

5/13/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966698	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/2/2013
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Name of Facility WELLSPRING ASSISTED LIVING FACILITY	Street Address, City, State, Zip Code 37815 15TH AVE WEST ZEPHYRHILLS, FL 33542
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0165</u> Reg. # <u>429.23 FS: 58A-5.0241 FAC</u> LSC _____	Correction Completed 05/02/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>✓</u> State Agency <u>✓</u> Reviewed By _____ CMS RO	Reviewed By <u>Paul R. Bm</u> Reviewed By _____	Date: <u>5/13/13</u> Date: _____	Signature of Surveyor: _____ Signature of Surveyor: _____	Date: _____ Date: _____
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Followup to Survey Completed on:

2/26/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES

NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 13, 2013

Administrator
Wellspring Assisted Living Facility
37815 15th Ave West
Zephyrhills, FL 33542

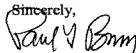
Dear Administrator:

This letter reports the findings of a state licensure survey revisit and an operation spot check conducted on May 2, 2013, by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was found corrected on the day of the revisit, and State (3020) Form, which indicates no deficiencies were found at the time of the visit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,


for

Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: Revisit Report & State Form 3020

