STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966321	**08/20/2018**
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

A complaint investigation (CCR 2018009790, 2018009947, 2018010862, and 2018010932) was conducted at American Well Care on . American Well Care had deficiencies at the time of the investigation.

(License #10549)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interviews and record review, the facility failed to meet the needs of two of two sampled residents (Resident #1 and Resident #2) by failing to maintain a general awareness of the whereabouts of Resident#1 and Resident #2 when they left the facility.

Findings included:

On at 12:25 PM a interview with the Administrator revealed the following: The Administrator stated they received a call from Staff C on around 7:00 PM. Staff C informed the Administrator that Resident#1 was not observed in the facility at the time. The Administrator confirmed the facility did not know the whereabouts of Resident #1.

A review of the Resident Sign Out Log from the facility revealed no indication that Resident #1 was signed out on , the times on the log were not completed. There was no entry for Resident #1 coming or going on when they left the facility.

On , the Administrator reviewed Resident #1's Medications Observation Records (MORS) with the surveyor for the month of 2018. The Administrator confirmed that Resident#1 was not provided their scheduled medications on the following dates: , and . It was discovered that the letter "C" was documented in the initial sections for dates , and . The Administrator confirmed the letter "C" is only documented in the initial slot on a resident's MORS if the residents is confirmed he or she is out of the facility.

A record review of Resident#1's Health Assessment Form (AHCA Form 1823) showed requirements for section (B) General Oversight was checked for observing wellbeing and whereabouts daily. Resident#1's AHCA Form 1823 was signed and dated by a licensed health care provider on .

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On [redacted] at 1:40 PM a interview was conducted with Resident #1's family member. They stated that the resident eloped twice since they have been residing at the facility. The first time was two months ago. The family member stated that the facility didn't have any idea where the resident went and neither did the family member. The family member stated that three day later, (after calling around to multiple assisted living facilities and hospitals), they found the resident in a shelter in another city. The family member stated that the resident was gone for about three days total without medications. The family member stated that they did not think the facility has enough staff to take care of their residents , there's only one staff on duty per shift, and they can't keep track of their residents.

On [redacted], it was identified that the facility has not met the required staffing hours for the current and past resident census. For the week of [redacted], 168 hours was scheduled, [redacted], 168 hours was scheduled and [redacted], 168 hours was scheduled. The facility is required to have a minimum of 253 weekly staffing hours under state law for 22 residents.

A review of records for Resident #2 showed that they had left the facility on [redacted]. An interview was conducted with Resident #2 at 12:33 PM on [redacted] and they stated that they "ran away" a month ago and came back but they were gone for a couple days. Resident #2 stated that they didn't tell anyone at the facility that they were leaving. They stated that they slept on benches and asked people for spare change while they were gone. The resident stated that they didn't get their medication when they were away from the facility. A review of Resident #2's current AHCA Form 1823 showed that they required daily oversight of their whereabouts.

An interview was conducted with the Administrator at 3:47 PM on [redacted]. The Administrator stated that Resident #2 eloped on [redacted]. The Administrator acknowledged that the facility did not contact the resident's power of attorney or primary care physician of the incident.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on interviews, and record review, the facility failed to follow its own policy and procedures for elopement. Specifically, the facility did not notify a resident's family member for one (Resident#2) of two residents reviewed for elopement.

Findings included:

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In an interview with the facility administrator on at 3:47 PM, the administrator confirmed the following; Resident #2 eloped on by leaving the facility without notifying staff or signing out. The administrator confirmed she did not make contact with Resident #2's Power of Attorney. The administrator stated, "He never answers."

On , a review of the sign-out log from the facility revealed no indication that Resident #2 was signed out on , 2018 and the spaces for the times on the log were blank. There was no entry for him coming or going on the , 2018 when he eloped.

In an interview with Resident #2 on at 12:33 PM, Resident#2 stated the following; "I ran away a month ago and came back. I was gone for a couple days. I didn't tell anyone. I slept on benches while I was gone. I asked for spare change while I was out. I didn't get my medication when I ran away."

According to the current facility Elopement Policy obtained on provided by the Administrator, it is the facility's policy to notify a Resident's family member when a Resident has left the property and does not inform staff of where he or she was going and 8 hours has passed without any one seeing the resident.
Resident #2 was out of his an extended amount of time (48 hours) and the facility was not aware of his whereabouts.

In an interview with the administrator on at 12:15 p.m., the administrator reviewed the current policy and procedures for elopement standards and confirmed the findings.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on interview and record review, the facility failed to maintain the minimum staffing hours required for 22 residents.

Findings included:

A review of the facility's staffing schedule for the current week the survey was conducted (-) showed a total of 168 direct care hours for the week. The requirement was 253 hours. Upon entering the facility at 8:50 AM, there was one direct care staff member present with a census of 22 residents.

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During an interview with the administrator at 4:45 PM on , they confirmed that the hours did not meet the requirements.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, interview, and record review, the facility failed to ensure that residents' nutritional needs were met as they did not substitute menu items with foods of comparable nutritional value, provide proof of a registered dietitian approved menu with serving sizes, maintain a file of six months of dated menus, or keep a six- month file of substitutions made to daily menu items (Substitution Log).

Findings included:

A dining and food service review was conducted on . During an interview conducted with Staff A at 9:09 AM on , Staff A stated that the residents had oatmeal for breakfast. Staff A stated that they did not serve omelets because there were no eggs in the facility. Staff A also stated that they did not serve toast because there was not enough bread to serve all the residents. The breakfast menu for this date was reviewed and it showed hot/ cereal, omelet, toast, margarine/jelly, coffee/decaf coffee, milk/water (photographic evidence obtained).

The menu for the lunch meal was reviewed and one of the items required was assorted breads/rolls (photographic evidence obtained). The lunch meal was observed at 12:20 PM on and there was no bread served to the residents. Staff A was interviewed at 12:35 PM on and asked why there was no bread served with the lunch meal. Staff A stated that no bread was served because there wasn't enough. Staff A stated that they couldn't give bread to some residents and none to others. There was no other food item served as a substitution.

A request was made to review the facility's menu cycle with serving sizes. The menu cycle was presented but did not include serving sizes. The Administrator was interviewed at 11:52 AM on and they stated that the current menus did not contain serving sizes.

A request was also made to review the facility's Substitution Log. The Administrator was interviewed at 12:08 PM on and they stated that there was no Substitution Log.

Class III

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0120 - Fiscal - Financial Stability - 429.17(3) FS: 429.275(1)58A-5.021(1) FAC

Based on observation, interview, and record review, the facility failed to show that it was operating on a sound financial basis that ensured adequate resources were available to meet the needs of the 22 residents residing in the facility.

Findings included:

A dining and food service review conducted on showed that the breakfast meal approved by a registered dietitian on this date included hot/ cereal, omelet, toast, margarine/jelly, coffee/decaf coffee, milk/water (photographic evidence obtained). During an interview conducted with Staff A at 9:09 AM on , they stated that the residents had oatmeal for breakfast. They stated that they did not serve omelets because there were no eggs in the facility. Staff A also stated that they did not serve toast because there was not enough bread to serve all the residents. The lunch meal was observed and also lacked bread being served (as required on the menu). Staff A was interviewed again after the lunch meal and stated that they couldn't serve bread to some residents and not to others and there was not sufficient bread in the facility for the residents.

Staff A was interviewed at 9:45 AM on and asked if there was enough food available for residents. Staff A stated that the weekly food supply comes in on Tuesdays, but by Friday they are running out of some items. When asked what was done about it, Staff A stated that they purchased food at their own expense. Staff A stated that the facility was understaffed. Staff A also expressed concern that the facility did not have financial resources to purchase needed supplies for the residents.

Staff B was interviewed at 10:04 AM on . When asked if there was there enough food available for residents they stated no. Staff B stated that they try to stretch available food to meet the residents' needs. Staff B also stated that they bring food for the residents to eat because they're not going to leave them hungry. Staff B stated that they just brought in eggs so that staff could prepare meat loaf for the day's lunch meal. Staff B stated that the residents don't get enough juice or milk. When asked if they get reimbursed when they lay out money for food, Staff B stated no. An observation of the facility's refrigerator at 9:15 AM revealed very little fruit juice and about a quart of milk (photographic evidence obtained).

An interview was conducted with Staff C at 11:00 AM on . Staff C stated that they buy food at their own expense for the residents and do not get reimbursed. Staff C stated that they also have to buy soap at times at their own expense.

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A tour of the facility conducted on beginning at 9:05 AM revealed exposed piping and electrical components near the back exit door, electrical outlets with no safety covers in the dining broken resident for and (photographic evidence obtained).

Upon entering the facility at 8:50 AM, there was one direct care staff member on duty to assist 22 residents. The staffing schedule for the current week was reviewed and revealed that 168 hours were scheduled. The resident census required 253 hours for the week. The Administrator was interviewed at 4:45 PM on and they confirmed the hours did not meet the requirements.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview facility failed to maintain a safe and clean living environment, free from safety hazards.

Findings included:

On at 8:53 AM the following was observed during a tour of the facility: exposed piping and electrical components near the back exit door, electrical outlets with no safety covers in the dining , and broken resident for and (photographic evidence obtained). In , Resident #3's mattress was observed. The mattress had no sheets, had a ripped plastic cover on it, and was soiled with what appeared to be . Resident #1's mattress was also observed in . It was a bare mattress without sheets and was soiled with what appeared to be feces and (photographic evidence obtained). had a strong stench of and feces present.

During a tour with the administrator on at 4:11 PM, they confirmed the broken doors, soiled mattresses with no sheets, and exposed piping and electrical components.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation and interview, the facility failed to acquire and maintain a monoxide alarm.

Findings included:

The interior of the facility was toured on and there was no observation of a monoxide

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alarm.

The Administrator was interviewed at 2:16 PM on . . . . . concerning the facility having a . . . . monoxide detector/alarm. The Administrator stated that they never had one.

Class III