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
	AL11965386	A. BUILDING: _____ B. WING _____	05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH	2400 SOUTH CONGRESS AVENUE BOYNTON BEACH, FL 33426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint survey (#2022000702) was conducted at Boynton Beach on . The facility had a deficiency identified at the time of the survey.	A 000		
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	A 165		

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A 165	Continued From page 1 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) [illegible], neglect, or [illegible] 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	A 165		

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A 165	Continued From page 2 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 record review and interview, the facility failed to file a 1-day and a 15-day Adverse Incident Report to the Agency for Health Care Administration (AHCA) per the required time frames for 1 of 1 sampled residents, Resident #1, who suffered an adverse incident. The findings included: Review of the facility's 15-day submission to AHCA dated [redacted] revealed that on [redacted] at 11:07 PM., Resident #1 and sustained an injury during care which necessitated the transfer of the resident to a higher level of care at a local hospital. On [redacted], the facility received a call from the local hospital who confirmed that Resident #1 had sustained a left [redacted]. Although the facility was informed of the the day after the resident was transferred to the hospital, they did not draft an Adverse Incident	A 165		

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A 165	Continued From page 3 Report or report the incident to state authorities for further follow up or investigation. On , the local Police arrived at the facility to investigate the incident which led to Resident #1 sustaining a left , . It was reported to the facility Resident #1 had alleged that the she suffered was the result of a staff refusing to assist her during transfer from the toilet to the wheelchair. This report triggered the facility to initiate further inquiries, to place the involved staff member on administrative leave, and to eventually terminate the staff member. Then, the facility filed the Adverse Incident Report to the state agency, AHCA. Review of the clinical record revealed Resident #1 was admitted to the facility on and was discharged from the facility on . Her admission diagnoses included history of lower extremities, tremors, to decreased hearing both , to the right and , . During an interview conducted with the Director of Nursing (DON) on at 9:58 AM, she reported that the resident had other physical health complications that could have contributed to the of her , . So, they did not determine the seriousness of the incident until the police came to investigate the situation and reported that Resident #1 alleged that the staff member caring for her on that day had refused to assist her during transfer which resulted in her falling. The DON said during their preliminary investigation, the staff member had denied the allegation and they were unable to determine	A 165		

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A 165	Continued From page 4 what truly had happened on the day of the incident. Consequently, the staff member was subsequently terminated. During an interview conducted with the Administrator on at 12:19 PM, he reported that he began employment at this facility in of 2022. He said that he was not working at the facility when the incident occurred. He however concurred that an Adverse Incident Report should have been filed with AHCA per the submission time requirements. Class III	A 165		