

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 02/22/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910826	(X3) DATE SURVEY COMPLETED 02/16/2016
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

A monitoring visit was conducted at Dunedin Assisted Living Facility on 2/16/16. Dunedin Assisted Living Facility had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 22, 2016

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

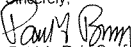
Dear Administrator:

This letter reports findings of a monitoring visit that was conducted on February 16, 2016, 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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,


Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone: (727) 552-2000. Fax: (727) 552-1162
AHCA.MyFlorida.com



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