Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55232	A. BUILDING: _____ B. WING _____	R 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS MARIA MANOR NURSING CARE CEN	10300 4TH ST N SAINT PETERSBURG, FL 33716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	INITIAL COMMENTS A revisit survey was conducted on 12/1/20 to 12/2/20 at Bon Secours Maria Manor Nursing Care Center, in conjunction with a revisit survey (VWSH12) and COVID-19 Focused Infection Control survey and complaint survey for complaint number 2020017346 and 2020018320 (79KG11). The previously cited deficiencies were corrected but the facility had a new deficiency cited (79KG11).	{N 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/16/20