STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910149	11/13/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Amer Home	1918 Barrington Drive, W. Clearwater, FL 33763	

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

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A limited nursing services (LNS) monitoring visit was conducted on

The Amer Home, assisted living facility, had deficiencies at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure the health assessment included the required information for one (#1) of 2 record review.

Findings include:

Resident #1 health assessment review revealed a health assessment form signed by the physician. The form did not indicate the type of help with taking with medication the resident needed and was not dated.

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to ensure the criteria for residency was met for one (#1) of 2 sampled residents.

Findings include:

Record review revealed home health nursing notes dated documenting resident #1 had a on the inner thigh measured 2.0 x 3.0 x 1.2 centimeters and was listed as a The home health plan of care form dated through revealed the 60 day summary documented resident #1 was provided care from through for 2

During an interview with staff #C on at approximately 10:40 am she reported resident #1 has a on his inner thigh and the one on the is healed.

Further review of resident #1 health assessment form signed by the physician revealed the form indicated on page 3, the resident did not have any or III pressure sores.

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The physician notes dated . . . . documented the right inner thigh . . . measured 2.5 x 1 x 0.2 centimeters and the stage listed as

Class III

AHCA
FOR THE AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Amer Home
1918 Barrington Drive, W.
Clearwater, FL 33763

Dear Administrator:

This letter reports the findings of a limited nursing services (LNS) monitoring visit that was conducted on , 2013, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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