STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	08/17/2015
NAME OF PROVIDER OR SUPPLIER **AMERICAN WELL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **6333 LANGSTON AVENUE** **NEW PORT RICHEY, FL 34652**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015005713, was conducted on .

American Well Care, assisted living facility, had deficiencies at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to maintain a clean and decent living environment with proper sanitation for its residents.

Findings Include:

During a tour of the facility, 2 resident rest facing the dining observed at 10:20 A.M. The rest the left hand side had a typed statement on the door reading, "Please do NOT lock ". Hand written underneath that statement read, " out of oder ". The rest observed to be in disrepair with a cracked toilet lid, holes in the wall above the toilet, no hand towels or soap available and feces on the inside of the toilet rim.
An interview took place with Staff A at 10:50 A.M. Staff A stated that there are a lot of people here that use the rest . Staff A acknowledged that there were no paper towels or hand soap in the rest .
Class III

0054 Medication - Records

Based on interview and record review, the facility failed to properly document medication observation records and note reasons why residents missed medication dosages for 1 (Resident #3) of 4 records reviewed.

Findings Include:

A medication observation was conducted on / . A review of residents' medication observation records (MORs) showed that Resident #3 missed the morning (8:00 A.M.) medications on . The medications not taken were denoted by a circle and included Meylate 2 mg, HBR 10 mg, Clonzapam 0.5 mg, DR 500 mg, DR 125 mg, 200 mg, and 500 mg.
A review of the back of the MORs showed no notation as to why Resident #3 did not take the

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	08/17/2015
NAME OF PROVIDER OR SUPPLIER **AMERICAN WELL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **6333 LANGSTON AVENUE** **NEW PORT RICHEY, FL 34652**	

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

medications on .
An interview took place with Staff B on at approximately 11:15 A.M. concerning the lack of documentation concerning Resident #3's missed dosages. Staff B stated that Resident #2 doesn't like to get up in the morning and that Staff #B didn't notate a reason for the missed dosages on the MORs.

Class III

0056 Medication - Labeling and Orders

Based on interview and record review, the facility failed to ensure that that prescriptions for residents who receive assistance with self-administration were refilled in a timely manner for 1 (Resident #2) of 4 records reviewed.

Findings Include:

A medication observation was conducted on at 11:00 A.M. A review of Resident 2's medication observation record (MOR) showed a notation, "All medications " followed by " waiting on refills " dated , 2 P.M. on the back of the MOR.

Medications that were circled (denoted as doses not taken) for Resident #2 ' s MOR for included DR 125 mg Tab, 5 MG Tablet, 10 GM/ 15 ML Liquid, and 7.5 MG Tablet. Medications that were circled on / included 10 MG Tablet, 10 MG Tab, DR 125 MG Tab, and Fish Oil 1000 MG Cap (Omega-3).
An interview took place on at approximately 11:15 A.M. with Staff B concerning Resident #2's missing medication dosages and the notation concerning the refill. Staff B acknowledged that Resident #2 did not have the medications to take as ordered. She stated that there was a mistake and didn't know what happened.

Class III

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to maintain required documentation of an annual, negative examination for 1 (Staff B) of 3 records reviewed.

Findings Include:

An employee record review was conducted on . It was discovered that Staff B ' s last

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	08/17/2015
NAME OF PROVIDER OR SUPPLIER **AMERICAN WELL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **6333 LANGSTON AVENUE** **NEW PORT RICHEY, FL 34652**	

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

documented proof of an annual, negative examination (exam) occurred on . Staff B provides direct care to residents at the facility.

An interview with the Staff A took place on at 12:15 P.M. Staff A reviewed Staff B ' s file and then stated that Staff B will have the exam done tomorrow.

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on interview and record review, the facility failed to ensure that there was proof of the required, 4 hour initial training for unlicensed persons who provide assistance with self-administration of medications for 1 (Staff E) of 3 records reviewed.

Findings Include:

An employee record review was conducted on . It was discovered that Staff E ' s file did not contain proof of the required 4 hour initial training for unlicensed persons who provide assistance with self-administration of medications. The record showed a training certificate for a 2 hour training update dated .

An interview with Staff B indicated that Staff E assists residents with self-administration of medications.

An interview with Staff A took place on at 12:18 P.M. Staff A reviewed Staff E ' s employee record and stated that she sees the 2 hour update but did not see the initial 4 hour training.

Class III

0093 Food Service - Dietarv Standards

Based on interview and record review, the facility failed to maintain a required file of menu substitutions covering the last 6 month period.

Findings Include:

A meal substitution log, menu cycle and a copy of the registered dietician ' s credentials were requested from Staff A after entering the facility. The administrator presented documents including the facility ' s " Substitution List " .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	08/17/2015
NAME OF PROVIDER OR SUPPLIER **AMERICAN WELL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **6333 LANGSTON AVENUE** **NEW PORT RICHEY, FL 34652**	

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

A review of the " Substitution List " shows it only dates back to .

Staff A indicated that this was the list available. The requirement of having a 6 month listing of meal substitutions was discussed with Staff A.

Class III

0162 Records - Resident

Based on interview and record review, the facility failed to maintain required resident records on premises for 1(#4) of 3 records reviewed.

Findings Include:

A resident record review conducted on revealed that Resident #4 ' s record could not be found. This record is required to contain documentation such as personal resident information (demographic data) as well as a copy of the Resident Health Assessment Form, AHCA Form 1823 (1823 Form). The 1823 Form is based on a completed medical examination by a licensed physician, physician ' s assistant or a licensed nurse practitioner to assist in determining the appropriateness of the resident ' s admission and continued stay in the facility.

An interview was conducted with Staff A at approximately 12:45 P.M on / . Staff A was asked to present Resident #4 ' s record for review. Staff A stated that the file was missing. Resident 4 ' s record was not produced by Staff A by the end of this visit.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015005713

Dear Administrator:

This letter reports the findings of a state licensure survey 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 attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 ricia Reid ufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com