STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942864	08/15/2016
NAME OF PROVIDER OR SUPPLIER **DOLPHIN HOUSE, INC. (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **9670 - 134 STREET, NORTH** **SEMINOLE, FL 33776**	

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

0000 Initial Comments

Assisted Living Facility

On August 15, 2016, an abbreviated biennial re-licensure survey was conducted at The Dolphin House, Inc. No deficient practice was identified during the survey.

(License # 8285)

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 12, 2016

Administrator
Dolphin House, Inc. (The)
9670 - 134 Street, North
Seminole, FL 33776

Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on August 15, 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 Caufman
For Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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