STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910479	11/07/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Maryland Manor	7632 Maryland Avenue Hudson, FL 34667	
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= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013008487, was conducted on .

The Maryland Manor Assisted Living Facility had a deficiency found at the time of this visit.

0167-Resident Contracts 58A-5.025(1) FAC

Based upon record review and interview the facility failed to ensure a contract was executed on or prior to admission for 2 (#2 & 3) of 3 residents reviewed.

Findings include:

1. A review of the record for resident #3, admitted on revealed the record did not contain a copy of a contract executed prior to or at the time of admission between the resident/responsible party and the facility.

2. A review of the record for resident #2 revealed the contract on file did not include a monthly rate. The resident was admitted on .

During interview at about 11:00 am he acknowledged he had not obtained a contract for resident #1 and did not include the monthly rate for resident #2 since he did not know the amount the resident would receive upon admission. The administrator adjusts the monthly rate depending on the residents ability to pay.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2013

Administrator
Maryland Manor
7632 Maryland Avenue
Hudson, FL 34667

Dear Administrator:

Re: **CCR# 2013008487**

This letter reports the findings of a complaint survey that was conducted on , 2013, by representative(s) 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. Staff from this office will conduct a review 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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