

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967814	(X3) DATE SURVEY COMPLETED 03/21/2016
NAME OF PROVIDER OR SUPPLIER WELLINGTON ELDER CARE 1	STREET ADDRESS, CITY, STATE, ZIP CODE 14097/14099 LILY COURT WELLINGTON, FL 33414	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Relicensure survey was conducted on 3/21/16 at Wellingotn Elder Care 1. The facility had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 4, 2016

Administrator
Wellington Elder Care 1
14097/14099 Lily Court
Wellington, FL 33414

RE: Relicensure Survey

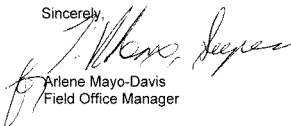
Dear Administrator:

This letter reports findings of a Relicensure survey that was conducted on March 21, 2016 by a representative of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,



Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State 5000-3547 form

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