

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/19/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966321	(X3) DATE SURVEY COMPLETED 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 11/1/2015 revealed resident #1 was admitted to the facility on 11/1/2015. 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
AL11966321

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
11/6/2015

Name of Facility
AMERICAN WELL CARE

Street Address, City, State, Zip Code
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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0030		ID Prefix A0054		ID Prefix A0056	
Reg. # 58A-5.0182(6) FAC: 429.28		Reg. # 58A-5.0185(5) FAC		Reg. # 58A-5.0185(7) FAC	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0078		ID Prefix A0084		ID Prefix A0093	
Reg. # 58A-5.019(2) FAC		Reg. # 58A-5.0191(5) FAC		Reg. # 58A-5.020(2) FAC	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0162		ID Prefix		ID Prefix	
Reg. # 58A-5.024(3) FAC		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By

State Agency

Reviewed By

CMS RO

Followup to Survey Completed on:

Reviewed By

Reviewed By

Date:

Date:

Signature of Surveyor:

Signature of Surveyor:

Date:

Date:

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

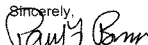
Dear Administrator:

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 Kaufman
Field Office Manager

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

BBT7

