

Agency for Health Care Administration

|                                                                                |                                                                                                                                                                                      |                                                                                                     |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966698</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>05/14/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WELLSPRING ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>37815 15TH AVE WEST</b><br><b>ZEPHYRHILLS, FL 33542</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                         | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                                        | Initial Comments<br><br>A follow up survey via desk review was conducted<br>on 05/14/2026 for Wellspring Assisted Living<br>Facility. Previous cited deficiencies were<br>corrected. | {A 000}                                                                                             |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X8) DATE