STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968928	01/25/2017
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5311 PROCTOR RD** **SARASOTA, FL 34233**	

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

0000 - Initial Comments

An unannounced ECC monitoring survey was conducted 1/ at Harborchase of Sarasota an asssisted living facility (license number #11968928) in Sarasota, Florida.

The following is description of the deficiency:

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on record review and interview the facility failed to ensure 3 (Staff #1, #2, and #3 of 3 staff review) for ECC training requirement.

The findings included:

Record review for Staff #1 revealed a date of hire of . The record had no documentation of having received the required ECC training

Record review for Staff #2 revealed a date of hire of . The record had no documentation of having received the required ECC training.

Record review for Staff #3 revealed a date of hire of . The record had no documentation of having received the required ECC training

On 1/ at 2:26 p.m. the Director of Resident Care said they currently have 5 residents receiving ECC care. Staff #1, #2, and #3 have been employed for at least 6 months and have not received any ECC training.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Harborchase Of Sarasota
5311 Proctor Rd
Sarasota, FL 34233

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2017 by a representative 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 the 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 , 2017.** 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 surveyor. Should you have any questions please call this office at 239-335-1315.

Sincerely,

Jon Seehawer, RN
Field Office Manager

JS:
Enclosure: State (5000-3547) Form

XG90

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