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
	AL11964850	A. BUILDING: _____ B. WING _____	03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF HAINES CITY	301 PENINSULAR DRIVE HAINES CITY, FL 33844

(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
A 000	Initial Comments A complaint survey (complaint numbers 2019019891, 2020000819 and 2020001310) was conducted at Savannah Court of Haines City Assisted Living Facility on . . . . . The facility had deficient practices identified at the time of the survey.	A 000		
A 168 SS=D	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than	A 168		

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
	AL11964850	A. BUILDING: _____ B. WING _____	03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF HAINES CITY	301 PENINSULAR DRIVE HAINES CITY, FL 33844

(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
A 168	Continued From page 1 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. 429.27, FS Property and personal affairs of residents. - (7) In the event of the . . . . of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964850	A. BUILDING: _____ B. WING _____	03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF HAINES CITY	301 PENINSULAR DRIVE HAINES CITY, FL 33844

(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
A 168	Continued From page 2 resident's . . . . , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility did not follow their contract to honor the refund policy for 1 (Resident #7) of 3 residents files reviewed for refunds. Findings Included: A record review on of the facility financial agreements for Resident #7 sections of Refund Policy: stated, "the facility shall provide a refund to the resident or responsible party with 45 days after the transfer, discharge or of the resident." On . . . . . a record review of the facility admissions and discharge log revealed Resident #7 was admitted to the facility on . . . . . and was discharged for reasons " " on . . . . . and transferred to a higher level of care one day of final payment to the facility. A record review on of Resident #7 financial agreement with the facility showed a date of . Resident #7 agreed to payment a monthly amount of $3,690 which was signed by Resident #7, her responsible party and the facility representative on . . . . . . Records revealed Resident #7 paid an additional one-time non-refundable administrative fee in the amount of $2,500 provided via check made out to the facility on . . . . . Resident #7 records showed a total amount of $6,190.00 was paid to the facility. Per review of Resident #7 financial agreement it showed Resident #7 was due	A 168		

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
	AL11964850	A. BUILDING: _____ B. WING _____	03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF HAINES CITY	301 PENINSULAR DRIVE HAINES CITY, FL 33844

(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
A 168	Continued From page 3 a refund in the amount of $3,690.00 by During an interview with the facility's Administrator on at 11:30 a.m., the Administrator stated, Resident #7 was admitted to the facility on and discharged a day later due being Bake Acted on /20219. The Administrator stated, he was told by the corporate office to deposit Resident #7's check in the amount of $6,190.00 on . When asked why he deposited Resident #7 check, the Administrator stated, "because she did not give a 30-day notice of discharge therefore she wasn't due a refund." The Administrator agreed that the reason for the Resident #7 discharge was due to emergency medical reasons " ." on which was involuntary. The Administrator stated that Resident #7 never moved into her room and received respite care for one day. However, the facility could not produce evidence that a $3,690.00 was refunded to Resident #7 and/or her responsible party on record. Class III	A 168		