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
	AL11963720	A. BUILDING: _____ B. WING _____	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS VERO BEACH	3855 INDIAN RIVER BLVD VERO BEACH, FL 32960

(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
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure adverse incident reports were filed electronically for 2 of 2 sampled residents (Resident #1 and #10) who sustained due to events over which facility personnel could exercise control rather than as a result of the resident's condition, and required the transfer of the residents from the facility to a unit providing more acute care. The findings included: A. Review of the records for Resident #1 on revealed a health assessment (AHCA Form 1823) dated that noted the resident required assistance with all ADLs (activities of daily living) except eating and had physical limitations of " wasting/atrophy". There was a mobile report dated that showed the resident sustained an "acute (more than 3 places) left (where , and connect) " as a result of a . The reason for the was noted as " , S/P (status post) ". Review of the Incident Reports completed for this resident included documented on at 1:00 PM and another on at 10:00 PM.	CZ821		

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CZ821	Continued From page 4 There was no Incident Report available for review for the noted with a . B. Review of the records for Resident #10 on revealed a health assessment (AHCA Form 1823) dated that noted the resident required assistance and supervision with all ADLs (activities of daily living) except eating and had " , poor balance, and very , memory, right , ". Review of a subsequent health assessment dated shows the resident has a "left , " and is "alert and oriented x2, ambulates with assistance, inattention, judgement". There was an After Visit Summary report dated that showed the resident had a on and an "active surgical , left upper ." placed on . Review of the Incident Reports completed for this resident included documented on at 6:05 AM, on at 7:00 AM, and another on at 07:04 AM. The two incidents that resulted in , for Residents #1 and #10 were not reported to the Agency on an adverse report as required. The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at the time of the survey.	CZ821		

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A 000	Initial Comments An unannounced Relicensure, Complaint (#2024000289, #2024010561, #2024012562, #2024013587, #2024014945) and a Generator Monitoring survey was conducted at Sodalis Vero Beach on . The provider had deficiencies at the time of the visit related to the Relicensure, Complaint #2024012562 (CZ821 and A0028) and Complaint #2024014945 (A0030).	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual	A 010		

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A 010	Continued From page 1 receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of	A 010		

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A 010	Continued From page 2 Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a	A 010		

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A 010	Continued From page 3 plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their	A 010		

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A 010	Continued From page 4 professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was determined that, the facility failed to monitor the continued appropriateness of residence for two individuals at an Assisted Living Facility (ALF) in relation to pressure injuries (PIs), for 2 of 3 sampled residents (Residents #7 and #10). The findings included: 1. On , the record for Resident #7 was reviewed and showed the resident's third party provider documentation included one Ancillary Professionals' Communication Note dated that noted " care done per orders". Review of the resident's electronic progress notes revealed no documentation of any . The resident's last health assessment (AHCA Form 1823) dated has "no" marked for the inquiry as to whether or not the resident has any pressure injuries. There was no subsequent assessment completed as required for a significant change after the resident's pressure injury was identified. The Memory Care Director (MCD) stated during interview at 11:30 AM on that the status of the was not known and the Home Health Agency/Registered Nurse (HHA/RN) would be able to provide this information. On at 12:00 PM, the RN stated this resident's pressure injury was located on his area and was currently a with as a possible date of onset. The RN provided an electronic copy of the order dated	A 010		

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A 010	Continued From page 5 by the Advanced Practice Registered Nurse (APRN) that indicated "skilled nursing to provide care to ...". There was no documentation of the staging and date of onset available for review at the facility. The RN stated that communication of the status of the was completed by texting between the APRN and Health and Wellness Director (HWD), and acknowledged that the Ancillary Professionals' Communication Note had not been completed by the HHA nurses every time they provided care at the facility. A subsequent interview was conducted at 12:10 PM on with the HWD, Administrator and RN present. The RN stated at this time that the 's date of onset may have been but that it had resolved sometime between that date and today, but had returned. There was no documentation available for review at this time to show the facility's monitoring of the 's status. 2. A list of residents receiving HHA care for was received by the facility on that did not include Resident #10. During interview with the HWD on at 11:40 AM, she was asked if the facility had any other residents who had a pressure injury other than Resident #7. She responded, "I don't think we have any up here (not in the secured unit)". On at 12:00 PM, the Home Health Agency/Registered Nurse (HHA/RN) stated Resident #10 had a pressure injury that was located on the left area and was currently a with as a possible date of onset, as this was the day he returned to the ALF from a Skilled Nursing Facility (SNF). This resident was not previously identified by the ALF	A 010		

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A 010	Continued From page 6 as having a pressure injury. There was no documentation of the staging and date of onset available for review at the facility. The RN stated that communication of the status of the was completed by texting between the APRN and HWD, and acknowledged that the Ancillary Professionals' Communication Note had not been completed by the HHA nurses every time they provided care at the facility. On , the record for Resident #10 was reviewed and showed the resident's third party provider documentation on file did not include any Ancillary Professionals' Communication Notes. Review of the resident's electronic progress notes revealed no documentation of any . The resident's last health assessment (AHCA Form 1823) dated has "no" marked for the inquiry as to whether or not the resident has any pressure injuries. There was no subsequent assessment completed as required for a significant change after the resident's pressure injury was identified. An interview was conducted at 12:30 PM on with the HWD who stated the APRN reported that the for Resident #10 was a ⌄ instead of a ⌄ . There was no documentation available for review at this time to show the facility's monitoring of the 's status. A resident requiring care of a ⌄ pressure injury may be retained in an ALF provided that the condition is documented in the resident's record; and, if the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. The Administrator is responsible for monitoring the continued appropriateness of	A 010		

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A 010	Continued From page 7 placement of a resident in the facility at all times. Resident #7 and #10 were inappropriate for ALF residency due to having a ⌄ pressure injury without documentation showing monitoring and improvement within 30 days, and a pressure injury worse than a ⌄ with no documentation of the monitoring of the . There were no records to show the stages of the since onset, and the monitoring of the condition of the that is required to determine appropriateness of continued residency in an ALF. The facility's policy and procedure for Third Party Providers requires the HWD to coordinate with the home health agencies to meet specific service goals and to document this in the HWD notes. It also requires that the third party providers "keep careful progress notes while the resident is receiving services and will, at a minimum, leave a copy with the HWD upon the completion of services". Additionally, the facility's policy and procedure for Reportable Events directs the Administrator (Executive Director) and HWD to contact the Regional Director of Operations (RDO) "within 24 hours if a resident moves into the facility with a ⌄ or greater ...returns the community with a similar , or develops a while living in the community". There was no evidence of their policy and procedure being followed for notification to the RDO, as there was no knowledge of or continuous monitoring of the status of the . The Administrator and HWD were notified of these findings on at 5:45 PM. The facility provided no additional information for	A 010		

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A 010	Continued From page 8 review at the time of the survey. Class III	A 010		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 3 of 3 sampled residents (Residents #3, #5 and #10) were assisted with grooming and hygiene as needed regarding nail care; and, failed to ensure assistance or supervision was provided as needed to prevent for 2 of 3 sampled residents (Residents #1 and #10). The findings included: (1) On at 10:10 AM, Residents #3 and #5 were observed in the secured unit with long, jagged edge with a dark substance underneath and nail polish that started in the middle of the nail, peeling off. Resident #10 was observed with long, jagged edge with a dark substance underneath. The residents had and were not able to be interviewed. The Administrator was notified of these findings on at 5:45 PM, and stated that it was unknown if the facility was allowed to clip	A 028		

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	AL11963720	A. BUILDING: _____ B. WING _____	08/18/2025

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A 028	Continued From page 9 residents' ᵕ . There was no documentation or information provided that indicated the residents' representatives were asked to assist, if the licensed nurse at the facility had attempted to provide this service, or if the caregivers were trained and expected to assist the residents as needed with trimming and cleaning their ᵕ . (2) The facility's Clinical Protocol: policy and procedure was reviewed on and instructed the facility to complete the following tasks after each to ensure the appropriate care and interventions were received: a. Notify the physician of . b. Notify the family and/or representative of the ... c. Med Tech or HWD (Health and Wellness Director) will complete a Resident Incident and Accident Report and document all care given in resident's progress note along with a list of individuals notified. d. Place the resident on 72-hour follow-up charting... e. The HWD and ED (Executive Director/Administrator) will consult on proper follow-up related to: 1. Resident service plan changes. 2. Risk/Assessment and follow-up. The facility's policy and procedure for Reportable Events directs the Administrator (Executive Director) and HWD to contact the Regional Director of Operations (RDO) "within 24 hours following any major injury to a resident. Major injuries include , , and hematomas". There was no evidence of their policy and procedure being followed for notification to the RDO, as there was no	A 028		

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A 028	Continued From page 10 documentation of this for the following . A. Review of the records for Resident #1 on revealed a health assessment (AHCA Form 1823) dated that noted the resident required assistance with all ADLs (activities of daily living) except eating and had physical limitations of " wasting/atrophy". There was a mobile , report dated that showed the resident sustained an "acute (more than 3 places) left (where , and , connect) " as a result of a . The reason for the , was noted as " , S/P (status post) ". Review of the Incident Reports completed for this resident included documented on at 1:00 PM and another on at 10:00 PM. There was no Incident Report available for review for the noted with a . The two other Incident Reports had missing information on each, including the type of injury, the Administrator's signature, the witness information, the description of what happened by the resident, the investigation into what lead up to the and what may have caused them, and any interventions put in place to prevent reoccurrence. There were no Progress Notes documented for any of the . B. Review of the records for Resident #10 on revealed a health assessment (AHCA Form 1823) dated that noted the resident required assistance and supervision with all ADLs (activities of daily living) except eating and had " , poor balance, and very , memory, right , ". Review of a subsequent health assessment dated shows the resident has a "left , " and is "alert and oriented x2, ambulates with assistance, inattention, judgement". There was an After Visit	A 028		

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A 028	Continued From page 11 Summary report dated that showed the resident had a on and an "active surgical , left upper ." placed on . Review of the Incident Reports completed for this resident included documented on at 6:05 AM, on at 7:00 AM, and another on at 07:04 AM. The three Incident Reports had missing information on each, including the type of injury, representative notification, the Administrator's signature, the witness information, the description of what happened by the resident, the investigation into what lead up to the and what may have caused them, and any interventions put in place to prevent reoccurrence. There were no Progress Notes documented for any of the . The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at the time of the survey. Class III	A 028		
A 030	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	A 030		

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A 030	Continued From page 12 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 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	A 030		

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A 030	Continued From page 13 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 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	A 030		

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A 030	Continued From page 14 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 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	A 030		

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A 030	Continued From page 15 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 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	A 030		

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A 030	Continued From page 16 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 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	A 030		

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A 030	Continued From page 17 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 observations, record review and interviews, the facility failed to adhere to residents' rights pertaining to a safe environment for 28 of 28 sampled residents in the secured unit in relation to control; and, failed to adhere to residents' rights relative to personal dignity for 30 of 30 current residents. The findings included: 1. On at 10:30 AM, the Memory Care Director (MCD) stated during interview that all 28 of the secured unit's residents that resided at the facility on or about were treated for . . At this time, the documentation to show these treatments was reviewed and contained 28 health care provider orders dated for Invermectin (pills) and (cream) (prescriptions used to treat) with a diagnosis listed as " ". There was no other documentation available to show any other steps taken to address a possible outbreak. At 2:00 PM on , a Department of Health (DOH) representative stated during interview that the facility had an outbreak of a like illness identified in , and that there was no other known outbreak of a like illness. She stated that she had contacted the Health and Wellness Director (HWD) on because of	A 030		

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A 030	Continued From page 18 information received about an outbreak, and that the HWD stated to her that there were no resident's experiencing this. She stated that the facility is required to notify the DOH if two or more residents experience a like illness, and that the DOH would give them guidelines to follow such as washing all of the residents' bedding and clothing. She said the facility would need to keep a line item list of residents experiencing this and update the DOH. She recommended testing of any residents who presented with a like illness before treating with prescribed medication. During observation of Residents #4 and #6 at 10:00 AM on , they were seen itching themselves constantly under their clothing around the area for approximately 15 minutes. Review of these residents' Medication Observation Records (MORs) dated revealed both had been treated for a like illness that included the two prescriptions used for the treatment of on and The facility's policy and procedure for Control requires the facility to "notify the local health department of any outbreak per local guidelines. The President will also be notified of any outbreaks or confirmed cases of in a resident residing in the community". The HWD acknowledged during interview on at 3:00 PM that the facility did not have documentation of the washing of the bedding and clothing that was reportedly completed in and as a result of the like illness. She stated there had been a possible test of Resident #4's skin in 2024 and that it was believed to be negative for , but	A 030		

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A 030	Continued From page 19 there was no documentation to show the test results. There was no evidence of any skin testing completed in , when the residents again experienced a like illness. She indicated Resident #4 and #6 had medical diagnoses that caused them to itch, but no documentation of these was available for review, and that the dermatologist would not be at the facility to conduct a skin test until next month. It is unkown why the like illness in , was not reported to the DOH representative during her interview with the HWD on , while the 28 residents were being treated for a like illness. 2. During observation of residents (30 current residents) in the secured unit on during lunch at 12:30 PM, approximately 5 plates were noted to have a whole chicken (uncut) with bacon wrapped around it. One resident was observed using a fork to pick the bacon off of the chicken. There were no knives available for residents to use to cut their food. Staff I (Caregiver) stated during interview at this time that the residents were "not allowed to have knives in memory care" and that this was told to her a "few months ago" by an unknown person. She was not able to explain why the residents were not able to have knives, and stated that the kitchen staff brought the utensils used by the residents for each meal. The Food Service Director was interviewed at 12:45 PM on and stated he did not know why knives were not brought over to the secured unit for the residents' lunch today and that there was no restriction of utensils for these residents that he was aware of.	A 030		

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A 030	Continued From page 20 The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at this time. Class III	A 030		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition	A 031		

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A 031	Continued From page 21 and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 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. 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. (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. This Statute or Rule is not met as evidenced by: Based on record review and interviews, it was determined that, the facility failed to coordinate care with a third party provider, including	A 031		

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(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 031	Continued From page 22 documentation of communication about the resident's condition and response to treatment or services ordered by the health care provider, which may impact the resident's appropriateness for continued residency in the facility in relation to pressure injuries (PIs) for 2 of 3 sampled residents (Residents #7 and #10). The findings included: 1. On , the record for Resident #7 was reviewed and showed the resident's third party provider documentation included one Ancillary Professionals' Communication Note dated that noted " care done per orders". Review of the resident's electronic progress notes revealed no documentation of any . The Memory Care Director (MCD) stated during interview at 11:30 AM on that the status of the was not known and the Home Health Agency/Registered Nurse (HHA/RN) would be able to provide this information. On at 12:00 PM, the RN stated this resident's pressure injury was located on his area and was currently a with as a possible date of onset. The RN provided an electronic copy of the order on her tablet dated by the Advanced Practice Registered Nurse (APRN) that indicated "skilled nursing to provide care to ...". There was no documentation of the staging and date of onset available for review at the facility. The RN stated that communication of the status of the was completed by texting between the APRN and Health and Wellness Director (HWD), and acknowledged that the Ancillary Professionals' Communication Note had not been completed by	A 031		

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A 031	Continued From page 23 the HHA nurses every time they provided care at the facility. A subsequent interview was conducted at 12:10 PM on with the HWD, Administrator and RN present. The RN stated at this time that the 's date of onset may have been but that it had resolved sometime between that date and today, and had returned. There was no documentation available for review at this time to show the facility's monitoring of the 's status. 2. On at 12:00 PM, the Home Health Agency/Registered Nurse (HHA/RN) stated Resident #10 had a pressure injury that was located on the left area and was currently a with as a possible date of onset, as this was the day he returned to the ALF from a Skilled Nursing Facility (SNF). There was no documentation of the staging and date of onset available for review at the facility. The RN stated that communication of the status of the was completed by texting between the APRN and HWD, and acknowledged that the Ancillary Professionals' Communication Note had not been completed by the HHA nurses every time they provided care at the facility. On , the record for Resident #10 was reviewed and showed the resident's third party provider documentation on file did not include any Ancillary Professionals' Communication Notes. Review of the resident's electronic progress notes revealed no documentation of any . Another interview was conducted at 12:30 PM on with the HWD who stated the APRN reported that the for Resident #10 was a instead of a . There was no	A 031		

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A 031	Continued From page 24 documentation available for review at this time to show the facility's monitoring of the 's status. A resident requiring care of a pressure injury may be retained in an ALF provided that the condition is documented in the resident's record; and, if the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. The Administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. Resident #7 and #10 were receiving care by a third party provider (HHA) for pressure injuries that affected their appropriateness for continued residency. There were no records to show the communication with the HHA about the condition of the . The facility's policy and procedure for Third Party Providers requires the HWD to coordinate with the home health agencies to meet specific service goals and to document this in the HWD notes. It also requires that the third party providers "keep careful progress notes while the resident is receiving services and will, at a minimum, leave a copy with the HWD upon the completion of services". The Administrator and HWD were notified of these findings on at 5:45 PM. The facility provided no additional information for review at the time of the survey. Class III	A 031		

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A 032	Continued From page 25	A 032		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 26 resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 1 of 1 sampled residents (Resident #7) who is at risk for elopement had identification on their person checked once daily as part of their elopement prevention policy and procedure. The findings included: On at 10:30 AM, Resident #7 was observed in the secured unit without identification (ID) on him. During interview with the Administrator at 11:15 AM, she confirmed that they did not have identification on him and that	A 032		

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A 032	Continued From page 27 they had to get an ID from the Department of Motor Vehicles. It was explained at this tim that the ID for residents at risk for elopement required an ID that includes the facility's name, address and phone number in addition to the resident's name. Review of the health assessment (AHCA Form 1823) dated shows the inquiry as to whether or not the resident is at risk for elopement marked "yes". The resident also had an incident report completed by the facility dated showing the resident eloped from the facility prior to moving into the secured unit. There was no documentation to show the facility was checking the resident daily to ensure the ID was on him. The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at this time. Class III	A 032		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National	A 083		

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A 083	Continued From page 28 Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure at least 1 staff member who had completed courses in First Aid and held a currently valid card documenting completion of such course, was in the facility during at all times for 3 of 3 care shifts reviewed (6:00 AM - 2:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM). The findings included: On , three (3) direct care staff, one staff from each shift, were reviewed for compliance regarding First Aid coverage for each shift. Staff A, a direct caregiver/med tech who worked in memory care from 6:00 AM - 2:00 PM, did not have a valid First Aid certification card showing completion of a First Aid course. Staff B, a direct caregiver who worked 3:00 PM - 11:00 PM in the assisted living unit, did not have a valid First Aid certification card showing completion of a First Aid course. Staff C, a direct caregiver/med tech who worked 11:00 PM - 7:00 AM in the assisted living unit, did not have a valid First Aid certification card showing completion of a First Aid course. The Administrator was informed on at	A 083		

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A 083	Continued From page 29 approximately 5:00 PM that none of the sampled staff held a valid First Aid certification card, and she was asked to provide evidence that at least 1 staff member on all shifts had completed a First Aid course and held a valid certification card. At the time the surveyors left the facility, the administrator could not show that at least 1 staff currently certified in First Aid was always working in the facility. The Administrator did state that the facility's licensed nurse, who is considered to have met the training requirements for First Aid, does work 9 AM - 5 PM, Mondays through Fridays. However, from 6:00 AM - 9:00 AM, there is no one with First Aid covering that part of the morning shift. The Administrator acknowledged that the facility was not in compliance with the First Aid requirement. Class III	A 083		
A 168	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the	A 168		

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A 168	Continued From page 30 facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. .... 429.27, FS Property and personal affairs of residents. - (7) In the event of the of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and	A 168		

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A 168	Continued From page 31 other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's , the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to include the required components of the refund policy and procedure in the residency agreement without additional verbiage that negates the requirement for a prorated refund based on the daily rate to be distributed in the event of a resident's or discharge due to medical reasons for 3 of 3 sampled residents (Residents #11, #12 and #13). The findings included: On , the executed contracts between the facility and Residents #11, #12 and #13 were reviewed. The contracts contained the required wording in the refund policy and procedure under "Refunds" that includes, "You are entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the date you vacate (the facility)...". However, the contract also includes a clause under "Early Termination By You With Notice" that nullifies the preceding required proration and states, "If your health status prevents you from continuing to reside at (the facility), you will continue to be charged all applicable daily fees until (the facility) receives notice of termination and until the apartment is vacated. In order to terminate this agreement due to reasons of health, the facility requires a physician's written letter stating that you cannot be sufficiently cared for at an assisted living	A 168		

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A 168	Continued From page 32 facility. Upon , your family will continue to be charged until the belongings are vacated from the apartment or fifteen (15) days, whichever is greater". The additional clause that requires a physician's letter when a resident is discharged for medical reasons, and also allows charges to continue after for 15 days, negates the requirement in the regulations that the policy and procedure ensures the resident is provided a prorated refund based on the daily rate from the date of or discharge for medical reasons and after belongings are removed. The refund policy and procedure is required to include the clause, "Except in the case of or discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract". This states that there is no notice required by the resident when they are discharged for medical reasons or if they expire. The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at this time. Class III	A 168		
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 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	A 170		

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A 170	Continued From page 33 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 interviews, the facility failed to provide a prorated refund based on the daily rate within 45 days of a resident's passing for 2 of 3 sampled residents (Resident #11 and #13); and, failed to provide a refund within 45 days of a resident's discharge after notification for 1 of 3 sampled residents (Resident #8). The findings included: 1. On or about , Resident #8 moved out of the facility with her belongings. The resident's representative stated during interview on at 4:37 PM that he received the 2nd refund amount that was due "a few weeks ago", more than a year after the discharge date. Review of the accounting and final charges with refund information was received by the Administrator on as a "View GL Transactions" print out. This accounting showed the representative was provided a refund in the amount of $1764.72 on . The Administrator stated during interview on at 5:00 PM that she did not know why the final accounting was not showing a second refund that was provided. After contacting a corporate representative, she confirmed that the representative was provided another refund on for $2700.00, as a result of a refundable deposit received when the resident moved in. This refund was provided approximately 1 year and 4 months late, not within the 45 days from date of discharge as required.	A 170		

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A 170	Continued From page 34 2. On , Resident #11 , , and the representative subsequently moved the resident's belongings out of the facility on or about . The facility continued to charge the resident's representative as noted on the final invoice for "rent" at $146.67 a day for 15 days after his and "tier" (care) at $3.34 a day for 2 days (and), totaling $2500.00. A refund was not provided, and the representative paid the final bill for this amount. The representative should have been charged for only 2 days "rent" for and , at $293.34. The refund that is currently due because the representative was erroneously charged is $2199.99. 3. On , Resident #13 , , and the representative subsequently moved the resident's belongings out on . The facility continued to charge the resident's representative as noted on the final invoice for "rent" at $135.48 a day for 13 days after his , totaling $1761.24 ($1761.29 was actual charge on invoice). A refund was not provided, and the representative paid the final bill for this amount. The representative should have been charged for only 1 day's "rent" for , at $135.48. The refund that is currently due because the representative was erroneously charged is $1625.81. Chapter 429.24 (3), Florida Statute, requires that a refund policy "to be implemented at the time of a resident ' s transfer, discharge, or shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal	A 170		

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A 170	Continued From page 35 use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings...Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days ' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident". The Administrator was notified of these findings on at 5:45 PM. The facility provided no additional information for review at the time of the survey. Class III	A 170		