

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966321	(X3) DATE SURVEY COMPLETED 12/08/2014
NAME OF PROVIDER OR SUPPLIER American Well Care	STREET ADDRESS, CITY, STATE, ZIP CODE 6333 Langston Avenue New Port Richey, FL 34652	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tag:

0084-Training - Assis Self-Admin Meds & Med Mgmt-12/08/2014



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 8, 2014

Administrator
American Well Care
6333 Langston Avenue
New Port Richey, FL 34652

Dear Administrator:

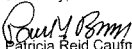
This letter reports the findings of a state licensure follow-up (desk review) conducted on December 8, 2014, by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiency was found corrected on the day of the desk review.

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(s). Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

For 
Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form (5000-3547)

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