

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968599	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/08/2024
NAME OF PROVIDER OR SUPPLIER WELLSPRINGS RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E WELCH RD APOPKA, FL 32712			
(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 desk review to an Extended Congregate Care (ECC) monitoring visit was conducted for Wellsprings Residence on 11/08/24. The facility had corrected deficiencies at the time of the review.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE