

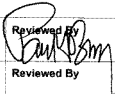
4/13/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968427	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/13/2015
Name of Facility A LA MY LOVE ALF	Street Address, City, State, Zip Code 6821 DOVER CT TAMPA, FL 33634	

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0008</u> Reg. # <u>429.26(4-6) FS; 58A-5.0181</u> LSC _____	Correction Completed 04/13/2015	ID Prefix <u>A0026</u> Reg. # <u>58A-5.0182(2) FAC</u> LSC _____	Correction Completed 04/13/2015	ID Prefix <u>A0091</u> Reg. # <u>58A-5.0191(12) FAC</u> LSC _____	Correction Completed 04/13/2015
ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed 04/13/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____ Reviewed By _____ CMS RO _____	Reviewed By  Date: <u>4/13/15</u> Date: _____	Signature of Surveyor: _____ Signature of Surveyor: _____ Date: _____ Date: _____	Date: _____ Date: _____
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Followup to Survey Completed on:

3/9/2015

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 14, 2015

Administrator
A La My Love Alf
6821 Dover Court
Tampa, FL 33634

Dear Administrator:

This letter reports the findings of a Biennial state licensure survey follow-up (desk review) conducted on April 13, 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,

Patricia Reid Cauffman
Field Office Manager

for

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

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
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