STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105886	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansley Cove Healthcare and Rehabilitation	1301 W Maitland Blvd Maitland, FL 32751

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)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to refund any and all monies due to the resident's representative within 30 days of the resident's date of death /discharge from the facility for 1 of 3 residents reviewed for discharge, of a total sample of 3 residents, (#1).Findings:Resident #1 resided at the facility for approximately nine years and passed away on [DATE]. Review of the resident #1's Medicaid eligibility/benefit dated [DATE] indicated the resident's gross monthly income to be $1159.22. Per the benefit, the resident was entitled to keep $160.00 a month to meet her personal needs. Review of the billing reconciliation reflecting the account from [DATE] to [DATE], revealed the resident's husband paid the monthly patient responsibility of $314.92 from the couples joint checking account.Further review of resident #1's billing reconciliation noted the patient responsibility of $314.92 continued to be drawn from the joint checking account in [DATE], after the resident had died 13 days earlier. Review of emails from the Business Office Manager to the corporate office from [DATE], and [DATE] revealed the corporate office accounting was notified by the Business Office Manager of resident #1's death and asked to remove resident #1 from the Automated Clearing House (ACH) payment.Review of emails dated [DATE], [DATE], [DATE], [DATE], and [DATE] revealed the facility was aware the resident's husband was requesting the refund from her account. An email dated [DATE] detailed the corporate office communication to the Business Office Manager and the Administrator which reported, the family is due a much bigger refund than what was originally thought.On [DATE] at 12:50 PM, the Corporate Regional Director of Operations verified resident #1's husband was owed a refund and was not sure what caused the delay. It was acknowledged that at the time of the survey the facility owed the resident's husband a refund of $1,905.35, over four months after she had passed away.On [DATE] at 12:53 PM, the Administrator confirmed the resident's family still had not received the refund from the facility. He said the facility's Business Office Manager did not have the authority to cut refund checks and they had been waiting for the corporate office to process the refund.Review of the facility's policy entitled Refund Policy/Procedure, Subject: Death of a Resident in a Facility, revised on [DATE] indicated it was the policy of the facility to provide services related to the death of a resident in a facility in accordance with state and federal regulations. Procedure 1 indicated, the facility must, upon the death of a resident with a personal fund deposited with the facility or advanced payments, convey within 30 days of the resident's death, a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

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