

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/21/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968765	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER WELLWOOD CARE CENTER II	STREET ADDRESS, CITY, STATE, ZIP CODE 17633 MEADOWBRIDGE DR LUTZ, FL 33549	

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

0000 Initial Comments

Assisted Living Facility

On 4/6/16 a Change of Ownership Survey was conducted at Wellswood Care Center II.

Wellswood Care Center II had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 21, 2016

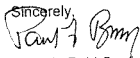
Administrator
Wellswood Care Center II
17633 Meadowbridge Dr
Lutz, FL 33549

Dear Administrator:

This letter reports findings of a change of ownership (CHOW) state licensure survey that was conducted on April 6, 2016 by representative(s) 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

 Patricia Reid Kaufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

1GGN

