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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain the Agency for Healthcare Administration Background Screening clearinghouse website for 9 (Staff A, B, C, D, E, F, G, H and I) of 9 staff reviewed for background screenings.	CZ814		

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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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
CZ814	Continued From page 1 The findings included: Review of the facility's background screening on at 11:00 a.m., showed Staff A with a date of hire of . Staff A was added to the Agency for Healthcare Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. Review of the facility's background screening showed Staff B with a date of hire of . Staff B was added to the Agency for Healthcare Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. Review of the facility's background screening showed Staff C with a date of hire of . Staff C was added to the Agency for Healthcare Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. Review of the facility's employee roster on at 11:00 a.m., showed Staff D had a hire date of . Staff D was not on the facility's background screening roster. Review of the facility's employee roster showed Staff E with a hire date of . Staff E was not on the facility's background roster. Review of the facility's employee roster showed Staff F with a hire date of . Staff F was not on the facility's background roster. Review of the facility's background screening showed Staff G with a date of hire of . Staff G was added to the Agency for Healthcare	CZ814		

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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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
CZ814	Continued From page 2 Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. Review of the facility's background screening showed Staff H with a date of hire of . Staff H was added to the Agency for Healthcare Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. Review of the facility's background screening showed Staff I with a date of hire of . Staff I was added to the Agency for Healthcare Administration Background Screening clearinghouse website on , which is outside of the 10-business day requirement. On at 2:25 p.m., the Administrator said she is the person responsible for putting people on the roster. She said she has been very busy and has not been able to keep it up. Unclassified .	CZ814		

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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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 An unannounced complaint survey #2021003436 and #2021007182 was conducted on [redacted] at Fruitville Holdings - Oppidan, Inc., an assisted living facility in Sarasota, Florida. Complaint # 2021003436 had 1 allegation which was substantiated. Complaint # 2021007182 had 2 allegations of which 1 was substantiated. The following is a description of the deficiencies. .	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007	A 025		

AHCA Form 3020-0001

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

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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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 025	Continued From page 1 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain the resident record up-dated with significant change documentation and failed to provide adequate supervision and physician notification of changes, that resulted in the resident requiring medical attention.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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 025	Continued From page 2 The findings included: Review of a progress note dated . . . indicated resident stated she wanted to go to the hospital. There was no documentation to show the facility addressed the resident's concern. Review of documentation on at 11:30 a.m. showed Resident #1 had . ,, . saturation of 70 on . There is no documentation in the record that the physician was notified and no documentation that the facility nurse was notified. Documentation on . . . . . showed the resident had an ,, saturation of 74 %. There is no documentation in the record that the physician was notified and no documentation that the facility nurse was notified. Interview on . . . . . at 2:28 p.m., the Facility Registered Nurse (RN), Case Manager said the resident did not stay at the facility very long. A lot of it had to do with the family involvement. The resident had high . . . , issues and would have rapid breathing, short breaths. The resident's family had come down one weekend and her ,, saturation levels were 78 %; her . , ... were 38 breaths per minute. The physician was aware of that and ordered a . ,, which came out negative. That weekend the family came to see her they asked to check her . ,, . saturation and they were told it was 78%, the family thought it was too low. The family called . -1. The staff checked it and it was 88%. The resident went to the hospital. The RN Case Manager said it was all related to the , she was having here. The doctor was aware and ordered an . . . (. . . . . , . . .) for . The RN Case Manager said, "On . . . . . , I was made aware of the . . level of 76%. And it was rechecked at 85% , she was	A 025		

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
	AL11965540	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRUITVILLE HOLDINGS - OPPIDAN, INC.	4024 FRUITVILLE ROAD SARASOTA, FL 34232

(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 025	Continued From page 3 not , ... She did not have an order for , , in the facility." The RN Case Manager said there is no health assessment for her as she was not there for 30 days. She was admitted . . . . . and sent to hospital on . . . . . . On . . . . . at 3:15 p.m., the RN, case manager said medication technicians were doing the , oximetry. He did not know if they were doing it correctly or not. He said the resident wore nail polish and he did not know if the medication technicians were removing the polish prior to taking the , ... ox. He said she was always , it's just the way she was. Class III	A 025		