STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967905	**08/07/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bayshore Guest Home	**512 Bayshore Rd Nokomis, FL 34275**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B

These are the results of Complaint Survey, CCR# 2013005102 which was conducted at Bayshore Manor an Assisted Living Facility (ALF) on .....

There was one allegation in this complaint, which was not confirmed.

There was 1 unrelated deficiency cited during this survey.

The following is a description of non-compliance:

0167-Resident Contracts 58A-5.025(1) FAC
Based on a review of resident records and interview with residents Power of Attorney (POA) and the Administrator, the facility failed to ensure there was a 30 day written notice of a raise in the rates for 2 (Residents #1 and #7) of 7 residents reviewed.

The findings include:

Review of Residents #1 and #7's records revealed there was a letter in both files indicated there will be a raise in the ..... effective ..... Further review of the letter revealed a note on the bottom indicating both POAs for these residents received the notification orally on ..... This did not meet the requirements for a written notice 30 days prior to the raise in the rates.

Interview with the Administrator on ..... at 1:30 p.m., revealed the Owner had spoken to the 2 POAs by telephone, but agreed they had not been provided with a written notice of the raise in rate.

Class

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bayshore Guest Home
512 Bayshore Rd
Nokomis, FL 34275

Re: CCR #2013005102

Dear Administrator:

This letter reports the findings of a Complaint survey that was conducted on , 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2013 to verify that the necessary corrections are in place to correct the deficiencies 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,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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