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
	AL11968596	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT BOYNTON BEACH ASSISTED LIVING	1708 NE 4TH STREET BOYNTON BEACH, FL 33435

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A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or . damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a	A 165		

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A 165	Continued From page 1 preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report	A 165		

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A 165	Continued From page 2 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on records review and interviews, it was determined that, the facility failed to file adverse incident reports involving 3 of 3 sampled residents (Resident #1, Resident #2, & Resident #3) who have eloped or left the facility unsupervised. The findings included: 1) Admission records review of Resident #1 revealed an admission date of . Resident #1 diagnoses included: Residual , ; mild, with , disturbance; ; , , unspecified; Sleep , ; Unspecified , not due to a substance or known physiological condition; , unspecified; hypertensive without ; , , unspecified; Dependence Cigarettes uncomplicated. On , Resident #1 was diagnosed with adjustment and . Review of the health assessment AHCA form 1823 dated documented that Resident #1 had , due to , , , but was not exit	A 165		

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A 165	Continued From page 3 seeking or at risk for elopement. An incident report dated at 10:00 A.M., documented that facility staff noticed Resident #1 was not at the facility during the morning medication administration time at 10:00 AM. The report revealed that the police was contacted after staff could not locate Resident #1 in the building and in the vicinity of the facility. However, review of the signing log revealed Resident #1 had left the facility on at 8:30 AM and did not return. Despite filing a missing person report with the police, no adverse incident report was filed. 2) Review of another incident report documented Resident #2 eloped from the facility on by jumping over the facility's courtyard fence/gate. Resident #2's 1823 dated documented Resident #2's diagnoses as , , , , { }, and . Resident #2 was noted to be at risk for elopement. On at 7:00 PM, Resident #2 went missing during the facility's monitoring check. A missing person report was filed with the police on . The resident's father, when contacted via telephone provided directives on the possible whereabout of Resident #2. Eventually, Resident #2 was located where his father had indicated a day later, and he was brought to the facility. Yet, the facility staff did not file an adverse incident report. 3) Review of another incident report dated revealed that Resident #3 had left the facility unsupervised on with a roommate. The roommate returned to the facility the same day and said he did not know the	A 165		

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A 165	Continued From page 4 whereabout of Resident #3. A missing person police report was filed on . Resident #3 did not return to the facility until as evidenced by review of the hospital discharge record. The form 1823 of Resident #3 dated documented he was not at risk of elopement, however he was diagnosed with , Generalized , , Sarcopenia, Difficulty in walking, Gait Apraxia, Unsteadiness on , , , , although independent with all activities of daily living. The Administrator did not file an adverse incident report. The Administrator reported on at 10:05 AM that when she found out that Resident #1 had eloped she told the staff to activate their elopement protocol. She said she filed a police report, and they searched the surrounding areas for the resident. The Administrator said she did not know she was supposed to file adverse incident reports whenever a resident was missing. She said the residents have the freedom to go out as they are pleased as long as they sign out. Consequently, as of , there were no adverse incident reports filed for Resident #1, Resident #2, and Resident #3. Class	A 165		
A 000	Initial Comments An unannounced Moratorium Monitoring and Complaint survey, complaint #2025005430, was conducted at Oasis at Boynton Beach Assisted Living was commenced on and concluded on . The facility had	A 000		

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A 000	Continued From page 5 deficiencies identified at the time of the visit.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises,	A 025		

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A 025	Continued From page 6 and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on resident records and the facility's elopement policy review, and interviews, it was evident that the facility failed to ensure that 2 of 3 sampled residents (Resident #1 & Resident #3) were closely monitored (supervised) to prevent their elopement from the facility. The findings included: Review of the facility's elopement policy documented the following: " Elopement is referred to as an unauthorized absence of the resident from the facility. The risk of and elopement increases when residents are mobile and especially if they suffer from or ."	A 025		

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A 025	Continued From page 7 The admission record revealed Resident #1 moved into the facility on with serious physical and mental illnesses. The following diagnoses were documented: Residual , ; , mild with , disturbance; ; , unspecified; Sleep , ; Unspecified not due to a substance or known physiological condition; and adjustment . Review of the health assessment form (AHCA form 1823) dated documented that Resident #1 was at risk for elopement. The AHCA form 1823 revealed Resident #1 was independent with all activities of daily living (ADL) including ambulation, self-care grooming, toileting, etc. Review of Resident #1's , consultation dated documented Resident #1 had , due to , . The Psychiatrist also noted that Resident #1 was a . Additionally, The , consultant documented that Resident #1 was not exit seeking. An interview conducted with Resident #1's primary physician on at 1:58 PM confirmed the information noted on the AHCA form 1823. The physician stated, that he saw the resident when he signed the form . Review of the facility's sign-in log evidenced there was no restriction or limitation set in place to prevent Resident #1 from away from the facility. Consequently, the log revealed Resident #1 had left the facility multiple times to different areas of the community unsupervised. It was documented that Resident signed out and in on the dates below. On , he went to the store returned the	A 025		

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A 025	Continued From page 8	A 025		

same day.
he went to the store, returned the samed day.
he went to the store, returned the samed day
he went to the corner store, returned the samed day
he went to the corner store, returned the samed day
he went to the corner store, returned the samed day
he went to the store, returned the samed day
he went to the mall, returned the samed day
destination unknown, returned the samed day
he went for a walk, returned the samed day
he went to the corner store, returned the samed day
he went to the store, returned the samed day
he went to the store, returned the samed day

However, on , Resident #1 signed out indicating he went to church at 8:30 AM, but Resident #1 did not return to the facility. As of , Resident #1 still did not return to the facility. The lack of supervision and Resident #1's habitual unsupervised outings created an opportunity for him to elope from the facility.

During an interview with the local police officer on , the facility waited over 24 hours to notify the local police department. It was revealed Resident #1 was not identified missing until the following day during the morning shift by the Wellness Coordinator. In which she notified the

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A 025	Continued From page 9 local police department. A media alert was broadcast by the local police department in an effort to locate the resident. When asked why the staff on duty the day of the incident never notified the local police department, no answer was provided. They stated, they are not sure why the med-techs and/or the direct care staff on duty didn't contact the local police department timely. 2) Review incident report documented Resident #3 eloped from the facility on by jumping over the facility couryard fence. Resident #3's AHCA form 1823 dated documented Resident #3's diagnoses as . , , , ( ), and . Resident #3 was noted to be at risk for elopement. On at 7:00 PM, Resident #2 went missing during the facility's monitoring check. A mising person report was filed with the police on . The resident's father, when contacted via phone, provided directives on the possible whereabout of Resident #2. Eventually, Resident #2 was located where his father had indicated and was brought to the facility. . In an interview conducted on at 11:18 AM with the Administrative Assistant, she reported that Resident #1 liked to sit by the entrance of the building to smoke. Resident #1 spent most of his time listening to his music outside, at the front of the building. He did not bother anyone, he listened and complied when staff spoke to him. They never had any problem with Resident #1. The Administrative Assistant also said that Resident #2 has not made any further attempts to leave the facility since his return. They continue to monitor them closely.	A 025		

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A 025	Continued From page 10 The lack of proactivity in preventing elopement and the facility staff's failure to follow their elopement protocol by ensuring residents at risk of elopement are closely monitored and supervised resulted in Resident #1 and Resident #2 eloping from the facility Class II	A 025		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of	A 032		

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A 032	Continued From page 11 all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on records review, interviews, and review, it was determined that, the facility failed to follow their elopement policy and procedure (protocol), for 3 of 3 sampled residents (Resident #1,	A 032		

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A 032	Continued From page 12 Resident #2 & Resident #3). The facility failure to implement their elopement policy resulted in multiple elopements for identified residents and delayed response time by facility staff. The findings included: Review of the facility's elopement policy titled, "Policy & Procedures/Process. Missing Resident -Elopement Response Team outlined" documented the following. It is the policy of 'the facility' to provide a safe and secure environment for all residents. In the event of resident elopement, it is the policy to implement its policies/procedures immediately to locate the resident in a timely manner. Procedure #1 outlined: All staff will notify highest ranking facility personnel of missing resident immediately. 1) Admission records review of Resident #1 revealed an admission date of , Resident #1 diagnoses included: residual , ; mild, with , disturbance; ; , , , unspecified; Sleep ; Unspecified not due to a substance or known physiological condition; , unspecified; hypertensive without ; , , unspecified; Dependence Cigarettes uncomplicated. On , Resident #1 was diagnosed of adjustment and . Review of the health assessment AHCA form 1823 dated documented that Resident #1 had , due to , but was not exit seeking, or at risk for elopement.	A 032		

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A 032	Continued From page 13 An incident report dated documented that facility staff noticed Resident #1 was not at the facility during the morning medication administration time at 10:00 AM. After a search of facility was conducted and staff was unable to locate Resident #1, the police were contacted. Review of the sign-out/sign-in log revealed Resident #1 had left the facility on at 8:30 AM and did not return. From 10:00 AM on , no one knew the whereabout of Resident #1 and no action was taken until at 10:00 AM. The facility did not activate their elopement protocol until a day after the resident had left the facility. The Administrator was asked to provide a copy of the police report, but she said she did not have the report. As of , Resident #1 was still missing. 2) An incident report dated documented that Resident #2 was reported to have attempted to climb over the backyard gate to elope from the facility. When staff interviewed Resident #2 after he was brought to the facility according to the incident report, Resident #2 said "he knew they would not permit him to leave, but he just needed fresh air". Another incident report reviewed on revealed that on at around 5:00 PM, Resident #2 could not be located in the facility. Resident #2 was not observed in his room during the 5:00 PM Med pass. Resident #2 was not located after Staff searched the facility. The police was notified, the resident's father as well. Resident #2's father provided information about where his son could be (off the grounds of the facility). Resident #2 was located where his father said he would be, and Resident #2 was brought to the facility unharmed.	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968596	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT BOYNTON BEACH ASSISTED LIVING	1708 NE 4TH STREET BOYNTON BEACH, FL 33435

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A 032	Continued From page 14 Review of the signing-in and out log revealed that Resident #2 also signed out on at 12:30 PM and documented he went to church. However, he did not return to the facility until the next day. On at 9:30 am, the Administrative Assistant confirmed that Resident #2 had eloped from the facility on all three occasions, on , , and on . The health assessment (AHCA form 1823) dated documented Resident #2 was diagnosed with , , , and , . It was also documented that Resident #2 was at risk for elopement. 3) Review of another incident report dated revealed that Resident #3 had left the facility on , with a roommate. The roommate returned to the facility the same day and said he did not know the whereabout of Resident #3. The incident report was completed by the facility's receptionist on and documented the resident had left the facility at 9:00 AM. However, the highest-ranking personnel, the Administrator and the Administrative Assistant were not informed until 9:00 PM. A missing person police report was filed on . Resident #3 did not return to the facility until , as evidenced by review of the hospital discharge record. The AHCA form 1823 for Resident #3 dated documented he was not at risk of elopement. Resident #3 was diagnosed with , Generalized , , Sarcopenia, Difficulty in walking, Gait Apraxia, Unsteadiness on ,	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968596	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 032	Continued From page 15 , , although independent with all activities of daily living. But, according to the facility's elopement protocol and the regulations, the facility failed to activate their elopement protocol in a reasonable timeframe. On at 11:55 AM, the Wellness Coordinator reported that three residents had left or eloped from the facility. One of the residents (Resident #2) left by climbing over the backyard gate, and the other two signed out but they did not return as expected. The Wellness Coordinator said that the facility's policy is for every resident who signs out to return to the facility by midnight or 12:00 AM, unless they have a day pass to be out longer with their family or loved ones. The Wellness Coordinator said they have increased supervision to prevent further elopements from happening. The Administrator reported on at 10:05 AM, that to minimize or eliminate elopement incidents, they have increased supervision for all their residents. The Administrator also said when she found out that Resident #1 had eloped, she told the staff to activate their elopement protocol. The Administrator stated , she will provide additional training to all staff to ensure they follow the protocol and supervise residents timely. Class II	A 032		