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 _____	08/26/2026

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

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ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, it was determined that, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) annually or to submit revisions within 30 days after being notified they were required. The findings included: An online record review of Palm Beach County's (PBC) Office of Emergency Management's (OEM) CEMP portal revealed the facility did not have an approved CEMP on file. The facility's CEMP first revision review was submitted and rejected. A draft status of an application was started but upon review was noted to be blank. During an interview conducted on at approximately 9:25 AM, the Administrator identified herself as the Plan Administrator for the CEMP and stated she also has outside assistance from an agency. When advised a review of the OEM website revealed there had not been a CEMP submitted since 2024 and asked if there was an update in the CEMP status, the Administrator stated there was not. The Administrator confirmed the facility's status remained delinquent, and they have not submitted a CEMP in over 2 years. No additional information was provided. Class III	ZZ830		

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A 000	Initial Comments An unannounced Change of Ownership (CHOW) and Generator Monitoring survey was conducted at Oasis at Boynton Beach on - . Deficiencies relatd to the CHOW were identified at the time of survey.	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	A 025		

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A 025	Continued From page 1 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, 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 observation, interview and record review, it was determined that, the facility failed to provide personal supervision, care and services as necessary to ensure the facility adequately monitored resident safety, health and well-being in 1 of 1 residents sampled for record review (Resident #1) and additional Residents observed and interviewed. The findings included: A. A review of Resident #26's record revealed an admission date of . A Resident Health Assessment dated documented	A 025		

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A 025	Continued From page 2 , History of , and , and identified a Regular, No Salt Added diet. An external dental physician order dated required Resident #26 to be on a puree diet "indefinitely" following surgery on . No reassessment or documentation supporting this change was present. During a concurrent observation and interview with Resident #26 on from 1:15 PM to 1:22 PM, she was observed in a recliner with her elevated and a surgical scar on her covered with tape. She stated staff had not cleaned her blender and she required smoothies due to her recent surgery. She stated she requested bananas and strawberries from the Administrator and dietary staff but had not eaten since returning from the hospital the previous day because the facility was not providing puree meals. In an interview at approximately 1:30pm, Staff L (Wellness Coordinator) was asked about discrepancy in diet orders for Resident #26 and stated the facility was providing her a chopped diet as that was Resident's preference. This diet did not match either order in Resident #26's record. In an interview at approximately 3:00pm while Staff A (Administrator) and Staff B (Administrative Assistant) were present, Staff M (Wellness Director) stated that Resident #26 told the facility she would not allow collaboration with her medical providers. Per Staff M were to manage Resident #26's medications only. B. On at approximately 12:50 PM, Resident #1 was observed yelling, berating staff and using a dustpan and broom to hit the	A 025		

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A 025	Continued From page 3 housekeeping cart and wet floor sign in the south hallway. No staff was observed to intervene. In an interview on at approximately 11:00am, Staff L was asked if Resident #1's aggressive actions were behavioral or the result of decline. Staff L stated she thought it was a behavioral issue and stated that Resident #1 had threatened to kill Staff B and then to , and kill his hospice nurse resulting in police intervention. Staff L could not recall exactly when this occurred, but stated that it was a recent occurrence. When asked what actions the facility had taken to address these concerns, Staff L identified that hospice was informed. A review of Resident #1's record revealed an admission date of . A Resident Health Assessment dated documented of or Behavior Needs of Alert and oriented x 3 with periods of restlessness. Progress notes entered by clinical care staff from to were reviewed and did not include information regarding a change in or concern about Resident #1's behavior. C. In an interview on at 9:30 AM, Staff L (Wellness Coordinator) stated the facility had a documented list of residents who self-administer medications. Documentation was not provided. The Wellness Coordinator was observed creating a list of residents who self-administer by marking names from the Agency's census copy. She stated the facility had seven residents who self-administer medications, including two who self-administer (Residents #17 and #21). She further stated both residents stored their in their rooms and were capable of safe storage and usage.	A 025		

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A 025	Continued From page 4 During a tour conducted on at 10:35 AM, vials and expired injectable pens were observed in an unlocked, unsecured miniature refrigerator in Resident #17 ' s room. During a concurrent medication reconciliation audit review and interview with the Wellness Director on from 12:09 PM to 12:35 PM, a random selection of resident medications was reviewed, including medications for Residents #17 and #21. When reviewing Resident #17 ' s medications, the Wellness Director stated the resident did not have in his room nor a refrigerator in the room. She was notified by the Agency that and vials were present in a miniature refrigerator inside Resident #17 ' s room. A subsequent tour conducted with the Wellness Director and Resident #17 on from 1:40 PM to 1:57 PM identified the following concerns: -An expired box of five (5) Basaglar 100 unit/mL [Exp] inside Resident #17 ' s refrigerator -An unsecured box containing more than three dozen SafetyGlide needles under the resident ' s bed -An unsecured dresser drawer filled with lancets, pen needles, and two unrefrigerated 100 unit/mL vials (used), dated and A review of Resident #17's revealed there was documentation on file for the monitoring of the resident's usage or storage. D. In an interview on at approximately	A 025		

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A 025	Continued From page 5 11:00 AM, Resident #19 stated she was in , and struggling with understanding her schedule of medication at the facility. She explained that she had multiple debilitating and previously had 3 operations. Resident #19 was observed to slowly ambulate in her wheelchair in an effort to obtain her , medication from the medication window - down two hallways from her room, at the front of the building. Resident #19 was hunched over, using her and only her left arm to propel her forward. While Resident #19 moved slowly toward the medication window, she stated that she needs her hair washed, but "Nobody tells me about what help I'm getting." She further stated that she had for 2 days and had to get a male aide to help her to clean herself. Resident #19 became tearful and was observed struggling to pass over thresholds and make turns in her wheelchair. Resident #19 stated that the facility had a fire 2 days ago and everybody had to go out in the heat. She also stated that she had a , in her heel and had concerns that it was or that she had another , . E. In an interview on at approximately 11:20 AM, Resident #20 stated she had a that had not resolved. She stated that a medication technician put some cream on it but it was not the right cream. She stated, "I don't know where my medicine is. It came but no one knows where it is. Me and my (family member) called and they said it came here ." She further stated that she doesn't need help to transfer but does needs help to shower. She stated that she has a Certified Nursing Assistant from an outside agency that comes once a week to help her bathe, but she wants more showers and hasn't been offered this assistance through the facility.	A 025		

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A 025	Continued From page 6 F. On at approximately 12:30 PM, this Surveyor observed several residents struggling to manage the floor , into the dining area from hallway. All those in wheelchairs had to turn around and go backwards through the doorway. Resident #29 was observed being wheeled out of the dining room by a care staff. As she was wheeled over the , in the floor, Resident #29 was heard to exclaim in , as her were getting stuck. Resident #29 did not have rests on her wheelchair, so her hung, dragging on the ground. Another care staff went to assist but Resident #29 continued to complain of , until she eventually was moved over the . was observed coming through a bandage wrapping on her left heel. G. In an interview on at approximately 2:30 PM Staff L (Wellness Coordinator) was asked where the facility's AEDs ( ) were located. Staff L stated she was not familiar with the term . She was then asked about an . She was also not familiar with this term. Staff B (Assistant Administrator) walked by and was asked about AEDs in the facility. Staff B stated the facility had two AEDs - one in the dining room and one in the Activity space. H. In an interview on at approximately 3:20 PM, Staff L stated incident reports could be completed by any staff and then would be reviewed by herself or Staff M and signed off on, then sent to Staff A (Administrator) or Staff B (Assistant Administrator) for final sign off. This Surveyor identified that several incident reports reviewed remained incomplete and did not contain any documentation on follow-up. Staff L acknowledged this concern but did not have an	A 025		

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A 025	Continued From page 7 answer for why this was the case. I. In an interview on at approximately 10:00 AM, Staff L was asked to review the census and identify those residents who self-administer medications. She identified 7 residents and stated she was pretty sure these were all the self-administration residents. She identified there is a list posted in the medication room. This Surveyor went with her to observe the list. Staff L showed this Surveyor where the list of self-administrating residents is to posted on a bulletin board inside an office; however the list was not posted. At approximately 11:00 AM, Staff M brought in list of self-administering residents which included only 5 residents. At approximately 11:30 AM, Staff L was asked about the discrepancy between the lists and stated there were two residents who should be on the list for self-administration of medication provided by Staff M. J. In an interview on at approximately 11:00 AM, Staff M was asked about the charting structure utilized by the facility and the challenge it created in tracking Resident care because of it. Staff M stated that progress notes are "all over the place" because, "We aren't the only ones who document. The kitchen does some, other staff do some. So those are in the chart." Staff M confirmed that only Staff L (Wellness Coordinator) and Staff M document into the electronic log of progress notes that was printed and maintained separately from Resident records. The electronic log of notes was completed by day, approximately once every two weeks, and included every resident in the facility.	A 025		

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A 025	Continued From page 8 These notes are not organized by Resident. Staff M stated that 3rd party notes are maintained both in the resident chart and also in separate binders - some stored in the clinical office and some at the front desk. This segmented charting structure did not allow for collaborative care provision amongst facility staff or between facility staff and third party providers. Class II. See also A0078 & A0152.	A 025		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph;	A 055		

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A 055	Continued From page 9 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.	A 055		

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A 055	Continued From page 10 (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to appropriately store and dispose of medications for 2 of 7 sampled residents (Residents #17 and #21). This was evidenced by the facility ' s failure to centrally store medications for residents who were unable to maintain their prescribed medications in a safe manner. The findings included: During a concurrent observation and interview with the Wellness Coordinator on at 9:30 AM, she stated the facility had a documented list of residents who self-administer medications. Documentation was not provided. The Wellness Coordinator was observed creating	A 055		

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A 055	Continued From page 11 a list of residents who self-administer by marking names from the Agency ' s census copy. She stated the facility had seven residents who self-administer medications, including two who self-administer (Residents #17 and #21). She further stated both residents stored their in their rooms and were capable of safe storage and usage. During a tour conducted on at 10:35 AM, vials and expired injectable pens were observed in an unlocked, unsecured miniature refrigerator in Resident #17 ' s room. During a concurrent medication reconciliation audit review and interview with the Wellness Director on from 12:09 PM to 12:35 PM, a random selection of resident medications was reviewed, including medications for Residents #17 and #21. When reviewing Resident #17's medications, the Wellness Director stated the resident did not have in his room nor a refrigerator in the room. She was notified by the Agency that , and vials were present in a miniature refrigerator inside Resident #17 ' s room. A subsequent tour conducted with the Wellness Director and Resident #17 on from 1:40 PM to 1:57 PM identified the following concerns: -An expired box of five (5) Basaglar 100 unit/mL [Exp] inside Resident #17 ' s refrigerator -An unsecured box containing more than three dozen SafetyGlide needles under the resident ' s bed -An unsecured dresser drawer filled with lancets, pen needles, and two unrefrigerated	A 055		

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A 055	Continued From page 12 100 unit/mL vials (used), dated and Furthermore, a tour conducted with the Wellness Director and Resident #21 on from 2:02 PM to 2:08 PM identified the following concern: -A set of prescribed Ultra Fine Pen Needles belonging to another resident stored unsecured on top of Resident #21 ' s refrigerator During an interview conducted with the Administrator on at 4:00 PM, she was notified that the facility failed to centrally store medications for Residents #17 and #21 despite their inability to maintain medications in a safe manner. She further acknowledged that the unsafe storage practices posed a safety hazard to other residents, as the rooms remained unlocked. Class III	A 055		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility	A 152		

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A 152	Continued From page 13 supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on interviews and observations, it was determined that, the facility failed to maintain the building in good working order placing the entire census of the facility (54 residents at the time of survey) at risk of or serious injury due to exposure to dangerous conditions including fire. The findings included: A. On at approximately 10:30 AM, while touring the south hallway this Surveyor smelled a strong chemical odor. Upon making entry to the facility's laundry room the smell intensified. The	A 152		

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A 152	Continued From page 14	A 152		

door leading to the exterior of the building from the laundry room was open and just outside of the door a dryer was observed. The ground surrounding the dryer was littered with clumps of lint. Upon inspection, a layer of scorched lint was evident on the base of the dryer. No mention of the fire was made by Staff A (Administrator) in entrance conference held at 9:25am the same day.

On at approximately 1:15 PM, Staff B (Assistant Administrator) brought in a copy of the adverse incident report submitted to the agency regarding the fire. It identified that the fire occurred . The Administrator stated that at approximately 1:00 PM on , Staff D (Cook) smelled fire, went to investigate and saw smoke in the laundry room. Staff D then went to the front desk to ask for assistance in contacting the authorities, but the fire sensor was tripped when the laundry room door was opened and went off automatically contacting the fire department and prompting a full evacuation of the facility.

In an interview on at approximately 10:30 AM, Staff A (Administrator) was asked to provide a written or electronic document outlining remediation plan for the fire.

In an interview on at approximately 12:30 PM, Staff A was asked again for a document outlining the remediation plan for the fire. She stated she will be asking the ownership for an outline of the planned changes. When asked for documentation from the responding Fire Department, Staff A stated did not receive any. Staff A stated the Fire Department thought the cause of the fire was likely due to gas, but the gas company came out to check and there were

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A 152	Continued From page 15 no leaks. She stated that underneath the industrial lint trap there was lint and debris accumulation which was identified as the probable cause of the fire. Staff A was asked why an incident report for the fire was not completed and entered into the incident log. Staff A identified that she did not complete one. A review of the agency's Fire Incident Report signed by Staff A and dated included the following information: Known or probable cause of fire: Commercial dryer excess of lint caught gas pilot. What steps have been taken by the facility to prevent reoccurrence: Clean and check dryer vents daily. Inservice will be held for all employees by by admin. A review of the Ongoing Fire Safety and Laundry Room Equipment Monitoring Plan dated included the following information: Purpose: This ongoing plan is being implemented following an unexpected fire incident that occurred on in the facility laundry room. The fire originated from the second-in-line commercial 50-, Maytag dryer. Laundry Room Cleaning and Maintenance: The following requirements shall be maintained: 1. The laundry room must be inspected and cleared of debris and lint accumulation at least once weekly. 2. Special attention must be given to the areas behind, beside and underneath all washing and	A 152		

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A 152	Continued From page 16 drying machinery. B. In an interview on at approximately 11:20 AM, Resident #20 stated she had mouse traps under her bed and that a mouse had been caught within the last week. She explained she saw a mouse on her bed several weeks ago and pest control came in approximately 2.5 weeks ago and put down sticky traps. She stated that pest control had not returned and a member of housekeeping was who removed the mouse. She stated that the sticky trap under bed was not replaced but another sticky trap remained and had been placed under her bookshelf closer to door - this was confirmed through observation. Class III	A 152		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of	A 078		

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A 078	Continued From page 17 testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description	A 078		

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A 078	Continued From page 18 to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Kitchen Supervisor performed assigned job duties, including overseeing the implementation of therapeutic diets as ordered by the physician, educating dietary staff, and ensuring adherence to preplanned, dietician-approved menus. This failure placed all 54 residents-the entire facility census-at risk, as all residents consume meals and food items prepared in the facility ' s kitchen. The findings include: On at approximately 9:20 AM, the Assistant Administrator stated Staff C was the Kitchen Supervisor and responsible for overseeing the kitchen. She stated he worked Tuesday, Wednesday, Friday, and Saturday, and that Staff D (Cook) was in charge of the kitchen when the Kitchen Supervisor was not onsite. A review of Staff D ' s personnel file revealed a hire date of for the role of "Cook." A job description signed by Staff D on outlined the following: Qualifications: - Have the ability to follow standard recipes. Duties and Responsibilities:	A 078		

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A 078	Continued From page 19 - This position is under direct supervision of the Administrator/Asst. Administrator - This individual will be expected to follow standard recipes - Must make sure that special diets are followed as doctors order. Must report to Administrator any significant changes in eating habits. Daily Tasks: - Check menu for all upcoming meals and document on substitution log/report to Admin/Asst. Admin of any substitutions that might have been made. Weekly Tasks: - Check menus for the following week, make sure orders are completed and in route for meals to be prepared. - File menus and recipes from the previous week in the proper place and order. It was noted that the job description was not signed by the Administrator. During an interview conducted with Staff D on at 10:30 AM, she stated the Kitchen Supervisor was not onsite and she was responsible for maintaining and running the kitchen in his absence. She stated she was preparing meals for the day and that the facility no longer had residents on therapeutic diets. During a concurrent tour of the kitchen with Staff D on at 10:40 AM, there were no planned and dated dietician-approved menus for 2026 posted. Staff D pointed to an undated menu that had expired in , .	A 078		

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A 078	Continued From page 20 During an interview with the Wellness Director and Wellness Coordinator on at 11:15 AM, the Wellness Coordinator stated the facility had three residents on therapeutic diets: Residents #18, #26, and #33. She stated Resident #18 was on a puree diet, Resident #33 was on a mechanical chopped diet, and Resident #26 had an external provider order requiring a puree diet. During a lunch observation on from 11:30 AM to 12:25 PM, Resident #33 was served unchopped pasta, sausage, green beans, and mixed berries despite an order for mechanical chopped texture. Residents #18 and #26 were not present in the dining room. Record reviews for Residents #18, #26, and #33 revealed outdated assessments, missing diagnoses, lack of documentation of therapeutic diet orders, no reassessment following external diet changes, and no documentation of diet changes. A review of the International , , Diet Standardization Initiative (IDDSI) guidance revealed the applicable levels were IDDSI Level 4 (Puree) and IDDSI Level 5 (Minced and Moist). Level 5 requires foods to be soft, moist, retain their shape when scooped, and contain only small lumps that can be easily mashed with the . These lumps should not exceed approximately 4 mm in width and 15 mm in length and must be easy to compress with minimal effort, without any thin liquid separating from the food. Level 4 Puree requires food to be completely smooth and moist with no lumps, requiring no chewing at all. Pureed food retains its shape on a plate, moves slowly under gravity, cannot be sipped through a straw or drunk from a cup, and should off a spoon in a single cohesive piece while still holding its form.	A 078		

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A 078	Continued From page 21 During meal observations, food served to residents ordered Level 4 and Level 5 diets did not meet these consistency requirements, and instead included whole items, chunks, and textures requiring chewing. During an interview on at approximately 10:50 AM, Staff C confirmed he was responsible for supervising kitchen operations and dietary staff. He acknowledged he was only present four days per week, and Staff D was in charge in his absences. When asked about menu postings, he retrieved a manila envelope containing menus and substitution logs from the Administrator and stated the facility was on Cycle 3. The menu indicated BBQ chicken or cheeseburger should have been served on , and shrimp, cheesy grits, and vegetables should have been served on . He stated he was unaware that Staff D did not follow the menu on , and stated he was not following the menu for because the steam tables for the food warmer were broken. He stated neither he nor his staff had ever used the substitution log when making menu changes. He further stated he did not contact the dietician or the Agency to notify them of the broken steam tables. Concerning residents on therapeutic diets, he stated the facility had three residents on therapeutic diets: Residents #18, #29, and #33, and that only Resident #18 was receiving a puree diet consisting of Ensure, pudding, and applesauce. He retrieved a frozen tub of condensed soup labeled "Frozen Ready To Cook Condensed Soup" when asked to provide a pureed meal. Regarding Resident #26, he stated she was "not really" on a puree diet and preferred smoothies.	A 078		

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A 078	Continued From page 22 During a lunch observation on from 11:15 AM to 12:30 PM, Resident #33 was again served unchopped items including boiled eggs, sliced ham, carrots, lettuce (chef salad), and a corn muffin. Residents #18 and #26 were not observed in the dining room. During a concurrent observation and interview with Resident #18 on from 12:45 PM to 1:05 PM, she was observed lying in bed attempting to eat gumbo containing chopped vegetables, rice, and small pieces of meat. She struggled due to missing and food spilled onto her exposed . She stated she typically received Jello and applesauce for meals. Her refrigerator contained over ten cups of applesauce and three bottles of Ensure Plus. USDA Dietary Guidelines identify protein needs for adults over at 0.80 g per kilogram per day. Ensure Plus provides 16 g of protein per bottle; applesauce contains less than 1.5 g per serving; Jello contains less than 1.2 g per serving. A review of Staff C ' s personnel file revealed a hire date of for the position of "Chef." A job description signed by Staff C and the Administrator on outlined the following: Job Description: Kitchen Supervisor Qualifications: Have the ability to follow standardized recipes provided by the facility's licensed dietician/ educator Duties and Responsibilities:	A 078		

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A 078	Continued From page 23 - This position is under direct supervision of the Administrator/Asst. Administrator - This individual will be expected to follow standard recipes - Must make sure that any special diets are followed as doctors order. Must be able to keep open contact with facility licensed dietician of special orders and be able to identify of each resident in a standard licensed assisted living facility. - Must report to Administrator/Asst. Administrator and or Wellness Dept of any resident significant changes in eating habits. Must ensure dietary staff is trained and equipped with the proper knowledge to identify a resident's change in eating habits as well. - Must know how to properly fill out paperwork needed for kitchen purposes and documentation on resident's changes and observations. Daily Tasks: - Check menu for all upcoming meals and document on substitution log/report to Admin/Asst. Admin of any substitutions that might have been made. Weekly Tasks: - Check menus for the following week, make sure orders are completed and in route for meals to be prepared. - File menus and recipes from the previous week in the proper place and order. Degree of Difficulty: - Responsible for quarterly dietary trainings. - Properly oversee dietary staff and properly train	A 078		

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A 078	Continued From page 24 staff to ensure performance is good. - Communicate in morning meetings with all dept heads on the resident's observations and or needed assistance. Training records showed SERV Safe Food Protection Manager certification dated and Nutrition and Food Service Training completed on , expiring . No current training documentation was found. During an interview with the Administrator on at 2:35 PM, she stated she would locate Staff C ' s current nutrition training. Documentation was provided on , dated . During an interview on at approximately 11:11 AM, the Administrator stated she had no documentation of recent trainings or in-services conducted with Staff D and no documentation of menu planning or special diet procedures. She stated Staff D was verbally instructed and had over 10 years of dietary experience. During a subsequent interview with the Administrator on at 2:10 PM, she was notified that the Kitchen Supervisor failed to implement specialty diets as ordered, notify providers of changes in eating habits, and follow dietician-approved menus. Furthermore, it was noted that his trained staff (Staff D) failed to perform their job duties related to the oversight of the meals and therapeutic diets in his absence. This failure affected the entire resident census due to the facility ' s reliance on dietician-approved menus for nutritional adequacy.	A 078		

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	AL11968596	A. BUILDING: _____ B. WING _____	08/26/2026

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A 078	Continued From page 25 Class III	A 078		
A 080	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and . . (c) Special needs of elderly persons, persons with mental illness, and persons with . and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and	A 080		

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A 080	Continued From page 26 related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:	A 080		

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A 080	Continued From page 27 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that, the facility failed to ensure the identified Assistant Administrator (Manager) met core training and core competency test requirements. The findings included: Observations and interviews throughout , and revealed that Staff B (Assistant Administrator) was fulfilling the role of Manager of the facility and serving as the Administrator's designee. In an interview conducted on at approximately 1:00 PM, both the Administrator and Staff B stated that Staff B has always served in the role of Assistant Administrator. In an interview conduct on at approximately 3:35 PM with the Administrator and Staff B, Staff B confirmed that she had previously taken the core training but did not sit for the core exam. She was informed that this was a requirement for all Administrators and Managers. Staff B stated that she was unsure she was willing to do so.	A 080		

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A 080	Continued From page 28 Class III	A 080		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents	A 160		

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A 160	Continued From page 29 if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.	A 160		

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A 160	Continued From page 30 (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure it maintained the required facility records. The findings include: During an interview with the Administrator on at 12:03PM, the facility's records were requested. A second request was made on at 1:30 PM for the same documents. During a further interview with the Administrator, she reported that she had the policies and would provide the records for review. No documents were provided for review.	A 160		

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A 160	Continued From page 31 The following documents were not available: Assistive Device Policy Grievance Policy Physical Policy and Policy Class III	A 160		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.	A 162		

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A 162	Continued From page 32 (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ␣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ␣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ␣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.	A 162		

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A 162	Continued From page 33 (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	A 162		

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A 162	Continued From page 34 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain required on site copies of monthly statements for residents for whom it served as representative payee, nor did it maintain quarterly written fund statements for residents with trust accounts, 6 out of 6 Residents ((Resident #15, Resident #27, Resident #29, Resident #35, Resident #36, Resident #37). The findings included: In an interview at approximately 2:20 PM, this surveyor met with Administrator to inquire about residents for which the facility served as representative payee. Administrator stated that she was unsure how much money was maintained for each Resident and identified that this information would need to be requested through the Administrative Manager. Administrator stated that the Administrative Manager also maintained income and expense sheets for the facility and that the Administrator did not have access to the information. The Administrator did not have information on balances for the 6 residents whose federal funds were directly deposited into a bank account owned by the facility. When asked about the accounting procedures for the facility, the Administrator stated this would be the role of the Accounts Payable Department. The Administrator stated she did not have knowledge of or access to the information.	A 162		

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A 162	Continued From page 35 At approximately 2:30 PM, the Administrator sent an email to the Administrative Manager and the Accounts Payable Department in order to obtain the requested financial information. There was no additional information provided. A record review of the financial information was unable to be completed as the information requested was not maintained on the premises of the facility and was not furnished for review. Class III	A 162		
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	A 165		

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A 165	Continued From page 36 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 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	A 165		

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A 165	Continued From page 37 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 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 interviews and record review, it was determined that the facility failed to report an elopement. The facility also failed to submit an Adverse Incident Report within one business day after the occurrence of an adverse incident for, for out of 1 sampled elopements (Resident #31). The findings included: Record review of Resident #31 revealed he was admitted on . Further review revealed a Health Assessment (1823 AHCA Form) dated	A 165		

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OASIS AT BOYNTON BEACH	1708 NE 4TH STREET BOYNTON BEACH, FL 33435

(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 165	Continued From page 38 documented as follows; Medical history and diagnoses: , , , , , , history of , s/p surgery, , , , . Physical and sensory limitations standing balance issues and generalized status: , memory, problem-solving, and reasoning. Assistance with Activities of Daily Living (ADLs): needs assistance with ambulation, bathing, , toileting, and transferring; needs supervision with eating and self-care. During facility record review on , the facility provided a document title ALF Incident Report, review of document dated 9:54 AM. The Administrator notified Staff B (Administrative Assistant / Assistant Administrator), signed by Staff K (Activity Director). Further review documented as follows: Let resident out to front to sit must wonder off and police dept called at 9:54AM stated Resident #31 was found in front of a nearby local Apartment , , he felled said he was . Further review revealed Resident #31 was sent to the local hospital. During an interview on at approximately 12:33 PM, the Administrator confirmed the facility failed to submit an Adverse Incident Report to the Agency for Health Care Administration (AHCA) within one business day after the occurrence of the adverse incident. She stated she should have reported the incident but did not. During an interview on at 12:58PM with staff K She stated that she let the Resident#31 out front and must have taken her off him. She stated she was not aware the	A 165		

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 _____	08/26/2026

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A 165	Continued From page 39 resident was gone until she received a call from the local police department stating they had found the resident and was taking him to the hospital. She stated she made the Administrator and Staff B aware of the incident on the day of . During an interview on at approximately 4:15 PM, Surveyors met with the Administrator, and he acknowledged the findings. No additional documents were provided during the survey. Class III	A 165		