AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967259	**04/27/2016**
NAME OF PROVIDER OR SUPPLIER **HERNANDEZ ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **6604 N ORLEANS AVE** **TAMPA, FL 33604**	

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

0000 Initial Comments

Assisted Living Facility

An abbreviated biennial relicensure survey with limited mental health (LMH) services was conducted at Hernandez Assisted Living Facility on 4/27/16. There was no deficient practice identified during the survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 9, 2016

Administrator
Hernandez ALF
6604 N Orleans Ave
Tampa, FL 33604

Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on April 27, 2016, 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 Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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