STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964934	05/26/2016
NAME OF PROVIDER OR SUPPLIER **CABOT RESERVE ON THE GREEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **4450 8TH STREET** **SARASOTA, FL 34232**	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted / through at Cabot Reserve on the Green an Assisted Living Facility with license number 9381 in Sarasota, Florida. An Extended Congregate Care Monitoring survey was completed at the same time.

The following is description of the deficiency.

0090 Training -

Based on record review and interview, the facility failed to ensure 3 (Staff A, B, and C) of 3 staff reviewed completed the required 1-hour training on the facility policy on " ."

The findings included:

1. Record review for Staff A found she was hired /. . The record had no documentation of the completion of a 1-hour training in " ."

2. Record review for Staff B found she was hired /. . The record had no documentation of the completion of a 1-hour training in " ."

3. Record review for Staff C found she was hired . The record had no documentation of the completion of a 1-hour training in " ."

4. On at 1:00 p.m., the Human Resource Director said the facility does not provide a 1-hour training in " ." They provide each new employee a copy of the facility's policy related to ."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 this deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. 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 deficiency 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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