

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966321</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/03/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**AMERICAN WELL CARE**

**6333 LANGSTON AVENUE  
NEW PORT RICHEY, FL 34652**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A Biennial Survey with Limited Mental Health, a fifth revisit to complaint investigation (Complaint Number 2019002873), a second revisit to complaint investigation (Complaint Numbers 2019008264 and 2019012291), a revisit to complaint investigation (Complaint Number 2019013833). Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000               |                                                                                                                          |                          |
| A 181<br>SS=D            | 59A-36.019(2) FAC Emergency Plan Approval<br><br>(2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency.<br>(a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised.<br>(b) A new facility as described in rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license.<br>(c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval.<br>1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule.<br>2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval.<br>(d) The local emergency management agency is | A 181               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
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| A 181                    | <p>Continued From page 1</p> <p>the final administrative authority for emergency management plans prepared by assisted living facilities.</p> <p>(e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and attempted record review, the facility failed to provide proof of an annual review and approval of its comprehensive emergency management plan (CEMP) by the local emergency management agency.</p> <p>Findings included:</p> <p>An interview was conducted with the Administrator at 1:29 PM on ..... and he was asked for proof of an annual review and approval for the facility's CEMP. The Administrator stated that he would attempt to find this documentation.</p> <p>The Administrator was interviewed again at 4:17 PM on ..... concerning proof of approval of the CEMP and he stated that he did not have it.</p> <p>Class III</p> | A 181               |                                                                                                                          |                          |