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
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 investigtaion for #20260000934 was conducted at Harmony Meadows on . Deficiencies were identified at the time of the survey.	A 000		
A 030 SS=I	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 1	A 030		

and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to provide the required 45-day notice of relocation or termination of residency for 5 (Residents #) of 5 residents reviewed. This failure to adhere to the statute deprived the residents of their right to safe and orderly transition and the legally mandated timeframe to secure alternative housing and care arrangements. This resulted in actual harm in housing instability to the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 6 residents and represented a systemic failure to implement a resident-centered discharge process. F.S 429.28 Resident bill of rights: (1) No resident of a facility shall be deprived d of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility have the right to: (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (k) At least 45 days' notice of relocation or termination of residency from the facility unless for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. . . In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. The findings included: Record review of the facility's notification of closure dated indicated the following: " ...Harmony Meadows will be discontinuing operations and initiating closure procedures as quickly as possible. We are working urgently with the Florida Agency for Health Care Administration	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 7 (AHCA) to ensure all residents are safely and appropriately relocated to other licensed facilities or appropriate settings that meet your needs. Important Details: Closure Timeline: We are beginning the closure process immediately and aiming to complete resident relocations in the coming days to weeks, with full oversight and assistance from AHCA to minimize disruption. Record review of the facility's Residency Agreement, Article VI; Termination; indicated the following: "6.1. Emergency Termination. This Agreement may be terminated immediately without prior notice in the event of an emergency for the following reasons: a. The RESIDENT is certified by a physician or other licensed health care professional to require an emergency relocation to a facility providing a more skilled level of care. b. The RESIDENT engages in a pattern of conduct that is harmful or offensive to other residents. 6.2. Non-Emergency Termination. This Agreement may be terminated after not less than forty-five (45) days' written notice of relocation or termination of residency from the FACILITY for the following non-emergency situations: After conclusive findings that the RESIDENT is significantly declining in medical status, by the RESIDENT's health care provider, and the Administrator after consultation with the health care provider determines the FACILITY can no longer meet the overall needs of the RESIDENT; or The RESIDENT no longer meets Admission or Retention Criteria according to the State Regulations and the FACILITY'S	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 8 ADMISSION/RETENTION DISHCARGE POLICIES AND PROCEDURES; or After the RESIDENT has been adjudicated mentally , , the guardian or REPRESENTATIVE or such RESIDENT shall be given forty-five (45) days' notice; or The RESIDENT consistently violates the House Rules and/or exhibits behavior that is disruptive to other Residents and or the Caregivers." During an interview on at 9:20 a.m., Resident #1 was observed sitting in wheelchair in the living room crying. She said that she was doing okay, but she feels horrible about leaving this place. Resident #1 said it was a that they kicked them all out and it felt unfair. She said her family member is coming and she is leaving today, but she doesn't know where she is going - her family member picked it out. Resident #1 asked if this surveyor could help them (the owner) not get another place like this as she didn't want anyone else to go through what the Owner was doing to them. During an interview on at 10:03 a.m., Resident #4 was observed resting in her recliner chair in her bedroom watching television quietly with tears in her . Resident #4 said she is aware that she is moving. Her family member is coming to pick her up today. She said that she doesn't know how she feels about it - it is a nice place, but it is a big change. During an interview on at 10:25 a.m., Resident #5 said she has been sitting in her room crying all day. She said she is aware that she had to move. She said that she found out in a letter on Monday ( ). She said that she is in the process of getting approved for Medicaid, so if she gets approved, then she might have a place	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 9 to go. She has only been here 2 months and has not received any money yet. She said she has no family, but the Administrator has been helping her try to find a place to go. She said this has been a great place, but she has no control over the situation. She said she doesn't understand why this is happening - maybe the owner just decided to be done with it and get on with their life. During an interview on at 12:54 p.m., Resident #4's family member stated I heard on Sunday afternoon ( ) when I was here visiting my mom and if I hadn't come that day, I would not have found out. I texted the owner that day and asked for the discontinuation of service and he sent it on Monday afternoon ( ). Resident #4's family member said, "he did not give us proper notice." During an interview on at 1:05 p.m., Resident #1's family member was crying during interview and said she found out about the facility's closure from Resident #4's family member who sent her a copy of the letter on Sunday ( ). She said the owner sent her the letter on Monday ( ). She said that she hopes the Owner never is able to open another facility again. She said that he and his wife did not care about anyone -it was always the Administrator as the backbone of the facility. Resident #1's family member said she has been going crazy trying to find a place for her mother due to the short notice and she has not been able to sleep or eat. During an interview on at 9:12 a.m., the Administrator stated that she put in her 2-week notice to leave her job on , , , , which she gave to all the residents, emailed a copy to the owner, and then to the families on the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 10 following Friday (date unknown). The Administrator stated, "what happened was, I was fully staffed. I put in my notice as I was having issues with one staff being a bully to other staff members The staff member called me and quit, so I climbed out of bed and came to work. This was on the 14th. The following night, I had another staff member text me before her shift and told me she was done, so I was down 2 employees at that time. I had one of my other staff members, prior to that, give her notice and said that she would only being staying until the end of , because she had to take care of her mom. The owner put the ad out that he was looking for a new Administrator. Two people came in for interviews. Neither was hired, because then i got the letter on Sunday . The staff came in and said, "we're closing?". The Owner wanted me to send the letter to the residents - I wasn't going to send the letter to the residents. He wanted me to fill out the paperwork for change of Administrator, I have never done that before and I wasn't going to do that - he is the owner." On at 12:37 p.m., communication was received from the Assisted Living Facility licensing Unit, Agency for Health Care Administration (AHCA), indicating the facility did not send the Agency any form of notification regarding closure of the facility as required by law. During an interview on at 11:12 a.m., the Owner stated, "the letter was sent to the residents and their families on . I thought the Administrator, had also informed them in person or by text - however she contacts them. He said the Administrator was the first person he informed the day before the letter was sent about	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968897	A. BUILDING: _____ B. WING _____	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY MEADOWS	711 CRESTLINE AVE S LEHIGH ACRES, FL 33974

(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 030	Continued From page 11 the closure. The Owner stated, " Yeah, so ummm, I got a resignation from the Administrator, and we had three caregivers resign, and so we are unable to cover their care, it was impossible to find an Administrator and three caregivers in that amount of time. Well, no I wasn't aware of using staffing agencies. But we were kind of on the fence as to whether to keep the facility open anyway's and it kind of put us in the situation where we kind of have to shut it down anyway's; we just can't keep it open. Unless of an emergency is what I was informed through an online search. Which financially, we wouldn't be able to provide. There was no one at AHCA that provided me with that information about the notice. I did a search online and used Grok (online search engine) for the legal process; for discharge of a resident with less than 45 days' notice, for an emergency situation and that is what it told me-. It wasn't a 3-day notice - it was letting them know of the circumstances and that the Administrator was leaving on this date ( ). I told the Administrator to notify AHCA and the Ombudsman to reach out for support. I asked her to do it as the Administrator, and she said that she hasn't had time." Review of the facility Admission/Discharge log revealed Resident #2 was discharged on , Resident #3 was discharged on , location discharged to; home with POA, the reason for discharge was documented as "closing." There was no discharge date, location discharged to, and reason for discharge documented on the facility log for Residents #1, #4, and #5. Class II	A 030		