

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/24/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966698	(X3) DATE SURVEY COMPLETED 05/12/2016
NAME OF PROVIDER OR SUPPLIER WELLSPRING ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 37815 15TH AVE WEST ZEPHYRHILLS, FL 33542	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR#2016001740) was conducted at Wellspring Assisted Living Facility on 5/12/16. Wellspring Assisted Living Facility did not have a deficiency at the time of the investigation.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 24, 2016

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

RE: CCR #2016001740

Dear Administrator:

This letter reports the findings of a complaint survey completed on May 12, 2016 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this 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 contact **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

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

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