

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968666	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/28/2023
NAME OF PROVIDER OR SUPPLIER HOMEWOOD LODGE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 430 SE MILLS ST MAYO, FL 32066		
(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 An unannounced complaint investigation (complaint number 2023005149) and a Generator Assessment was conducted at Homewood Lodge Assisted Living Facility on 8/28/2023 and 8/29/2023. Deficiencies were identified at the time of survey.	A 000			
A 011	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide a written discharge notice to 1 of 3 residents sampled, Resident #1. Findings include: A review of the facility's Admissions/Discharge log was conducted on 8/28/2023 and revealed Resident #1 was admitted to the facility on 8/28/2023 from another assisted living facility. Resident #1 was discharged from the facility on 8/28/2023 due to being transferred to hospital. On 8/28/2023 at 11:40 AM, during an interview with the Administrator, she stated Resident #1 was not given a 45-day notice because she was a harm to herself and others. She stated the facility could not except her. On 8/28/2023 at 12:18 PM, during an interview with the Administrator, she stated "Usually we would send a 45-day notice, but it would say	A 011			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968666	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/28/2023
NAME OF PROVIDER OR SUPPLIER HOMEWOOD LODGE ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 430 SE MILLS ST MAYO, FL 32066			
(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 011	Continued From page 1 'immediate.'" The Administrator stated that no written notice of discharge was given to Resident #1 or sent to her Power of Attorney. Class III	A 011			