AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969038	07/06/2016
NAME OF PROVIDER OR SUPPLIER **NUEVO HORIZONTE ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8111 N OLA AVE** **TAMPA, FL 33604**	

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

0000 Initial Comments

Assisted Living Facility

On 7/6/16 an initial state licensure survey was conducted at Nuevo Horizonte ALF Inc. Nuevo Horizonte Assisted Living Facility Inc. had no deficiencies at the time of the visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 12, 2016

Administrator
Nuevo Horizonte Alf Inc.
8111 N Ola Ave
Tampa, FL 33604

Dear Administrator:

This letter reports the findings of an initial state licensure survey conducted on July 6, 2016, by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Filed Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
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