

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966321	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/28/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AMERICAN WELL CARE

**6333 LANGSTON AVENUE
NEW PORT RICHEY, FL 34652**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A Revisit to 01/03/2020 Biennial Survey with Limited Mental Health and Generator Monitoring, a second Revisit to 10/30/2019 Complaint Investigation (Complaint Number: 2019013833), a third Revisit to 08/20/2019 Complaint Investigation (Complaint Numbers: 2019008264 and 2019012291), and a Complaint Investigation (Complaint Numbers: 2020000274 and 2020001741) were conducted at American Wellcare on 02/28/2020. Deficiencies were found to be corrected at the time of survey.	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE