

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER SUN TOWERS RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 101 TRINITY LAKES DRIVE SUN CITY CENTER, 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 An extended congregate care (ECC) monitoring visit was conducted on 5/9/13 in conjunction with a complaint survey, see (Aspen Event FNOK11). The Sun Towers Retirement Community, assisted living facility, had no deficiencies found relative to this ECC monitoring visit. However, deficiencies were found relative to the complaint survey.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

STATE FORM

6800

UZK711

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 29, 2013

Administrator
Sun Towers Retirement Community
101 Trinity Lakes Drive
Sun City Center, FL 33573

Dear Administrator:

Re: CCR# 2013004571 & ECC monitoring visit

This letter reports the findings of a complaint survey and an extended congregate care (ECC) monitoring visit that was conducted on May 9, 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit relative to the complaint survey. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies 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 deficiencies 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

Enclosure: State Form 3020

