

Agency for Health Care Administration

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|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911596</b>                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/26/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OASIS LIVING QUARTERS LLC</b> |                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2855 WEST COMMERCIAL BLVD</b><br><b>FORT LAUDERDALE, FL 33309</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                | ID<br>PREFIX<br>TAG                                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 000}                                                              | <p>Initial Comments</p> <p>An unannounced Wellness Monitoring survey was conducted on 03/26/2025 at Oasis Living Quarters LLC. The facility had no deficiencies identified at the time of the survey.</p> <p>The facility Census is 19.</p> | {A 000}                                                                                                       |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE