

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911452	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2012
NAME OF PROVIDER OR SUPPLIER SUN CITY SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3855 UPPER CREEK DRIVE RUSKIN, FL 33573		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments Assisted Living Facility Complaint surveys, CCR# 2012010357 & CCR# 2012008514 were conducted on 10/03/12 in conjunction with a capacity increase, see (Aspen Event PZSZ11). The Sun City Senior Living, assisted living facility, had no deficiencies found relative to the complaint surveys. A deficiency was cited relative to the capacity increase, see (Aspen Event PZSZ11).	A 000			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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775111

If continuation sheet 1 of 1

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

October 12, 2012

Administrator
Sun City Senior Living
3855 Upper Creek Drive
Ruskin, FL 33573

Dear Administrator:

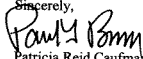
Re: capacity increase & CCR# 2012010357 & CCR# 2012008514

This letter reports the findings of a capacity increase & two complaint surveys that were conducted on October 3, 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit relative to the capacity increase. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your 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 **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

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