

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967989	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/16/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ADVENT SQUARE

**4798 NORTH DIXIE HIGHWAY
BOCA RATON, FL 33431**

(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 (#2022005110 & #2022014815) and a Generator Monitoring survey were conducted on _____ at Advent Square. The facility had a deficiency identified related to Complaint #2022014815 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	A 165		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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A 165	Continued From page 1 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 abuse, 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	A 165			

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A 165	Continued From page 2 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 record review and interview, the facility failed to file Adverse Incident Reports as required for 1 of 3 sampled residents (Resident #1) after sustaining post incidents. The findings included: On , Resident #1's record was reviewed. There were three Incident Reports that the facility completed for that Resident #1 sustained which resulted in . The facility is required to submit an Adverse Incident Report to the Agency for any event over which facility personnel could exercise control rather than as a result of the resident's condition and results in a or the transfer of the resident to a unit providing more acute care due to the incident. The following incidents were not documented on	A 165		

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A 165	Continued From page 3 Adverse Incident Reports and submitted online to the Agency within one business day of the occurrence of the incident: A. On Resident #1 tripped and sustained a witnessed in the dining room. The resident was subsequently transferred to the emergency room for evaluation. The diagnosis was a right B. On Resident #1 sustained a witnessed after being pushed by another resident with 2 staff members present. The resident was subsequently transferred to the emergency room for evaluation. The diagnosis was a left C. On Resident #1 was found on the floor in her room at 5:30 AM when staff went in to assist with morning care. The resident's resulted in a During an interview conducted with the Assistant Administrator and the Administrator on 11/16/22 at 1:00 PM, they confirmed that the incidents that resulted in were not documented on Adverse Incident Reports and submitted to the Agency electronically. The facility provided no additional information for review at this time. Class III	A 165		