

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 02/01/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932650	(X3) DATE SURVEY COMPLETED 01/26/2016
NAME OF PROVIDER OR SUPPLIER SUNNILAND ASSISTED LIVING FACILITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4234 SUNNILAND STREET SARASOTA, FL 34233	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on 1/26/16 at Sunniland Assisted Living Facility, an Assisted Living Facility in Sarasota, Florida.

No deficiencies were found at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 1, 2016

Administrator
Sunniland Assisted Living Facility, LLC
4234 Sunniland Street
Sarasota, FL 34233

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on January 26, 2016 by a representative 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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