

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11910826	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER Dunedin Assisted Living Facility	STREET ADDRESS, CITY, STATE, ZIP CODE 534 Howell Street Dunedin, FL 34698	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

L243-Lmh - Training-07/23/2014



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 23, 2014

Administrator
Dunedin Assisted Living Facility
534 Howell Street
Dunedin, FL 34698

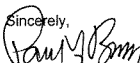
Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on July 23, 2014, by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the desk review.

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 Form (5000-3547)

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