STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968789	**05/27/2016**
NAME OF PROVIDER OR SUPPLIER **MY MOM'S HOME ALF LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9003 WEST CLUSTER AVENUE** **TAMPA, FL 33615**	

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

0000 Initial Comments

Assisted Living Facility

On May 27, 2016 a change of ownership survey with limited mental health (LMH) was conducted at My Mom's Home. My Mom's Home had no deficiencies at the time of the survey. License #12640

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 7, 2016

Administrator
My Mom's Home ALF LLC
9003 West Cluster Avenue
Tampa, FL 33615

Dear Administrator:

This letter reports findings of a change of ownership (CHOW) state licensure survey with limited mental health (IMH) that was conducted on May 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 **Teresa Ryan**, RNC, at (727) 552-2000.

Sincerely,

Teresa Ryan RNC

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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