



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 18, 2013

Administrator
Renaissance Retirement Center, LLC
300 West Airport Blvd.
Sanford, FL 32771

Re: CCR #2013003306

Dear Administrator:

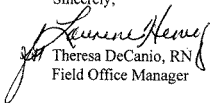
This letter reports the findings of a complaint survey completed on June 4, 2013 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS-2567, and State (3020) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact Lorraine Henry at (407) 420-2502.

Sincerely,


Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922141	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER RENAISSANCE RETIREMENT CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST AIRPORT BLVD. SANFORD, FL 32771			
(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 6/4/13 conducted Assisted Living Facility complaint inspection CCR#2013003306 in conjunction with CCR#2013005267. There were deficiencies found at the time of the visit pertaining to CCR#2013005267.	A 000			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

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MH3Z11

If continuation sheet 1 of 1