

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/25/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OASIS LIVING QUARTERS LLC

**2855 WEST COMMERCIAL BLVD
FORT LAUDERDALE, FL 33309**

(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 (#2023011980, #2023012818, #2023014086, and #2023014545) survey was conducted on _____ at Oasis Living Quarters LLC. The facility had a deficiency identified related to Complaint #2023014545 at the time of the survey.	A 000		
A 168	429.24(3)(a) FS; 429.27(7), FS Resident Refund Policy 429.24 (3)(a) . . . The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of _____ or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than _____	A 168		

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: AL11911596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/25/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OASIS LIVING QUARTERS LLC

**2855 WEST COMMERCIAL BLVD
FORT LAUDERDALE, FL 33309**

(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 168	Continued From page 1 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. 429.27, FS Property and personal affairs of residents. - (7) In the event of the of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's, the funds shall be deposited in the Health Care Trust Fund administered by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to honor resident's rights by failing to issue a refund for 1 of 1 residents reviewed for refunds, Resident #1.	A 168		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/25/2023
NAME OF PROVIDER OR SUPPLIER OASIS LIVING QUARTERS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309		
(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 168	Continued From page 2 The findings included: During review of facility files and documents, a of email documentation related to Resident #1 was provided to this surveyor. A review of the email communications revealed communication between Resident #1's guardian and the facility. Further review of the documents revealed that on , Resident #1's guardian provided the facility with a 30-day notice terminating Resident's #1's residency, making his last day of residency , which resulted in a refund of \$1969.14 (Documentation obtained). In an interview conducted with Resident #1's guardian on at 1:16 PM, she stated the refund has not been given. She stated she and Resident #1's sibling were co-guardians for him until , at which time they were released by the courts. She further stated the checks for payment of Resident #1's rent was coming from a depository prior to the rent payment which she stated she made via her credit card as she was advised that no additional payments would be made from the depository after . In an interview conducted with Director of Nursing (DON) Staff B on at 12:54 PM, she presented information contained in the (name of electronic financial system); the system used by the facility to document/track resident payments. A review of Resident #1's profile in the system revealed that he had a credit balance of \$1969.14. She further stated that a refund had not been made to the resident as there was some as to where it was to be sent. In an interview conducted with Executive Director	A 168			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/25/2023
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

OASIS LIVING QUARTERS LLC

**2855 WEST COMMERCIAL BLVD
FORT LAUDERDALE, FL 33309**

(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 168	Continued From page 3 Staff A, DON Staff B and the Managing Member on at 2:26 PM, they were informed of the credit/refund due to Resident #1, to which they acknowledged. They were also given the contact information for Resident #1. Executive Director Staff A stated they would be sending the refund by weeks end. Class III	A 168		