STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968753	**10/28/2015**
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 October 28, 2015. Trailwinds Assisted Living, LLC. with Limited Nursing Services component had no deficiencies identified at time of survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 10, 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 October 28, 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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