

Agency for Health Care Administration

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|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966458</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/11/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CENTRAL TAMPA ASSISTED LIVING</b> |                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5010 40 STREET NORTH<br/>TAMPA, FL 33610</b>                                 |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                    | Initial Comments<br><br>Assisted Living Facility<br><br>Two complaint surveys, CCR# 2013001219 and<br>CCR# 2013001301, were conducted on 2/11/13.<br><br>Central Tampa Assisted Living Facility had no<br>deficiencies found at the time of the visit. | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0900

POL911

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

February 18, 2013

Administrator  
Central Tampa Assisted Living  
5010 40 Street North  
Tampa, FL 33610

**Re: CCR# 2013001219 & CCR# 2013001301**

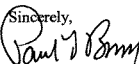
Dear Administrator:

This letter reports the findings of two complaint surveys completed on February 11, 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, indicating no deficiencies were identified during this 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 contact **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,  
  
For Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

