

Agency for Health Care Administration

|                                                                  |                                                                                                                              |                                                                                                     |                                                                                                                          |  |                                                                    |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965638</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/19/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANNS HOUSE-GULF HAVEN</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6343 ROWAN ROAD</b><br><b>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 post closure monitoring survey was conducted<br>at Ann's House-Gulf Haven on 9/19/2024.            | A 000                                                                                               |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE