

7/2/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966698	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 06/30/2015
Name of Facility WELLSPRING ASSISTED LIVING FACILITY		Street Address, City, State, Zip Code 37815 15TH AVE WEST ZEPHYRHILLS, FL 33542

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>A0010</u> Reg. # <u>58A-5.0181(4) FAC</u> LSC _____ Correction Completed 06/20/2015	ID Prefix <u>A0079</u> Reg. # <u>58A-5.019(3) FAC</u> LSC _____ Correction Completed 06/20/2015	ID Prefix <u>A1243</u> Reg. # <u>58A-5.0191(8) FAC</u> LSC _____ Correction Completed 06/20/2015			
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	ID Prefix _____ Reg. # _____ LSC _____ Correction Completed		ID Prefix _____ Reg. # _____ LSC _____ Correction Completed	
Reviewed By _____ State Agency _____ Reviewed By _____ CMS RO _____	Reviewed By <u>[Signature]</u> Date: <u>7/7/15</u> Reviewed By _____ Date: _____	Signature of Surveyor: _____ Signature of Surveyor: _____	Date: _____ Date: _____		Date: _____ Date: _____
Followup to Survey Completed on: 03/12/2015			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

04V012



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 8, 2015

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

RE: CCR #2015000424 and CCR #2014012117

Dear Administrator:

This letter reports the findings of a complaint survey revisit conducted on June 30, 2015 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit.

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/src
Enclosure: State Form (5000-3547)

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