

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966321	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/30/2016
NAME OF FACILITY AMERICAN WELL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6333 LANGSTON AVENUE NEW PORT RICHEY, FL 34652

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0081	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/30/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	☒	REVIEWED BY (INITIALS) <i>PFB</i>	DATE 12/30/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/10/2016			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

December 30, 2013

Administrator
American Well Care
6333 Langston Avenue
New Port Richey, FL 34652

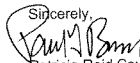
Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on December 30, 2013, by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was found corrected on the day of the desk review. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 Cauffman
Field Office Manager

PRC/kpr

Enclosure: Revisit Report

DT9D

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