STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964948	**06/19/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE DR PHILLIPS 2	**8015 PIN OAK DR. ORLANDO, FL 32819**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A Complaint Investigation CCR#2015003857 was conducted on . Brookdale at Dr. Phillips 2 Assisted Living Facility had a deficiency found at the time of the visit.

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview the facility failed to ensure 2 of 3 sampled residents (#1 & 2) received their refunds within 45 days of discharge from the facility.

Findings:

Review of Account History Reports revealed for:
Resident #1 the financial move out was . The refund check for $6,375.36 was dated , to the responsible party.
Resident #2 the financial move out was . The refund check for $4,992.00 was dated . to responsible party.

The facility did not provide a refund within 45 days of discharge from the facility.

In an interview with the nurse and administrator at 5 PM who stated, billing was stopped when the family came out and emptied the returned the keys. They also stated they were not aware the residents did not get their refund in 45 days, the refunds were made by the corporate office.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brookdale Dr Phillips 2
8015 Pin Oak Dr.
Orlando, FL 32819

RE: CCR #2015003857

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please forward documentation of correction to the Field Office.** Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964948	06/19/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE DR PHILLIPS 2**	STREET ADDRESS, CITY, STATE, ZIP CODE **8015 PIN OAK DR.** **ORLANDO, FL 32819**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

AMENDED / /

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0167 Resident Contracts

AMENDED /

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Findings:

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1. Resident #1 the financial move out was / /. The refund check for $6,375.36 was dated / / to the responsible party.

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The facility did not provide a refund within 45 days of discharge from the facility.

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Class

RICK SCOTT
GOVERNOR

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AMENDED

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Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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