

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Siesta Key Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4602 Northgate Court Sarasota, FL 34234	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, residents representatives and staff interviews, the facility failed to ensure the Residents funds were conveyed to the appropriate party within the required 30-day timeframe after death or discharge from the facility, for 3 (Residents #15, #26, #27) of 3 Residents reviewed. The findings included: Review of the facility policy Refund of Overpayments Policy #10410, effective date February 1, 2019, revised date [DATE] states, Refunds Due Resident: 2. Within thirty (30) days of death of a resident, the residents personal funds and final accounting of those funds will be made available to the residents representative or to the probate administering the residents care. 1. Review of the clinical record for Resident #15 revealed an admission date of [DATE] and a discharge date of [DATE]. On [DATE] at 2:10p.m., in a telephone interview, Resident #15's Power of Attorney said that while his mother was in the facility she had about \$1800.00 or more in her account. He said his mother died in [DATE]. A few weeks after his mother died, he went to the facility to see about getting his mother's funds recuperated. Resident #15's Power of Attorney said he went to the facility about 6 times and called about 20 times, but no one would talk to him. He said he finally got the refund around [DATE]. On [DATE] at 9:18 a.m., in an interview, the Regional Director of Business Office Services said the refund of funds to a resident's family with a power of attorney on file is given within 30 days of a resident passing. She said that when Resident #15 expired on [DATE], she had a balance of \$1826.15 in her account. She said that she did not have documentation that the facility reached out to the family to notify them of the refunds due. She said that the refund was issued to Resident #15's family on [DATE]. 2. Review of the clinical record for Resident #26 revealed a date of admission of [DATE] and a discharge date of [DATE]. Review of the facility provided Resident Fund Statement revealed an ending balance of \$116.46 as of [DATE]. On [DATE] at 3:18p.m., in an interview, the Regional Director of Business Office Services verified that Resident #26 was discharged from the facility on [DATE]. She verified that the ending balance of Resident #26's account was \$116.46. The Director of Business Office Services said that the facility has not yet issued a refund to the resident. She stated the expectation of the facility is that refunds for discharged Residents are completed within 30 days of discharge. 3. Review of the clinical record for Resident #27 revealed an admission date of [DATE] and a discharge date of [DATE]. Review of the facility provided Resident Fund Statement revealed an ending balance of \$221.18 as of [DATE]. On [DATE] at 9:38 a.m., in an interview, the Regional Director of Business Office Services verified that Resident #27 was discharged from the facility on [DATE] and that the resident's account balance as of today, [DATE] was \$381.36. She confirmed that as of [DATE], the facility had not issued a refund to the resident. On [DATE] at 11:01a.m., in an interview, the Administrator said that her expectation was that once a Resident is discharged or expires, their account funds are refunded in accordance with facility policy of 30 days.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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