STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922298	**02/11/2016**
NAME OF PROVIDER OR SUPPLIER **FAMILY TRADITIONS III**	STREET ADDRESS, CITY, STATE, ZIP CODE **352 LAKE ROAD** **VENICE, FL 34293**	

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

0000 Initial Comments

An unannounced complaint survey for CCR #2015012471 was conducted on / / at Family Traditions III, an Assisted Living facility in Venice, Florida.

The complaint contained one allegation, which was substantiated with a deficiency.

The following is description of the deficiency found at the time of the visit.

Z828 Administrative Fines: Violations

Based on observations, record review, and interview, the facility was in violation of their license by exceeding the licensed capacity.

The findings included:

On / / at 9:00 p.m., during a tour of the facility, the facility's license was viewed and indicated the capacity was for 6 residents. A total of 7 residents were observed sleeping in beds in 5 of the facility's

Staff A (caregiver) confirmed there were currently 7 residents residing at the facility and all were receiving assistance with medications and required supervision. Staff A provided demographic information sheets for all 7 of the residents. She said there had been 9 residents staying at the facility at the end of last year but 2 had been discharged.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Family Traditions Iii
352 Lake Road
Venice, FL 34293

RE: CCR #2015012471

Dear Administrator:

This letter reports the findings of a state licensure survey that was completed on , 2016 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 the 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.

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, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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