RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 25, 2016

Administrator
Sabal House
150 Crossville Street
Cantonment, FL 32533

RE: CCR# 2015012312

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring visit and a Revisit to a previous state licensure complaint survey conducted on March 14, 2016 by a representative of this office.

Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), 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 April 25, 2016.**

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 850-412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/kb
Enclosure

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965159	R 03/14/2016
NAME OF PROVIDER OR SUPPLIER **SABAL HOUSE**	STREET ADDRESS, CITY, STATE, ZIP CODE **150 CROSSVILLE STREET** **CANTONMENT, FL 32533**	

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

0000 Initial Comments

An unannounced follow up survey for a complaint survey of 1/13/2016 was conducted on 3/14/16 in conjunction with a Limited Nursing Services monitoring visit. The deficiency of 1/13/2016 was found corrected at the time of the survey. Deficient practice was identified with the Limited Nursing Services monitoring visit.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11965159 Y1	A. Building B. Wing Y2	3/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SABAL HOUSE	150 CROSSVILLE STREET CANTONMENT, FL 32533

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed 03/14/2016	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) [signature]	DATE 3/25/16	SIGNATURE OF SURVEYOR [signature]	DATE 3/25/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO