AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968675	**06/30/2016**
NAME OF PROVIDER OR SUPPLIER **HERNANDEZ ALF II LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3010 W HAYA ST** **TAMPA, FL 33614**	

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

0000 Initial Comments

Assisted Living Facility

On June 30, 2016 a biennial relicensure survey in conjunction with complaint survey (CCR#2016005582) (ASPEN 97JX11) was conducted at Hernandez II ALF. No deficient practice was identified during the survey. License #12543

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 15, 2016

Administrator
Hernandez ALF II LLC
3010 W Haya St
Tampa, FL 33614

RE: CCR #2016005582 & Biennial

Dear Administrator:

This letter reports the findings of a complaint survey completed on June 30, 2016 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

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

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