

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 08/15/2018  
FORM APPROVED

|                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                     |                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11966698</b>                         | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><br><b>07/27/2018</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> |                                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                      |                                                                                                     |                                                                     |
| <p><b>0000 - Initial Comments</b></p> <p>Assisted Living Facility</p> <p>A second Revisit to a 04/23/18 Complaint Survey (CCR#: 2018001727) in conjunction with a Revisit to 06/07/18 Biennial Survey with Limited Mental Health and Limited Nursing Services was conducted at Wellspring Assisted Living Facility on 07/27/18. Wellspring Assisted Living Facility had no deficient practice identified at the time of survey.</p> <p>(License#: 10854)</p> |                                                                                                     |                                                                     |