STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	06/12/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
American Well Care	6333 Langston Avenue New Port Richey, FL 34652	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, CCR# 2014002980 & CCR# 2014003687, were conducted on , in conjunction with a change of ownership survey with limited mental health services (LNS).

The American Well Care, assisted living facility, had a deficiency found at the time of this visit.

The following unrelated deficiency was cited relative to CCR# 2014003687: A 0165.

No deficiencies were cited relative to CCR# 2014002980.

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and Interview, the facility failed to submit a preliminary adverse incident report within 1 business day after an incident that required fire department emergency services, law enforcement investigation, and resident incarceration. The facility also failed to file a full report within 15 days of the incident.

Findings include:

During the afternoon of , a resident (#3) of the assisted living facility started a fire in an exterior shed located toward the left/back of the property. The shed was consumed by the fire when Fire Department emergency services personnel were dispatched to the facility on at approximately 4:10pm. Police investigation of the incident determined that the resident (#3) deliberately started the fire and walked away. Resident (#3) was for the crime of arson and incarcerated.

Per interview with Staff A on Resident #3 had a disagreement with another resident earlier in the day of the Incident and gathered items belonging to the other resident; while staff were busy preparing for dinner, Resident #3 went outside for a cigarette, as usual-It is then that Resident #3 purposely went to an exterior shed located toward the left/back of the property and started the fire. Nobody saw the fire until smoke was seen coming from the area due to time elapsed for fire to erupt and given shed ' s location away from the facility to the rear of the property.

The facility failed to submit an Incident Report pertaining to the Incident that prompted Complaint-CCR# 2014003687. The Incident Report was submitted to AHCA by the Administrator on (following AHCA facility visit). When interviewed via phone on , the Administrator stated to Surveyor that she did not report the incident because she did not think it was an adverse incident. When interviewed at the facility on , the Owner stated that the Incident " absolutely " needed to be reported and stated that the

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Administrator told him she had submitted the report.

Per fax submitted by current Administrator on : " At the time of the fire I was not the Administrator & I asked previous Administrator to file it & he said it was not necessary. " Per Surveyor notes from survey conducted at the facility on , a Change of Ownership occurred on , and the new, current Administrator began employment on . AHCA Surveyor had conducted an Interview with the new Administrator and new owner during the facility visit. The Adverse Incident occurred on .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
American Well Care
6333 Langston Avenue
New Port Richey, FL 34652

RE: CHOW with LMH & **CCR# 2014003687 & 2014002980**

Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey with limited mental health (LMH) services and a complaint survey that were conducted on , 2014, by representative(s) of this office.

Attached are the provider's copies of the State (5000-3547) Forms, which indicate no deficiencies were identified relative to the CHIW with LMH and the deficiency that was identified relative to the complaint survey. 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 deficiency 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,

Patricia Reid Gaufman
Field Office Manager

PRC/kpr

Enclosures: State (5000-3547) Forms

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