

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 06/02/2015
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968753	(X3) DATE SURVEY COMPLETED 05/19/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)		

0000 - Initial Comments

A Limited Nursing Services Monitoring survey was conducted on May 19, 2015. Trailwinds Assisted Living, LLC with Limited Nursing Services component did not have deficiencies found at time of survey.



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

June 2, 2015

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

Dear Administrator:

This letter reports findings of a Limited Nursing Services Monitoring licensure survey that was conducted on May 19, 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

AMD:ve
Enclosure

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