STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966870	01/14/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Repeat Tags:
0011-Admissions - Discharge-58a-5.0181(5) Fac
0025-Resident Care - Supervision-58a-5.0182(1) Fac
0092-Food Service - General Responsibilities-58a-5.020(1) Fac

Revisit New Tags:
0027-Resident Care - Arrangement For Health Care-58a-5.0182(3) Fac
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0163-Records - Resident, Penalties For Alteration-429.49 Fs

Specific Tag Findings:
These are the results of an unannounced follow-up survey conducted on at Fruitville Holdings, Oppidan, Inc., an Assisted Living Facility in Sarasota, Florida.

The following deficiencies were recited: A 0011, A 0025, and A 0092. The following additional deficiencies were cited: A 0027, A 0030 and A 0163.

0011-Admissions - Discharge 58A-5.0181(5) FAC

Based on observation, record review and interview, the facility failed to ensure 1 (Resident #2) of 2 sampled residents met residency criteria and failed to meet the needs of the resident for continued residency at the assisted living facility. Resident #2 was documented as requiring total assistance with ADLs (Activities of Daily Living) and is totally dependent on staff for transfers; staff are using improper technique while transferring Resident #2 causing pain to the resident during transfers; and inspite of implementing a close visual supervision protocol, staff failed to consistently implement the protocol and Resident #2 continues to himself while smoking.

The findings include:

1. During the entrance conference on at 9:00 a.m., the Director of Maintenance (DOM) and Staff B (who is a certified nursing assistant) said Resident #2 continues to unsafely smoke at the facility. Staff B said as a result of the biennial survey when it was identified Resident #2 was himself from smoking, the facility offered Resident #2 a smoking apron and special glove in an effort to prevent him from further from smoking. Staff B said two days after trialing the smoking apron, the resident refused the apron and the glove. Staff B said because of the way the resident holds his hand, he couldn't use the glove. The Director of Maintenance said Resident #2 is noncompliant with transfers and the facility is in the process of working on obtaining a TLF (Transitional Living Facility) license because Resident #2 remains a total lift. Staff B said after the biennial survey . Resident #2 started to be a two man pivot transfer. Staff B stated, "(Resident #2's) swelled up real bad and the transfer type was hurting (Resident #2's) so they had to go back to the two man lift. Resident #2 went to the hospital and after Christmas, Resident #2 has been a total two person lift." Staff B said that Resident #2 was on and cream. He further indicated Resident #2 is still receiving the cream, and the resident is still .

Record review on revealed that the record documents Resident #2 was admitted to the facility on with diagnoses of and limited use of the left arm.

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Review of the health assessment dated revealed that it indicated that Resident #2 required total help with ambulation, bathing, and dressing and assistance with toileting, and transferring.

Review of the current health assessment, dated revealed that it indicated that Resident #2 requires assistance with ambulation, bathing, dressing, toileting and transferring. The assessment documents the resident is a 2 person assist pivot transfer. The assessment also documents the resident requires total care with ADLs (Activities of Daily Living).

The Health Assessment shows conflicting information (total vs. assistance with ADLs).

In an interview on at 9:36 a.m., the Administrator said she called the OT (Occupational to come out and assess Resident #2 for safe smoking aand the OT recommended the apron. Because the resident refused the apron, they tried a safety glove and he refused that. She said they decided to place the resident on close visual supervision. She explained staff are to remain within 3 feet of the resident and visually supervise the resident for safe smoking. She said no one informed her that Resident #2 was dependent on 2 people for transfers.

In an interview and observation in the presence of Staff B on 9:45 a.m., Resident #2 held his left hand up and showed two cigarette to his left thumb and scabs and peeling skin to his left middle finger. A cigarette the size of a pencil eraser tip to the web space between the left thumb and forefinger was observed. The area was deep red and the was moist with a small amount of yellow tissue on the base. A second the same size was observed along the side and middle of his thumb. The was reddish brown. Resident #2 said the to his left thumb and middle finger were from ashes from his cigarettes.

During this same interview and observation, Resident #2 said he developed an to his from improper transfers. He said he ended up in the hospital twice around the holidays. After he came back, which was about 5 weeks ago, he wouldn't let the staff pivot transfer him anymore. He said he gets lifted out of bed by two staff members. Resident #2 said his were still tender. Observation of the showed no acute redness or .

A telephone interview was conducted with the Occupational (OT) on at 10:15 a.m. The OT said he received a referral from the facility to do a smoking evaluation for Resident #2. The OT said the facility told him Resident #2 was having more difficulties managing his cigarettes. The OT did a smoking safety evaluation and recommended a flame retardant smoking apron. He was not aware Resident #2 refused to wear the apron. He was not aware Resident #2 was still his fingers. The OT said he had been out to the facility several times to assess the resident for transfers because the physical was out on maternity leave. The OT stated, "Everytime I've been out here he's either refused or had a medical issue at the time where they couldn't do it. This has been an ongoing issue with him refusing. I have not worked with him (Resident #2) regarding transfers."

The Administrator provided a document entitled, "Protocol Form", completed by the OT and dated . The form included the following information: "...(Resident #2) is to be under close visual supervision during smoking breaks. This supervision must continue throughout the full smoking break, from when the cigarette is lit until it is extinguished. Staff will be required to document each smoking break with provided form. (Resident) must wear a

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flame retardant smoking apron during all smoking breaks."

In an interview on at 10:20 a.m., the Licensed Practical Nurse (LPN) said she was not aware of the 2 cigarette to the resident's left thumb or scabbed areas to Resident #2's middle finger. She was aware the resident requires close visual supervision while smoking, but said she did not know staff were required to document each smoking break on a form provided by the OT. She said no one told her Resident #2 was a total lift of two people for transfers.

During an interview on at 10:33 a.m., Staff B said he was not aware of the on Resident #2's left thumb and left middle finger. He said staff document Resident #2's activities of daily living (ADL's) on the ADL sheet and smoking is included, however, he is not familiar with any specific form provided by the OT. Staff B said he sits with Resident #2 and supervises his smoking.

Observation in the presence of the LPN on at 11:18 a.m. showed Resident #2 seated in his wheelchair on the lanai smoking a cigarette. Staff B was observed outside of the lanai, approximately 6 feet away from Resident #2 talking on his phone and with his back turned toward the resident. The resident opened his left hand which revealed one reddish brown area on the inside portion of his thumb and a reddened moist area on the top of the webspace between the thumb and forefinger. This had a yellow center. Multiple small scabbed areas were observed on the top of the left middle finger.. The LPN called Staff B back into the lanai, reminding Staff B to stay close to Resident #2 while she went inside to call the doctor.

Review of the ADL flowsheets from through failed to consistently document when Resident #2 was being supervised during his smoke breaks. Incomplete documentation was observed during the weeks of , 12/1, 12/8, , and

During an observation on at 10:10 a.m., the House Director, (HD) and Staff B entered Resident #2's transfer the resident out of his bed to his wheelchair. Resident #2 was laying flat in bed with multipodus boots braces) on his lower extremities. The HD asked Staff B where Resident #2's gait belt was. Staff B pointed to the laundry basket and said it was wet. Without applying a gait belt, both staff assisted Resident #2 to a sitting position at the edge of his bed. The multipodus boots rested on the floor; however, the resident's feet were not flat against the bottom of the inside of the boots. While both staff held the resident under each of his arms with one hand, they lifted the resident by the back of his pants and swung him into his wheelchair. The resident stated, "Ow, Ow, my crotch, my crotch."

A telephone interview was conducted with the Physical Assistant (PTA) on at 10:42 a.m. The PTA said the facility had asked him to come in and work on some sliding board transfers with the resident about a month or two ago. He said Resident #2 preferred stand pivot transfers as opposed to sliding board transfers so he had staff present and showed both the staff and Resident #2 how to correctly do a stand pivot transfer. He said staff are to rock the resident forward and have the resident push up with his hands from his wheelchair to help as much as possible and then get the resident to a standing position (feet flat on floor, knees locked). The PTA said after they get the resident to a standing position, staff are to encourage Resident #2 to take a couple steps and escort him over and have him sit at the edge of the bed, bring his legs up and lay him down. The PTA said a gait belt is to be used during the process. The PTA confirmed he was familiar with Resident #2 and did remember

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Resident #2 was a quadriplegic and had foot drop. The PTA re-stated Resident #2's knees should be locked while in a standing position. The PTA said there was no specific foot wear necessary for this process. He said there was no need for two people to assist Resident #2 with the process of the transfer.

Review of the "Transfer Protocol Form" dated [illegible] by the OT included the following: "...Client requires [illegible] of one to two trained staff to perform sliding board or stand pivot transfer to and from wheelchair and bed. Client should be wearing a gait belt and slip resistant shoes during transfer. Staff is to maintain hands on assistance at all times including when client is seated in bed."

Record review on [illegible] documents physician's orders dated [illegible] which indicate, "physical [illegible] for lower (illegible)".

Review of the "Protocol Form", undated and signed by the PTA, included the following: "...Client is to transfer with use of stand pivot transfer. This is the safest transfer for this client. Make sure you use a gait belt. Scoot towards front of chair. If able, have client help as much as possible...it is easier to stand him up by grabbing [illegible] for it initiates standing...Cheat Sheet: Wear gait belt...it is easier to lift client by [illegible] which initiates stand."

The specific type of transfer technique to be used for Resident #2 conflicted between the PTA and OT.

In an interview with the Administrator (ADM), LPN and HD on [illegible] at 11:00 a.m., they were unaware of the [illegible] physician's order for physical [illegible]. The ADM said she called the rehab department associated with their facility because that's who'd been working with Resident #2 in the past, but the physical [illegible] was on maternity leave. She was unable to produce documentation the resident was appropriately evaluated by a physical [illegible] for the stand pivot transfers. The ADM did not know why the OT came out to assess the resident for transfers when the order was for [illegible] but figured it was because the original [illegible] was out on maternity leave. The ADM, LPN and HD confirmed Resident #2 cannot walk and cannot stand upright with his knees locked and did not know why the PTA said he could. The LPN stated, "He didn't remember the resident" despite the repeat affirmation by the PTA that he did remember Resident #2. The ADM confirmed she did not give Resident #2 the choice of which [illegible] center he would prefer. The ADM said the orders must have been missed and she would call the physician for clarification.

Inspite of the facility implementing a close visual supervision protocol, Resident #2 has continued to [illegible] his fingers while smoking. Staff have failed to ensure Resident #2 is adequately supervised as evidenced by inadequate safe smoking documentation on the ADL flow sheets. The LPN, Administrator and House Director said they did not know Resident #2 was continuing to [illegible] himself while he is supervised by staff and unaware of the status of the [illegible] on Resident #2's left thumb and middle finger, and acknowledged Staff B's failure to closely visualize Resident #2 while smoking. Resident #2 and Staff B confirmed the resident is a total lift of two people for transfers. Staff B and the HD used improper technique while transferring Resident #2 out of bed causing Resident #2 to yell out in pain during the process.

Class II

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0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, record review and interviews, the facility failed to adequately supervise 1 (Resident #2) of 2 sampled residents for safe smoking. This failure contributed to Resident #2 continuing to [redacted] himself from hot ashes while smoking.

The findings include:

During the entrance conference on [redacted] at 9:00 a.m., the Director of Maintenance (DOM) and Staff B (who is a certified nursing assistant) said Resident #2 continues to unsafely smoke at the facility. Staff B said as a result of the biennial survey when it was identified Resident #2 was [redacted] himself from smoking, the facility offered the resident a smoking apron and special glove in an effort to prevent Resident #2 from further [redacted] from smoking. He said two days after trialing the smoking apron, the resident refused the apron and the glove. Staff B said because of the way the resident holds his hand, he couldn't use the glove.

In an interview on [redacted] at 9:36 a.m., the Administrator said she called the OT (Occupational [redacted] to come out and assess Resident #2 for safe smoking who recommended the apron. Because the resident refused the apron, they tried a safety glove and he refused that. She said they decided to place the resident on close visual supervision. She explained staff are to remain within 3 feet of the resident and visually supervise the resident for safe smoking.

In an interview and observation on [redacted] 9:45 a.m., Resident #2 held his left hand up and showed two cigarette [redacted] to his left thumb and scabs and peeling skin to his left middle finger. A cigarette [redacted] the size of a pencil eraser tip to the web space between the left thumb and forefinger was observed. The area was deep red and the [redacted] was moist with a small amount of yellow tissue on the [redacted] base. A second [redacted] the same size was observed along the side and middle of his thumb. The [redacted] was reddish brown. Resident #2 said the [redacted] to his left thumb and middle finger were from ashes from his cigarettes.

A telephone interview was conducted with the Occupational [redacted] (OT) on [redacted] at 10:15 a.m. The OT said he received a referral from the facility to do a smoking evaluation for Resident #2. The OT said the facility told him Resident #2 was having more difficulties managing his cigarettes. The OT did a smoking safety evaluation and recommended a flame retardant smoking apron. He was not aware Resident #2 refused to wear the apron. He was not aware Resident #2 was still [redacted] his fingers.

The Administrator provided a document entitled, "Protocol Form", completed by the OT and dated [redacted] The form included the following information: "...(Resident #2) is to be under close visual supervision during smoking breaks. This supervision must continue throughout the full smoking break, from when the cigarette is lit until it is extinguished. Staff will be required to document each smoking break with provided form. (Resident) must wear a flame retardant smoking apron during all smoking breaks."

In an interview on [redacted] at 10:20 a.m., the Licensed Practical Nurse (LPN) said she was not aware of the 2 cigarette [redacted] to the resident's left thumb or scabbed [redacted] areas to Resident #2's middle finger. She was aware the resident requires close visual supervision while smoking, but said she did not know staff were required to document each smoking break on a form provided by the OT.

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During an interview on at 10:33 a.m., Staff B said he was not aware of the on Resident #2's left thumb and left middle finger. He said staff document Resident #2's activities of daily living (ADL's) on the ADL sheet and smoking is included, however, he is not familiar with any specific form provided by the OT. Staff B said he sits with Resident #2 and supervises his smoking.

Observation in the presence of the LPN on at 11:18 a.m. showed Resident #2 seated in his wheelchair on the lanai smoking a cigarette. Staff B was observed outside of the lania, approximately 6 feet away from Resident #2 talking on his phone and with his back turned toward the resident. The resident opened his left hand which revealed one reddish brown area on the inside portion of his thumb and a reddened moist area on the top of the webspace between the thumb and forefinger. This had a yellow center. Multiple small scabbed areas were observed on the top of the left middle finger.. The LPN called Staff B back into the lanai, reminding Staff B to stay close to Resident #2 while she went inside to call the doctor.

Review of the nursing progress notes between and failed to show evidence of any monitoring of the to the resident's fingers.

Review of the ADL flowsheets from through failed to consistently document when Resident #2 was being supervised during his smoke breaks. Incomplete documentation was observed during the weeks of , 12/1, 12/8, , and

Inspite of the facility implementing a close visual supervision protocol, Resident #2 has continued to his fingers while smoking. Staff have failed to ensure Resident #2 is adequately supervised as evidenced by inadequate safe smoking documentation on the ADL flow sheets; LPN, Administrator and House Director unaware Resident #2 is continuing to himself when he is supervised by staff and unaware of the status of the on Resident #2's left thumb and middle finger; and Staff B's failure to closely visualize Resident #2 while smoking.

Class II

0027-Resident Care - Arrangement for Health Care 58A-5.0182(3) FAC

Based on observation, record review and interview, the facility failed to ensure 1 (Resident #2) of 2 sampled residents received physical services ordered by the physician.

The findings include:

During the entrance conference on at 9:00 a.m., the Director of Maintenance (DOM) and Staff B (who is a certified nursing assistant) said Resident #2 is noncompliant with transfers and the facility is in the process of working on obtaining a TLF (Transitional Living Facility) license because Resident #2 remains a total lift. Staff B said after the biennial survey . Resident #2 started to be a two man pivot transfer. Staff B stated, "Resident #2's swelled up real bad and the transfer type was hurting his so they had to go back

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to the two man lift. (Resident #2) went to the hospital and after Christmas, (Resident #2) has been a total two person lift." Staff B said Resident #2 was on ... and cream. He further indicated Resident #2 is still receiving the cream, and the resident is still ...

Record review on ... documents Resident #2 was admitted to the facility on ... with diagnoses of ... and limited use of the left arm.

Review of the health assessment dated ... showed Resident #2 required total help with ambulation, bathing, and dressing and assistance with toileting, ... and transferring.

Review of the current health assessment, dated ... showed Resident #2 requires assistance with ambulation, bathing, dressing, ... toileting and transferring. The assessment documents the resident is a 2 person assist pivot transfer. The assessment also documents the resident requires total care with ADLs (Activities of Daily Living).

The ... Health Assessment shows conflicting information (total vs. assistance with ADLs).

In an interview on ... at 9:36 a.m., the Administrator said no one informed her Resident #2 was dependent on 2 people for transfers.

In an interview and observation in the presence of Staff B on ... 9:45 a.m., Resident #2 said he developed an ... to his ... from improper transfers. He said he ended up in the hospital twice around the holidays. After he came back, which was about 5 weeks ago, he wouldn't let the staff pivot transfer him anymore. He said he gets lifted out of bed by two staff members. Resident #2 said his ... were still tender. Observation of the ... showed no acute redness or ...

A telephone interview was conducted with the Occupational ... (OT) on ... at 10:15 a.m. The OT said he had been out to the facility several times to assess the resident for transfers because the physical ... was out on maternity leave. The OT stated, "Every time I've been out here he's either refused or had a medical issue at the time where they couldn't do it. This has been an ongoing issue with him refusing. I have not worked with him (Resident #2) regarding transfers."

In an interview on ... at 10:20 a.m., the Licensed Practical Nurse (LPN) said no one told her Resident #2 was a two person lift for transfers.

During an observation on ... at 10:10 a.m., the House Director, (HD) and Staff B entered Resident #2's ... transfer the resident out of his bed to his wheelchair. Resident #2 was laying flat in bed with multipodus boots ... braces) on his lower extremities. The HD asked Staff B where Resident #2's gait belt was. Staff B pointed to the laundry basket and said it was wet. Without applying a gait belt, both staff assisted Resident #2 to a sitting position at the edge of his bed. The multipodus boots rested on the floor; however, the resident's feet were not flat against the bottom of the inside of the boots. While both staff held the resident under each of his arms with one hand, they lifted the resident by the back of his pants and swung him into his wheelchair. The resident stated, "Ow, Ow, my crotch, my crotch."

Record review on ... documents physician's orders dated ... which indicate, "physical ... for lower

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(illegible)."

In an interview with the Administrator (ADM), LPN and HD on at 11:00 a.m., they were unaware of the physician's order for physical The ADM said the orders must have been missed and she would call the physician for clarification.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview, the facility failed to ensure 1 (Resident #2) of 2 sampled residents received physical services ordered by the physician and failed to provide the resident the opportunity to select the company of his choice.

The findings include:

During the entrance conference on at 9:00 a.m., the Director of Maintenance (DOM) and Staff B (who is a certified nursing assistant) said Resident #2 is noncompliant with transfers and the facility is in the process of working on obtaining a TLF (Transitional Living Facility) license because Resident #2 remains a total lift. Staff B said after the biennial survey , Resident #2 started to be a two man pivot transfer. Staff B stated, "Resident #2's swelled up real bad and the transfer type was hurting his so they had to go back to the two man lift. (Resident #2) went to the hospital and after Christmas, (Resident #2) has been a total two person lift." Staff B said Resident #2 was on and cream. He further indicated Resident #2 is still receiving the cream, and the resident is still

Record review on documents Resident #2 was admitted to the facility on with diagnoses of and limited use of the left arm.

In an interview on at 9:36 a.m., the Administrator said no one informed her Resident #2 was dependent on 2 people for transfers.

In an interview and observation in the presence of Staff B on 9:45 a.m., Resident #2 said he developed an to his from improper transfers. He said he ended up in the hospital twice around the holidays. After he came back, which was about 5 weeks ago, he wouldn't let the staff pivot transfer him anymore. He said he gets lifted out of bed by two staff members. Resident #2 said his were still tender. Observation of the showed no acute redness or

A telephone interview was conducted with the Occupational (OT) on at 10:15 a.m. The OT said he had been out to the facility several times to assess the resident for transfers because the physical was out on maternity leave. The OT stated, "Every time I've been out here he's either refused or had a medical issue at the time where they couldn't do it. This has been an ongoing issue with him refusing. I have not

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worked with him (Resident #2) regarding transfers."

In an interview on at 10:20 a.m., the Licensed Practical Nurse (LPN) said no one told her Resident #2 was a two person lift for transfers.

During an observation on at 10:10 a.m., the House Director, (HD) and Staff B entered Resident #2's transfer the resident out of his bed to his wheelchair. Resident #2 was laying flat in bed with multipodus boots braces) on his lower extremities. The HD asked Staff B where Resident #2's gait belt was. Staff B pointed to the laundry basket and said it was wet. Without applying a gait belt, both staff assisted Resident #2 to a sitting position at the edge of his bed. The multipodus boots rested on the floor; however, the resident's feet were not flat against the bottom of the inside of the boots. While both staff held the resident under each of his arms with one hand, they lifted the resident by the back of his pants and swung him into his wheelchair. The resident stated, "Ow, Ow, my crotch, my crotch."

Record review on documents physician's orders dated which indicate, "physical for lower (illegible)".

In an interview with the Administrator (ADM), LPN and HD on at 11:00 a.m., they were unaware of the physician's order for physical The ADM said she called the rehab department associated with their facility because that's who'd been working with Resident #2 in the past, but the physical was on maternity leave. She was unable to produce documentation the resident was appropriately evaluated by a physical for the stand pivot transfers. The ADM did not know why the OT came out to assess the resident for transfers when the order was for but figured it was because the original was out on maternity leave.

In an interview on at 11:53 a.m., Resident #2 said he was never given a choice as to which company he would like to use.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC

Based on record review and interview, the facility failed to ensure the designee responsible for food service obtained continuing education requirements specified in Rule 58A-5.0191, F.A.C.

The findings include:

During the biennial survey on , the House Director's (HD) personnel file was reviewed. (The HD is designated responsible for food services.) At the time of the biennial survey, the HD's personnel file failed to contain evidence of 2 hours of continuing education annually for the period of

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A revisit survey was conducted on . . . During an interview on at 12:26 p.m., the HD admitted she had not obtained 2 hours of continuing education. She said she had talked to the Registered Dietitian about coming to the facility to provide the continuing education and she was supposed to come out at the end of the month but didn't know exactly when.

Class III

0163-Records - Resident, Penalties for Alteration 429.49 FS

Based on interview and record review, the medical director, who is also the primary physician, failed to date physician's orders and progress note on the actual date he completed the entries for 1 (Resident #2) of 2 sampled residents.

The findings include:

1. During the followup survey on , physician's orders for physical . . dated . . . . . (untimed) were observed in Resident #2's record.

During an interview with the Administrator (ADM), Licensed Practical Nurse (LPN), and House Director (HD) on , they confirmed they were not aware of the physician's order dated for physical . . The Administrator said she was going to call the physician and get the order clarified because part of the order was illegible and she couldn't understand his writing. The ADM and LPN confirmed physical . . wasn't ordered. The ADM, LPN and HD were asked to provide additional documentation after the physician's order was clarified.

Record review showed a physician's order dated . . . . immediately above the physician's orders (for physical . . . and below the . . . order were orders by the same physician dated . . . . and . . . .

A telephone interview was conducted with the ADM, LPN, and Medical Director on . . . at approximately 9:43 a.m. The ADM said she had additional orders from the physician. The physician said he saw Resident #2 and updated and amended his notes. The ADM said she faxed the additional documentation to the area office.

Review of the documentation on . . . provided by the ADM revealed physician's orders dated . at 3:30 p.m. and . . . . . at 9:15 a.m. that were not previously in Resident #2's record at the time of the follow-up survey. In addition, a physician's progress note dated . included additional documentation that was not previously on his note.

The physician failed to document his orders and amendment to his progress notes as "late entries" for the actual date of completion on . . . . . .

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Fruitville Holdings - Oppidan, Inc
4038 Fruitville Road
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2015 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2015.**

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,

Jon Seehawer, RN
Acting Field Office Manager

JS
Enclosure: State Form

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