STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966361	**02/27/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Caregivers Touch, A.L.F.	**4536 W Idlewild Ave Tampa, FL 33614**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0152-Physical Plant - Safe Living Environ/other-02/27/2015
0162-Records - Resident-02/27/2015

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 2, 2015

Administrator
Caregivers Touch, A.L.F.
4536 West Idlewild Ave.
Tampa, FL 33614

Dear Administrator:

This letter reports the findings of a revisit, to a Biennial state licensure survey with Limited Mental Health (LMH) Services, conducted on February 27, 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,

Paul Brown

For Patricia Reid Caufman
Field Office Manager

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

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