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
	AL11964948	A. BUILDING: _____ B. WING _____	C 07/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DR PHILLIPS MC	8015 PIN OAK DR. ORLANDO, FL 32819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments There were two (2) Complaint Investigation #2026010222 and #2026010997 and a generator monitoring was conducted at Brookdale Dr. Phillips Memory Care on . The facility had deficiencies at the time of the survey visit.	A 000		
A 170 SS=D	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 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 review of the facility's documentation, resident record review and interview, the facility failed to provide a timely refund for 1 of 2 sampled residents (#1) within 45 days after discharge as required. Findings: A record review for Resident #1 revealed admission date . Resident #1 was discharged to a skilled nursing home for a higher level of care and Resident #1's personal belongings were removed from the facility on . The contract agreement signed and executed on and listed contractual monthly rate due at that time was $7960.68 minus the non-refundable	A 170		

AHCA Form 3020-0001

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

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A 170	Continued From page 1 community fee $3500.00 that was included equal $4460.68. A facility's billing ledger was provided showing a refund was owed to Resident #1 amount of $892.14 for the six (6) remaining days left in , . as follows below: a) $7960.68 was paid to the facility on , (check#5229)-$3500.00 (non-refundable fee) =$4460.68. b) $4460.68 divided by 30 days in , =$148.69 (daily rate). c) $148.69 x 6 days left in , =$892.14 owed/refund due to Resident #1. On at 1:32 PM, an interview with the Business Office Manager confirmed that the $892.14 refund had not been paid to Resident #1 in a timely manner. On at 2:50 PM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) Class III	A 170		