STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963902	**04/06/2016**
NAME OF PROVIDER OR SUPPLIER **AMERICARE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2992 DAY ROAD** **DELTONA, FL 32738**	

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

0000 Initial Comments

An unannounced capacity increase survey was conducted at Americare Assisted Living on . Americare Assisted Living had deficiencies identified at the time of survey and did not meet physical plant requirements for the requested increase in capacity.

0004 Licensure - Requirements

Based on observation and interview, the facility failed to ensure that physical plant standards were met, in order to increase the facility's capacity from 38 to 48.

The findings include:

A tour of the facility on at 12 PM revealed the facility had 3 resident that they planned on making semi-private (two residents to a) which were currently in use as single occupancy (# , #29, & #30). These identified by the facility, were going to be converted to double occupancy to increase the facility's capacity. Observation of #10, #29, & #30 revealed each of the had one bed, and one dresser. The were designed and furnished for single occupancy. The facility was only set up to meet the physical plant standards for an increase of 7 and not 10, as requested on the application for capacity increase.

In an interview with the Administrator on at 12:45 PM, she reported that the facility has not given written notice to the residents in #10, #29, & #30, that their would be changed from private to semi-private. In a follow up conversation with the Administrator on at 2:35 PM, she confirmed that #10, #29, & #30 were not set up as double occupancy , and still had the furnishings for a single resident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Americare Assisted Living
2992 Day Road
Deltona, FL 32738

Dear Administrator:

This letter reports the findings of a state licensure capacity incrase survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering,QIDP
Health Facility Evacuator Supervisor
Division of Health Quality Assurance

AF/JM/sm
Enclosure
XG90

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