

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968753	(X3) DATE SURVEY COMPLETED 03/03/2015
NAME OF PROVIDER OR SUPPLIER Trailwinds Assisted Living, Llc	STREET ADDRESS, CITY, STATE, ZIP CODE 14929 Sw 39th St Miami, FL 33185	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

An Initial survey was conducted 03/03/15. Trailwinds Assisted Living, LLC did not have deficiencies at time of the survey. A Recommendation for a standard license with 6 beds will be forwarded to the unit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 11, 2015

Administrator
Trailwinds Assisted Living, LLC
14929 Sw 39th St
Miami, FL 33185

Dear Administrator:

This letter reports the findings of an initial Licensure survey conducted on March 3, 2015 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

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Enclosure

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