

Agency for Health Care Administration

|                                                             |                                                                                                                                                              |                                                                                      |                                                                                                                          |                          |                                                                    |
|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968177</b>       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>08/28/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>YOUR HOUSE ALF 2</b> |                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5816 N GRADY AVE<br/>TAMPA, FL 33614</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 was conducted on 08/28/25 for<br>Your House ALF 2. Previous cited deficiencies<br>were corrected via desk review. | {A 000}                                                                              |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X8) DATE