUPPLIER **ARENAS BLANCAS CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **4380 NW 175TH ST** **MIAMI GARDENS, FL 33055**	

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

0000 - Initial Comments

An Initial Licensure Survey was conducted on 08/15/17. Arenas Blancas Corp. with a Standard license had no deficiencies found at the time of the survey. A recommendation will be sent to the Assisted Living Unit for licensure for six persons.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969248	A. BUILDING: _____ B. WING _____	08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARENAS BLANCAS CORP	4380 NW 175TH ST MIAMI GARDENS, FL 33055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An Initial Licensure Survey was conducted on 08/15/17. Arenas Blancas Corp. with a Standard license had no deficiencies found at the time of the survey. A recommendation will be sent to the Assisted Living Unit for licensure for six persons.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE