AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	12/21/2015
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

On 21, 2015 a biennial relicensure survey in conjunction with a 2nd revisit to / and complaint (CCR 2015005713) was conducted at American Well Care. Deficient practice relative to the biennial relicensure was identified during the survey.

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to show proof of a written statement from a health care provider, within 30 days of employment, documenting that the individual does not have any signs or symptoms of communicable (Communicable Statement) for 1 (Administrator) of 4 employee records reviewed.

Findings included:

A review of employee records conducted on / revealed that the record for Administrator did not contain a Communicable Statement. Administrator ' s employment record showed a date of hire of .

An interview with Administrator was conducted at 5:00 PM on / and she stated that she doesn ' t have a signed Communicable Statement.

Class III

0081 Training - Staff In-Service

Based on interview and record review, the facility failed to show proof of training in control for 1(Staff B) of 4 employee records reviewed.

Findings included:

A review of employee records was conducted on / .

A review of Staff B ' s record showed a lack of a training certificate for control. Staff B provides personal care to residents and her employee record showed a date of hire of .

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	12/21/2015
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)

An interview was conducted with Administrator at 5:06 PM on [illegible] and she stated that she didn't have a training certificate for [illegible] control for Staff B.

Class III

0083 Training - First Aid and

Based on interview and record review, the facility failed to show proof of currently valid cards documenting completed courses in First Aid (First Aid Card) and [illegible] (Card) for 2 (Staff B and Staff C) of 4 employee records reviewed.

Findings included:

A review of employee records was conducted on [illegible].

A review of Staff B's record showed a lack of a First Aid Card and [illegible] Card. A review of the facility's staffing schedule showed that Staff B works alone at times during the 6 AM- 2 PM shift.

A review of Staff C's record revealed a lack of a First Aid Card. A review of the facility's staffing schedule showed that Staff C works alone on the 11 PM-7 AM shift.

An interview was conducted with Administrator on [illegible] at approximately 5:00 PM and she stated that she didn't see the required First Aid Card and [illegible] Card for Staff B's and Staff C's employee records.

Class III

0093 Food Service - Dietary Standards

Based on observation, interview and record review, the facility failed to maintain a required file of menus served over the past 6 months. Additionally, the facility failed to maintain a sufficient, 3-day supply of water to be utilized for food preparation and drinking in the event of an emergency.

Findings included:

During a dining and food service review conducted on [illegible], Administrator was asked for the facility's file documenting menus served over the past 6 months.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	12/21/2015
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)

During the review of the facility ' s 3-day emergency water supply conducted on / , Staff A showed (11) 5 gallon water to be filled in the event of an emergency. This potential 55 gallon water supply did not meet the minimum requirement for the facility ' s current census.

Administrator was interviewed at 4:55 PM on / and she stated that she did not have a facility file documenting menus served over the past 6 months.

An interview was conducted with Staff A at 4:56 PM on / and she stated that she was not able to locate additional 5 gallon water for the facility ' s emergency supply.

Class III

0161 Records - Staff

Based on interview and record review, the facility failed to maintain personnel records containing a copy of a job description for 1(Administrator) of 4 employee records reviewed. Additionally, the facility failed to maintain an employment application containing references for 2(Administrator and Staff C) of 4 employee records reviewed.

Findings included:

A review of employee records conducted on / revealed a lack of an employment application and job description for Administrator. The facility has a licensed capacity of 24 residents.

A review of Staff C ' s employee record on / showed an employment application without references furnished as required.

On / at 4:57 PM, Administrator stated that the owner had copies of her employment application and job description that were not in her employee record. Additionally, at 5:07 PM on / , Administrator acknowledged that Staff C ' s employment application did not contain required references.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 1, 2015

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

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) 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 , 2016.** 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 Patricia Reid Caufman
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