STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965888	03/31/2016
NAME OF PROVIDER OR SUPPLIER **MARY'S ON BAYSHORE**	STREET ADDRESS, CITY, STATE, ZIP CODE **441 Bayshore Drive** **VENICE, FL 34285**	

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

0000 Initial Comments

An unannounced Relicensure and a Limited Nursing Service (LNS) specialty license survey was conducted on / at Mary's on Bayshore, an Assisted Living Facility in Venice, Florida.

The following is description of the deficiencies.

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on observation, record review and interview, the facility failed to ensure 1 (Staff B) of 1 staff who assist with the self-administration of medications had received the required initial 4 hours of training.

The findings included:

On / at 9:50 a.m. Staff A, who is not a licensed nurse, was observed assisting residents with the self-administration of medications.

Record review for Staff B, the Assistant Administrator, found no documentation of having received the initial 4 hours training in assisting with the self-administration of medications.

On / at 3:30 p.m. the Administrator and the Assisted Administrator said they could not locate documentation that the Assisted Administrator had completed the 4-hour initial training in assisting with the self-administrator of medications.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Mary's On Bayshore
441 Bayshore Drive
Venice, FL 34285

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 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, 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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