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 _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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<br><br>These are the results of a Financial Monitoring survey conducted on , at Oppidan, Inc., an Assisted Living Facility. | A 000 | | |
| A 126 | 58A-5.021(7) FAC Fiscal - Resident Accounting<br><br>(7) RESIDENT ACCOUNTING.<br>(a) If the facility provides safekeeping for money or property; holds resident money or property in a trust fund; or if the facility owner, administrator, or staff, or representative thereof, acts as a representative payee; the resident or the resident ' s legal representative shall be provided with a quarterly statement detailing the income and expense records required under subsection (4), and a list of any property held for safekeeping with copies maintained in the resident ' s file. The facility shall also provide such statement upon the discharge of the resident, and if there is a change in ownership of the facility as provided under Rule 58A-5.014, F.A.C.<br>(b) If the facility owner, administrator, or staff, or representative thereof, serves as a resident ' s attorney-in-fact, the resident shall be given, on a monthly basis, a written statement of any transaction made on behalf of the resident.<br>(c) Within 30 days of receipt of an advance rent or security deposit, the facility shall notify the resident in writing of the manner in which the licensee is holding the advance rent or security deposit.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to provided 4 (Residents #1, #2, #3, and #4) of 5 residents with resident accounts at the facility with a quarterly statement detailing the | A 126 | | |

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| A 126 | Continued From page 1<br>funds being held in their accounts<br><br>The findings include:<br><br>On . a review of facility records revealed the facility has resident accounts for five residents. The facility did not have records showing Residents #1, #2, #3, and #4 or their respective Power of Attorney (POA), received quarterly statements detailing the amount in their individual resident accounts.<br><br>On . at 12:27 a.m. an interview was conducted with the facility's Nurse Case Manager (NCM). The NCM admitted Residents #1, #2, #3, and #4 have not received a quarterly statement for the past two quarters. She stated she was not sure if statements were being sent to the residents' POA from a corporate level.<br><br>The Assistant Administrator was interviewed on . at 3:15 p.m. He stated he spoke with a corporate representative who confirmed the residents or their POAs were not receiving quarterly statements.<br><br>Class III | A 126 | | |

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Oppidan, Inc.
4024 Fruitville Road
Sarasota, Florida 34232

Dear Administrator:

Re: Financial Monitoring survey

This letter reports the findings of a state licensure survey that was conducted on . 2013 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct the deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure
XG90

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