

Agency for Health Care Administration

|                                                                            |                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |                          |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11910790</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/16/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE PAVILION OF NEW PORT RICHEY</b> |                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5539 CHARLES STREET<br/>NEW PORT RICHEY, FL 34653</b>                        |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 000}                                                                    | Initial Comments<br><br>A revisit to 04/06/2022 biennial survey, was done<br>in conjunction with a complaint survey (#<br>2022005694) at The Pavilion of New Port Richey<br>on 05/16/2022 . Deficiencies were not identified<br>at the time of the survey. | {A 000}                                                                        |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE