

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>AL11965540</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/15/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OPPIDAN, INC.</b> |                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4024 FRUITVILLE ROAD<br/>SARASOTA, FL 34232</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>This is to report the finding of an unannounced Limited Nursing Service (LNS) survey at Oppidan an Assisted Living Facility (ALF) in Sarasota Fl. on 5/15/13.</p> <p>The census at the time of the survey was 9 residents. No residents were receiving LNS services at the time of the survey.</p> <p>No deficiencies were cited relevant to the survey during this visit.</p> | A 000                                                                                       |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

YD2X11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

May 16, 2013

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

Dear Administrator:

This letter reports findings of a Limited Nursing Service (LNS) survey that was conducted on May 15, 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams  
Field Office Manager

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Enclosure: State Form

