AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	R 11/06/2015
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

On , 2015 a Revisit to 8/17/2015 Survey was conducted at American Well Care Assist Living Facility. Deficient practice was identified during the survey.

0008 Admissions - Health Assessment

Based on observation, interview and record review, the facility failed to maintain required 1823 (health assessment) on file for 1(#1)of 3 records reviewed.

Findings Include:

A review of the facility admission discharge log on / revealed resident #1 was admitted to the facility on / /. However, a review of resident #1 file did not show evidence of a (1823 Health Assessment) when resident file was reviewed.
During an interview with the facility Administrator. The Administrator confirmed all resident's should have a current 1823 - Health Assessment located in their medical records file. However, she stated "I'm not sure what happened to the resident's 1823 (Health Assessment) I know he has one, but can't find it anywhere."

No further documentation was provided to surveyor at this time.

Class III

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11966321	A. Building B. Wing	11/6/2015

Name of Facility	Street Address, City, State, Zip Code
AMERICAN WELL CARE	6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0030** Reg. # **58A-5.0182(6) FAC; 429.28** LSC		ID Prefix **A0054** Reg. # **58A-5.0185(5) FAC** LSC		ID Prefix **A0056** Reg. # **58A-5.0185(7) FAC** LSC	
ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC		ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC		ID Prefix **A0093** Reg. # **58A-5.020(2) FAC** LSC	
ID Prefix **A0162** Reg. # **58A-5.024(3) FAC** LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** Paul Bonn	**Date:** 11/18/15	**Signature of Surveyor:**	**Date:**	
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**	

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2015.**

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. Should you have any questions please call this office at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

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

BBT7

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