



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 13, 2016

Administrator
Sabal House
150 Crossville Street
Cantonment, FL 32533

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on May 13, 2016 by a representative of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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. Should you have any questions please call me at 850-412-4540.

Sincerely,

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

DH/kc
Enclosure

DT9D



**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 05/13/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965159	(X3) DATE SURVEY COMPLETED R 05/05/2016
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

A desk review revisit survey was completed on May 13, 2016 for a complaint survey that was originally conducted on March 14, 2016 at Sabal House Assisted Living Facility in Cantonement FL. Based on an acceptable plan of correction and supporting documentation, deficiencies were corrected.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965159	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/5/2016
NAME OF FACILITY SABAL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 AN278	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.031(3) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/14/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KC	DATE 5-13-16	SIGNATURE OF SURVEYOR Kristi Conner KDC	DATE 5-13-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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