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 |
|---|---|---|---|
| | AL11910478 | A. BUILDING: _____ B. WING _____ | R 10/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELANCE AT PASADENA | 1255 PASADENA AVENUE, S. SAINT PETERSBURG, FL 33707 |

| (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<br><br>A revisit to an complaint investigation (# 2023012726) was conducted at Elance at Pasadena on . Deficiencies were identified at the time of the visit. | {A 000} | | |
| {A 170} SS=D | 429.24(3)a Resident Refund Policy<br><br>....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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that a resident or their responsible party received a refund within 45-days of resident's transfer or discharge from the facility for one (Resident # 15) of one sampled resident.<br><br>Findings included:<br><br>In a record review of the refund check issued to Resident #15 ( ) conducted on there was no record that the refund check addressed to the resident at a local address had been mailed or cashed.<br><br>In an interview with the responsible party for Resident #15 conducted on at 1:03pm | {A 170} | | |

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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910478 | A. BUILDING: _____ B. WING _____ | R 10/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELANCE AT PASADENA | 1255 PASADENA AVENUE, S. SAINT PETERSBURG, FL 33707 |

| (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 170} | Continued From page 1<br><br>they had not received the refund check at their northern address where they had requested it be sent.<br><br>In an interview conducted on at 1:56pm with the Director of Clinical Services she said that they should have followed up to see if the refund was received.<br><br>Photo Evidence Obtained.<br><br>Class III | {A 170} | | |