

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/08/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967584	(X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER YOUR HOUSE ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 4008 W BROAD STREET TAMPA, FL 33614	

**SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)**

0000 - Initial Comments

ASSISTED LIVING FACILITY.

A Biennial Licensure Survey was conducted on 6/1/15.

The Your House ALF had no deficiencies found at the time of this visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 8, 2015

Administrator
Your House ALF
4008 W Broad Street
Tampa, FL 33614

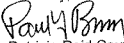
Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on June 1, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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,

for 
Patricia Reid Caulman
Field Office Manager

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

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