AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910149	**06/26/2015**
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

ASSISTED LIVING FACILITY

A Limited Nursing Services (LNS) monitoring visit was conducted on .

Amer Home , Assisted Living Facility, had deficiencies at the time of the visit.

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record review and interview, the facility failed to have a contract with a nurse when the facility has a Limited Nursing Services (LNS).
Findings include:
1. A record review of the Limited Nursing Service book revealed Nurse -A was contracted with the facility dated . 1, 2014, however she was not the nurse contracted with the facility.
2. An interview was conducted with Care Giver A on , at 9:15 AM stated that the Nurse named on the contract did not live in this state, but lived in another state.
3. An interview was conducted with the Assistant Administrator of the facility on . at 9:31 AM verified that another nurse was the nurse in the facility , but had no contract in place at the time of the visit.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a limited nursing services monitoring visit that was conducted on , 2015 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. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after 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/clt
Enclosure: State (5000-3547) Form

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