

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2013
NAME OF PROVIDER OR SUPPLIER OPPIDAN, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 These are the results of the follow-up to a Financial Monitoring survey conducted on 01/22/13, at Oppidan, Inc., an Assisted Living Facility. This follow-up was conducted by desk review on 05/15/13. The citation was cleared by this desk review.	{A 000}		

AHCA Form 3020-0001

TITLE

(X8) DATE

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

STATE FORM

6090

RQ3C12

If continuation sheet 1 of 1

5/15/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11965540

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
5/15/2013

Name of Facility
OPPIDAN, INC.

Street Address, City, State, Zip Code
4024 FRUITVILLE ROAD
SARASOTA, FL 34232

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # A0126 LSC	Correction Completed 05/15/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
[Signature] HFES
Reviewed By

Date:
5-15-13
Date:

Signature of Surveyor
[Signature] HFES
Signature of Surveyor

Date:
5-15-13
Date:

Followup to Survey Completed on:
1/22/2013

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 15, 2013

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

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted by desk review on May 15, 2013 by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosures: State Form and Revisit Report

