

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964934	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER CABOT RESERVE ON THE GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 4450 8TH STREET SARASOTA, FL 34232		
(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)	
{A 000}	Initial Comments This is the follow-up to Complaint survey CCR# 2012006419 conducted on _____ at Cabot Reserve on the Green, an Assisted Living Facility. One deficiency was found to be uncorrected.		{A 000}		
{A 030}	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida _____ Hotline " 1(800)96 1(800)962-2873 " shall be posted in full view in a		{A 030}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5099

H9LX12

If continuation sheet 1 of 8

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{A 030}	Continued From page 1 common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's _____ and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use		{A 030}		

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{A 030}	Continued From page 2 and can remove or avoid without assistance shall not be considered a physical 429.28 Resident bill of rights - (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as		{A 030}		

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{A 030}	Continued From page 3 provided in s. 429.27. (g) Share a _____ his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally _____, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____ interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be	{A 030}			

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{A 030}	Continued From page 5 contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies." On : at 1:12 p.m. the Administrator was questioned about the personal funds for Residents #6 #9 and #16. The Administrator stated, "Since we are Representative Payee for the 3 residents, the money goes into the bank in Miami. If the residents' wants the money we have to request a check, because we don't write checks locally." The billing records for all the residents were requested. A review of the : 2012 bills for Residents #6, #9, and #16 revealed Resident #9 received her SSI personal funds of \$54 in the form of a check and the money was put into her Personal Needs Account (PNA). The billing statements did not reflect money going into a PNA account for Resident #6 and #16. An interview was conducted with Resident #16 at 2:39 p.m. on . In the interview Resident #16 said, "My social security check comes in and they just take the rent out of it, because it goes into the bank." She denied having any money		{A 030}		

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(A 030)	Continued From page 6 from SSI and she does not know anything about having a PNA account. She told the surveyor that she did not have much money and that if she did have personal funds she would go shopping. She continued by saying, "I used to by all my clothes from Lane Bryant. I was thinking not too long ago to get some new clothes I haven't had any for a few years. I just feel like I should have some new clothes." She stated she also needs a TV and some lamps for her The Administrator was re-interviewed on . . . at 3:13 p.m. She admitted Residents #6 and #16 are not receiving their allotted \$54 per month for personal expenses. When asked what the money went towards the Administrator stated she got letters from the Power of Attorney's (POA) for Residents #6 and #16 to apply the residents' personal funds towards their . . . board to supplement their rent. The letter for Resident #16 reads, "Dear [POA for resident #16]: This letter is confirm the conversation we had today regarding [Resident #16's] . . . and the amount she pays for her . . . board (which is less than the actual . . . As we discussed, [Resident #16's] full Social Security Income check has been and is currently being applied in total to her . . . board rate. It is understood that [Resident #16] does not receive a personal needs allowance of \$54, since the entire amount of the Social Security is being applied towards her rent. As [Resident #16's] Power of Attorney, you agreed with this decision upon her admission to [this facility] and continue to agree with this decision." Resident #6 has a letter which is nearly identical to the above letter in her file.		(A 030)		

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{A 030}	Continued From page 7		{A 030}		
	An interview was conducted with Resident #6 on _____ at 4:00 p.m. She stated, "No I don't have any money." She was asked if she was aware of the \$54.00 SSI check she should have received. She denied being aware these funds existed or we available to her. She stated, "\$54.00 I didn't know that." I'm not happy about that [not getting her money]. She continued by saying, "They should have really [given her the money]." She added that she would like to go shopping for make-up and undergarments with her the money is she had it. On _____ at 4:06 a.m. The Administrator admitted in an interview Residents #9 and #16 are still paying for the E-MOR system with their personal fund from SSI. The Administrator states Resident #9 pay for the fee from her \$54.00 just as she would pay any bill. The administrator also told the surveyor the facility subtracts the \$10.00 fee from the \$54.00 Resident #16 receives and applies the remanding \$44.00 to her rent. Class II Correction Date: _____				

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11964934(Y2) Multiple Construction
A. Building
B. Wing(Y3) Date of Revisit
9/11/2012

Name of Facility

CABOT RESERVE ON THE GREEN

Street Address, City, State, Zip Code

4450 8TH STREET
SARASOTA, FL 34232

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # 58A-5.021(5) FAC LSC	Correction Completed	ID Prefix Reg. # 58A-5.021(7) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By

State Agency

Reviewed By

CMS RO

Reviewed By

Reviewed By

Date:

Date:

Signature of Surveyor

Signature of Surveyor:

Date:

Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Cabot Reserve On The Green
4450 8th Street
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a Complaint revisit survey conducted on 2012 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than 2012.**

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 this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure

