AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966942	04/27/2016
NAME OF PROVIDER OR SUPPLIER **WELLSWOOD CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **907 CLANTON AVENUE** **TAMPA, FL 33603**	

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

0000 Initial Comments

Assisted Living Facility

On , 2016, a biennial relicensure survey was conducted at Wellswood Care Center. Deficient practice was identified during the survey.

Z813 Results of Screening & Notification in File

Based on record review and interview the facility failed to ensure that a staff member, who provides direct resident care, held a current level II background screening.

Findings included:

On in record review for Staff B with a hire date of , who provides direct resident care, there was no record of a level II background screening.
On at 2:58pm an interview was conducted with the executive director. The executive director stated Staff B does provide direct resident care and does not currently have a level II background screening on file.

Unclassed

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Wellswood Care Center
907 Clanton Avenue
Tampa, FL 33603

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency 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.

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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 ufman
Field Office Manager

PRC/kpr

Enclosure: State Form (5000-3547)

XG90