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
	AL11969061	A. BUILDING: _____ B. WING _____	R 06/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CREEK OF ST	165 SILVER LN SAINT , FL 32084

(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 revisit to a relicensure survey and complaints (complaints 2023009785 and 2023012593) was conducted at Silver Creek of St. through . Deficient practice was identified at the time of the survey.	{A 000}		
A 170 SS=D	429.24(3)a Resident Refund Policy ....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. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to provide a timely refund to the resident or responsible party within 45 days after the discharge for 3 of 4 sampled residents, Resident #1, #2 and #3. The findings include: During an interview conducted on at 3:12pm with the Business Office Manager (BOM) she was asked to explain the facility's discharge policy. She stated that once a resident moved out they verify their belongings are gone. She stated that she works with the corporate accounts receivable department to issue resident refunds once the room was completely vacated and the resident was physically gone from the facility. She stated the ledgers were reviewed to confirm	A 170		

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
	AL11969061	A. BUILDING: _____ B. WING _____	R 06/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CREEK OF ST	165 SILVER LN SAINT , FL 32084

(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 billing accuracy. She stated if a refund was due, the refund request is then sent to the corporate accounts receivable department and all refunds were issued by the corporate office. She stated the refunds should be issued within 45 days, adding they were behind in the process due to a change in management. A Resident Move-Out Summary/Refund Request form for Resident #2 documented the move out date as . The refund of $1,959.23 for Resident #2 was issued in 49 days, on . Photographic evidence obtained. Resident #3's Resident Move-Out Summary/Refund Request showed a discharge date of . The refund of $6,664.00 for Resident #3 was issued in 69 days, on . Photographic evidence obtained. The BOM confirmed on at 10:21am that refunds for Resident #2 and #3 were issued past the 45 day deadline. On at 1:50pm, the Administrator and a Regional representative provided the requested billing information for Resident #1. Review of the documentation provided revealed Resident #1 moved out and billing stopped on but she was not issued a refund for 62 days. They confirmed the refund of $2,076 was issued on . Neither were able to provide information to explain why the refund was issued after the 45 day deadline. Photographic evidence obtained. On the facility's interim Administrator provided additional information for refunds requested under the new management company which took over in . Review of the	A 170		

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
	AL11969061	A. BUILDING: _____ B. WING _____	R 06/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER CREEK OF ST	165 SILVER LN SAINT , FL 32084

(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 2 information sent from the facility showed three of the four refunds processed under the new management company were processed beyond 45 days. Photographic evidence obtained. On a representative for Resident #1 confirmed the refund was provided on . Review of the Resident Refund Policy and Procedure Revised revealed: Resident refunds will be sent out with in 45 days of Move Out (due date). In the event the paperwork arrives from the community as this deadline approaches, please take appropriate steps to expedite these refunds. CLASS III	A 170		