

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964119</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/08/2026</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**GABLES ESTATES INC**

**1881 SW 37TH AVENUE  
MIAMI, FL 33145**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| ZZ875                    | <p>430.5025(4 &amp; ) / ;<br/>Training</p> <p>(4) Employees of covered providers must complete the following training for 's and related forms of :</p> <p>(a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of .</p> <p>(b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department.</p> <p>1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion.</p> <p>2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies.</p> <p>3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider.</p> <p>(c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each</p> | ZZ875               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GABLES ESTATES INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1881 SW 37TH AVENUE<br/>MIAMI, FL 33145</b>                                  |                          |                                                        |
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| ZZ875                                                         | Continued From page 1<br><br>employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers.<br>(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.<br>(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with _____'s or related forms of _____, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:<br>1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).<br>2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of _____-specific training. Such training must include, but is not limited to, understanding _____ and related forms of _____, the stages of _____'s communication strategies, medical information, | ZZ875                                                                          |                                                                                                                          |                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GABLES ESTATES INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1881 SW 37TH AVENUE<br/>MIAMI, FL 33145</b>                                  |                          |                                                        |
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| ZZ875                                                         | Continued From page 2<br><br>and stress management.<br>3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or on-experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning . chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.<br>(f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request.<br>2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. | ZZ875                                                                          |                                                                                                                          |                          |                                                        |

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| ZZ875                                                         | <p>Continued From page 3</p> <p>(7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant.</p> <p>(8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board.</p> <p>(9) Each person employed, _____, or referred to provide services before _____, must complete the training required in this section before _____. Proof of completion of equivalent training completed before _____ shall substitute for the training required in subsection (4). Each person employed, _____, or referred to provide services on or after _____, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6).</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the staff received and reviewed basic written information about interacting with _____ and Related (ADRD) for one out of three (Administrator) sampled staff.</p> <p>Findings included:</p> <p>A review of the Administrator's record showed no documentation that she received and reviewed basic written information about interacting with ARDR. The Administrator was hired on _____.</p> | ZZ875                                                                          |                                                                                                                          |                          |                                                        |

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| ZZ875                                                         | Continued From page 4<br><br>On _____ at 12:25 PM, the Owner stated<br>she would make sure the Administrator received<br>the basic written information about interacting<br>with _____ and Related _____.<br><br>Class III | ZZ875                                                                                   |                                                                                                                          |                          |                                                        |

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| A 000                                                         | Initial Comments<br><br>A re-licensure survey and a generator monitoring<br>were conducted at Gables Estates Inc on<br>. Deficiencies were identified at the<br>time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 000                                                                          |                                                                                                                          |                          |                                                        |
| A 031<br>SS=D                                                 | 59A-36.007(6) FAC Resident Care - Third Party<br>Services<br><br>(6) THIRD PARTY SERVICES.<br>(a) Nothing in this rule chapter is intended to<br>prohibit a resident or the resident's representative<br>from independently arranging, , and<br>paying for services provided by a third party of the<br>resident's choice, including a licensed home<br>health agency or private nurse, or receiving<br>services through an out-patient clinic, provided<br>the resident meets the criteria for admission and<br>continued residency and the resident complies<br>with the facility's policy relating to the delivery of<br>services in the facility by third parties. The<br>facility's policies must require the third party to<br>coordinate with the facility regarding the<br>resident's condition and the services being<br>provided.<br>(b) When residents require or arrange for<br>services from a third party provider, the facility<br>administrator or designee must allow for the<br>receipt of those services, provided that the<br>resident meets the criteria for admission and<br>continued residency. The facility, when requested<br>by residents or representatives, must coordinate<br>with the provider to facilitate the receipt of care<br>and services provided to meet the ,<br>resident's needs.<br>(c) The administrator or designee must ensure<br>that:<br>1. Care coordination includes documented<br>communications about the resident's condition<br>and response to treatment or services ordered by | A 031                                                                          |                                                                                                                          |                          |                                                        |

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| A 031                                                         | <p>Continued From page 1</p> <p>the physician which may impact the resident's appropriateness for continued residency in the facility;</p> <p>2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and</p> <p>3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition.</p> <p>4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3.</p> <p>(d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to have the initial care plan from hospice for one out of six (Resident # 1) sampled residents.</p> | A 031                                                                          |                                                                                                                          |                          |                                                        |

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| A 031                                                         | Continued From page 2<br><br>Findings included:<br><br>On _____ at 12:25 PM, the Owner stated,<br>"Resident # 1 was recently admitted to a new<br>hospice care."<br><br>A review of Resident #1's record showed the<br>resident was admitted to hospice on _____.<br>There was no documentation of the initial care<br>plan.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | A 031                                                                          |                                                                                                                          |                          |                                                        |
| A 078<br>SS=D                                                 | 59A-36.010(2) FAC Staffing Standards - Staff<br>(2) STAFF.<br>(a) Within 30 days after beginning employment,<br>newly hired staff must submit a written statement<br>from a health care provider documenting that the<br>individual does not have any signs or symptoms<br>of communicable _____. The examination<br>performed by the health care provider must have<br>been conducted no earlier than 6 months before<br>submission of the statement. Newly hired staff<br>does not include an employee transferring without<br>a break in service from one facility to another<br>when the facility is under the same management<br>or ownership.<br>1. Evidence of a negative<br>examination must be documented on an annual<br>basis. Documentation provided by the Florida<br>Department of Health or a licensed health care<br>provider certifying that there is a shortage of<br>_____ testing materials satisfies the annual<br>examination requirement. An<br>individual with a positive _____ test must<br>submit a health care provider's statement that the<br>individual does not constitute a risk of _____. | A 078                                                                          |                                                                                                                          |                          |                                                        |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964119</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/08/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GABLES ESTATES INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1881 SW 37TH AVENUE<br/>MIAMI, FL 33145</b>                                  |                          |                                                        |
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| A 078                                                         | <p>Continued From page 3</p> <p>2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable .</p> <p>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.</p> <p>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.</p> <p>(d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.</p> <p>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:</p> <ol style="list-style-type: none"> <li>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,</li> <li>2. Maintain time sheets for all staff.</li> </ol> <p>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GABLES ESTATES INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1881 SW 37TH AVENUE<br/>MIAMI, FL 33145</b>                                  |                          |                                                        |
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| A 078                                                         | <p>Continued From page 4</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to ensure that the staff had a negative communicable and statement within 30 days of being hired for one out of three (Administrator) sampled staff.</p> <p>Findings included:</p> <p>A review of personnel records revealed that the Administrator had been hired on and had a health/physical examination done on , however the doctor did not write the results of the test and did not specify if the staff appeared to be at risk of transmitting communicable and</p> <p>On at 12:25 PM, the Owner stated that she had done it, and the doctor forgot to write the results.</p> <p>Class III</p> | A 078                                                                          |                                                                                                                          |                          |                                                        |
| A 167<br>SS=D                                                 | <p>59A-36.018 FAC; 429.24 FS Resident Contracts</p> <p>59A-36.018 Resident Contracts.</p> <p>(1) Pursuant to section 429.24, F.S., the facility must offer a contract for execution by the resident or the resident's legal representative before or at the time of admission. The contract must contain the following provisions:</p> <p>(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services that the resident elects to receive;</p> <p>(b) The daily, weekly, or monthly rate;</p>                                                                                                                                    | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | <p>Continued From page 5</p> <p>(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule that must be attached to the contract;</p> <p>(d) A provision stating that at least 30 days written notice will be given before any rate increase;</p> <p>(e) Any rights, duties, or _____ of residents, other than those specified in section 429.28, F.S.;</p> <p>(f) The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments;</p> <p>(g) A refund policy that must conform to section 429.24(3), F.S.;</p> <p>(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or _____ facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;</p> <p>(i) A provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility;</p> <p>(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that</p> | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | <p>Continued From page 6</p> <p>the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in section 429.26(8), F.S., will take effect;</p> <p>(k) A provision that residents must be assessed upon admission pursuant to subsection 59A-36.006(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4), of that rule;</p> <p>(l) The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and,</p> <p>(m) The facility's policies and procedures related to a properly executed DH Form 1896,</p> <p>(2) The resident, or the resident's representative, must be provided with a copy of the executed contract.</p> <p>(3) The facility may not levy an additional charge for any supplies, services, or accommodations that the facility has agreed by contract to provide as part of the standard daily, weekly, or monthly rate. The resident or resident's representative must be furnished in advance with an itemized written statement setting forth additional charges for any services, supplies, or accommodations available to residents not covered under the contract. An addendum must be added to the resident contract to reflect the additional services, supplies, or accommodations not provided under</p> | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | <p>Continued From page 7</p> <p>the original agreement. Such addendum must be dated and signed by the facility and the resident or resident's legal representative and a copy given to the resident or resident's representative.</p> <p>429.24 FS</p> <p>(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.</p> <p>(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and _____ of the residents, other than those specified in s. 429.28; and other matters that the parties deem appropriate. A new service or accommodation added to, or implemented in, a resident's contract for which the resident was not previously charged does not require a 30-day written notice of a rate increase. Whenever money is deposited or advanced by a resident in a contract as security for performance of the contract agreement or as advance rent for other than the next immediate rental period:</p> <p>(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on</p> | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | <p>Continued From page 8</p> <p>financial statements; and shall be used, or otherwise expended, only for the account of the resident.</p> <p>(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.</p> <p>(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or . . . .</p> <p>(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or . . . . facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.</p> <p>(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.</p> <p>(4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility.</p> <p>(5) Neither the contract nor any provision thereof relieves any licensee of any requirement or . . . imposed upon it by this part or rules adopted under this part.</p> | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | <p>Continued From page 9</p> <p>(6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055.</p> <p>(7) Notwithstanding the provisions of this section, facilities which consist of 60 or more apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's ... or relocation due to , , hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units.</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain a complete resident contract for one out of six (Resident #1) sampled residents.</p> <p>Findings included:</p> <p>A review of Resident #1's record revealed the contract missed the signature and date. Resident #1 was admitted on . . .</p> <p>On . . . at 12:25 PM, the Owner acknowledged that the facility did not have documentation of Resident #1's complete contract.</p> | A 167                                                                          |                                                                                                                          |                          |                                                        |

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| A 167                                                         | Continued From page 10<br><br>Class III                                                                                      | A 167                                                                                   |                                                                                                                          |  |                                                        |