STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942892	01/14/2016
NAME OF PROVIDER OR SUPPLIER **SUNRISE SENIOR VILLAGE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **11722 NORTH 17TH STREET TAMPA, FL 33612**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR 2015011459 ad 2016000301) was conducted at Sunrise Senior Village Assisted Living on / . Sunrise Senior Village Assisted Living had a deficiency at the time of the investigation.

0167 Resident Contracts

Based on interview and record review, the facility failed to provide a resident contract that included a required refund policy that conforms with Section 429.24(3) F.S. concerning refunds to the resident or responsible party within 45 days after the transfer, discharge, or of the resident (45 Day Refund Policy).

Findings included:

A record review was conducted on / at approximately 1:30 PM. During this review, the administrator was asked for a copy of the facility ' s resident contract and presented a copy of the facility ' s Lease Agreement.

A review of the facility ' s residential Lease Agreement included a clause entitled " Refund Policy " . A review of this clause revealed that the required 45 Day Refund Policy was not included.

The administrator was asked to review the Lease Agreement for the required 45 Day Refund Policy and at 1:45 PM she stated that she did not see the 45 Day Refund Policy.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sunrise Senior Village Assisted Living
11722 North 17th Street
Tampa, FL 33612

RE: CCR #2015011459 & 2016000301

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

for Patricia Reid Caufman
Field Office Manager

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