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
	AL11968369	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER TREASURES AT ST JOHNS	100 HILLCREST HEIGHTS AVE ST JOHNS, FL 32259

(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 investigation (complaint #2025016805) was conducted at Silver Treasures at St. Johns on 1/29/26. Deficiencies were identified at the time of the investigation.	A 000		
A 170	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 death 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 record review and interview, the facility failed to provide refunds within 45 days for 3 of 3 residents (Resident #1, Resident #2 and Resident #3) whose records were reviewed. Findings Included: 1. A review of Resident #2's record revealed that she passed away on 9/24/25, while residing at the facility. A Release of Resident Suite form was signed by a family member which indicated her belongings were removed from the facility on 9/25/25, and if a refund was due, it would be credited within 45 days. Photographic evidence obtained, The record showed that the resident's September 2025 rent had been paid in full and was credited to her account. A refund of $1,097.25 was due to	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
	AL11968369	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER TREASURES AT ST JOHNS	100 HILLCREST HEIGHTS AVE ST JOHNS, FL 32259

(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 Resident #2's family. Photographic evidence obtained. There was no reference to, or copy of, a refund check in the resident's record. A review of Resident #3's record revealed that she passed away on 9/9/25, while residing at the facility. and A Release of Resident Suite form was signed by a family member indicating her belongings were removed from the facility on 9/11/25, and if applicable, a refund would be issued in 45 days. Photographic evidence obtained. The record showed that the resident's September 2025 rent had been paid in full and was credited to her account. The record showed that a refund of $4,169.55 was due to the resident's family. There was no reference to or copy of a refund check, due by 10/26/25, in the resident's record. In an interview with the Accounting Specialist at 11:50am on 1/29/26, she stated that the refund check had still not been issued to the Resident #2 or #3's family representative. 2. A review of Resident #1's record revealed that she passed away on 8/18/25, while residing at the facility. Her Release of Resident Suite form indicated her belongings were removed from the unit on 8/22/25. Photographic evidence obtained. The record showed Resident #1s August 2025 rent had been paid in full and was credited to her account. A prorated refund of $1,684.37 was due to the resident's family by 10/6/25. The record showed a check in the amount of $1,684.37 was not issued to the family of Resident #1 until 1/15/26. Photographic evidence obtained.	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
	AL11968369	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER TREASURES AT ST JOHNS	100 HILLCREST HEIGHTS AVE ST JOHNS, FL 32259

(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 In an interview with the Accounting Specialist at 11:55am on 1/29/26, she verified that Resident #1's refund check was issued to her family on 1/15/26. In an interview with the Administrative Assistant and the Accounting Specialist at 1:00pm on 1/29/26, it was discussed that the 3 records reviewed revealed that none of the families received refunds of their prepaid funds within the regulated timeframe. They both stated they were aware of requirements. Class III	A 170		