Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	AL11963974		06/03/2020

NAME OF PROVIDER OR SUPPLIER: AMERICAN ADVANCED SENIOR CARE LLC

STREET ADDRESS, CITY, STATE, ZIP CODE: 2298 BELLEAIR ROAD, CLEARWATER, FL 33764

(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 A Focused Control Survey and a Complaint Investigation (complaint number 2020009553) Survey was conducted on at American Advanced Senior Care. The facility had deficiencies at the time of the survey.	A 000		
A 181 SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (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. (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. (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. 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. 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. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.	A 181		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	AL11963974		06/03/2020

NAME OF PROVIDER OR SUPPLIER
AMERICAN ADVANCED SENIOR CARE LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
2298 BELLEAIR ROAD
CLEARWATER, FL 33764

(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 181	Continued From page 1 (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to review its emergency management plan on an annual basis and submit to the local emergency management agency for review and approval. In addition the facility failed to have documentation of testing the generator to ensure that it was operational. Findings included: A record review conducted on . . . . . of the facilities Comprehensive Emergency Management Plan (CEMP) revealed that the facilities last approved CEMP expired on . . . . . . During and interview conducted on . . . . . at 10:05am, the Administrator confirmed the lack of an approval letter from the local emergency management agency for their emergency management plan. The Administrator stated, "We don't have a current CEMP approved by the county." An attempted record conducted on . . . . . revealed that the facility had no documentation of testing the generator to ensure that it was that it was operational. During an interview conducted on at 12:20pm, the Administrator confirmed the lack of documentation of the generator being tested to ensure that it was operational. The Administrator stated, "I can't find anything about it being tested."	A 181		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	AL11963974		06/03/2020

NAME OF PROVIDER OR SUPPLIER

AMERICAN ADVANCED SENIOR CARE LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

2298 BELLEAIR ROAD
CLEARWATER, FL 33764

(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 181	Continued From page 2 Class III	A 181		