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
	AL11953328	A. BUILDING: _____ B. WING _____	08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH PLACE	1230 POWERS AVENUE HOLLY HILL, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2026002280) was conducted at Savannah Place on , 20206. Deficiencies were identified at the time of survey.	A 000		
A 170	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or 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 interview and record review the facility failed to provide a refund to the resident or responsible party within 45 days after residency ended for 1 of 3 resident reviewed, Resident #1. The findings include: Record review of the contract for Resident #1 found it was signed by his sister on . The monthly rent was $4,500.00. Record review of the facility records provided by the Administrator revealed Resident #1 , at the facility on . Further review of the contract found the following statement. "If the event of the resident's : Fees will be prorated based on the date of . Any credit balance will be refunded to the estate or responsible party within 30 days of written	A 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953328	A. BUILDING: _____ B. WING _____	08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH PLACE	1230 POWERS AVENUE HOLLY HILL, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 170	Continued From page 1	A 170		

notice and return of key and property. Personal property must be claimed within 14 days unless other arrangements are made. The facility will document the final date of service, prorate the remaining balance, and issue a refund check payable to the estate or the responsible party." The contract also stated the agreement was month-to- month, and "either party may terminate this agreement early with 45 days written notice." There was no notice in the resident contract that prorated refunds would be based on when property was removed, only that personal items should be removed within 14 days. Nothing in the contract addressed conditions or timing in which the facility would make claims against a refund. Photographic evidence obtained.

An interview was conducted with the Administrator on at 10:51 AM. He confirmed the contract required Resident #1 to give a 45-day notice of termination. The Administrator was asked if he gave a refund to Resident #1's sister. He stated that Resident #1's family contacted him on and informed him they were going to take the resident on a trip on and wanted to do a bed hold. He stated they called and confirmed on they were taking him out on and they wanted to hold his room for the entire month. The Administrator stated when he spoke to Resident #1's sister on , the day the resident , , she was informed she needed to pick up the resident's belongings. He stated she agreed to come get everything but she still has not. He stated on , he spoke to the resident's sister and she never requested a refund, but she called again on wanting a refund for the entire month. He stated that she did not understand that what she paid in was for the entire month, so he ended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953328	A. BUILDING: _____ B. WING _____	08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH PLACE	1230 POWERS AVENUE HOLLY HILL, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 170	Continued From page 2	A 170		

the call and informed her he would reach out to his assistant and determine what she was owed. He stated he did not speak to her after that because of the way she spoke to him on the phone. He stated he decided against the refund because he still had the residents' clothes.

The Administrator provided evidence that Resident #1's sister paid the facility $2000.00 on , $2000.00 on and $500.00 on , for a total of $4,500.00 for . Nothing was provided to show a prorated refund was issued for Resident #1's rate, or that any claims against the refund were made, including charges related to storing personal items.

During further interview with the Administrator on at 11:30 AM, he was asked again why he did not give a refund. He stated he did not because when he spoke to the sister on , he had informed her she needed to remove the resident's belongings, which were clothes. There was also equipment in the room from the Hospice provider, who removed their devices on . He stated the facility put the residents' clothes in the closet and decided to hold the items until they heard from Resident #1's sister. He stated the facility decided not to use the room again for any residents because they were keeping the resident's clothes in the closet and about a month ago and made the room into an office. He stated they now don't need the room because they converted another room that was private into a semi-private room.

An observation on at 12:30 PM, of the room the Administrator stated was used by Resident #1. The closet was half full of linens and had two plastic containers with resident

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
	AL11953328	A. BUILDING: _____ B. WING _____	08/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH PLACE	1230 POWERS AVENUE HOLLY HILL, FL 32117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 170	Continued From page 3 clothes. The room itself and a desk and filing cabinets that belonged to the facility. Class III	A 170		