

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 09/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968177	(X3) DATE SURVEY COMPLETED 09/26/2016
NAME OF PROVIDER OR SUPPLIER YOUR HOUSE ALF 2	STREET ADDRESS, CITY, STATE, ZIP CODE 5816 N GRADY AVE TAMPA, FL 33614	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation, (CCR# 2016008969), was conducted at Your House ALF 2 (Lic. #12104) on 9/26/16. Your House ALF 2 had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 29, 2016

Administrator
Your House ALF 2
5816 N Grady Ave
Tampa, FL 33614

RE: CCR# 2016008969

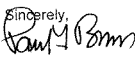
Dear Administrator:

This letter reports the findings of a complaint survey completed on September 26, 2016, by representative(s) of this office.

Attached is the provider's copy of the 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 Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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