STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	11/10/2016
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

Three complaint investigations, (CCR# 2016010391, CCR# 2016011485, and CCR# 2016011567), were conducted at American Well Care on / . American Well Care, Assisted Living Facility, had a deficiency at the time of the investigation.

(License # 10549)

0081 Training - Staff In-Service

Based on interview and record review, the facility failed to provide proof of training for direct care staff, within 30 days of employment, for 2 (Staff A and Staff B) of 3 employee records reviewed.

Findings included:

A review of employee records showed Staff A's date of hire of and Staff B's date of hire of / . A review of Staff A's and Staff B's records revealed no proof of training in the topics of resident rights/ recognizing and reporting , neglect, and (, Neglect, and). Staffing schedules showed that both Staff A and Staff B provided direct care to the residents of the facility.

Administrator was interviewed at 1:24 PM on / / and acknowledged that there was no proof of training for , Neglect, and in Staff A's and Staff B's records.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR# 2016011485, CCR# 2016010391, & CCR# 2016011567

Dear Administrator:

This letter reports the findings of three complaint surveys that were 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 deficiency. 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.

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,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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