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 _____	11/14/2024

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

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that facility staff were registered, and their employment status maintained on the Background Screening Clearinghouse (BGS) Roster for 10 out of 34 Staff reviewed (Staff Q, R, S, T, U, V, W, X, Y and Z). The findings included: Review of the facility's BGS Roster on revealed that current/active staff members identified on the facility internal staff roster were not on the BGS roster (Staff Q, R, S, T, U, V, W, X, Y, Z). In an interview conducted with the Administrator Staff A on at 6:00 PM, she stated that she was not aware these staff members were not registered in the facility's Background Screening Clearinghouse (BGS) roster, and that their	CZ814		

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CZ814	Continued From page 2 employment status was not updated or maintained within the BGS Clearinghouse. She stated she will go through the BGS roster and make sure it is updated to reflect the facility roster. No changes were made during the survey. Unclassified	CZ814		
CZ830	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	CZ830		

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CZ830	Continued From page 3 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 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	CZ830		

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CZ830	Continued From page 4 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 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 and interview the facility failed to timely submit/or secure approval of their Comprehensive Emergency Management Plan (CEMP) letter from the Local County Emergency Management Division. The Findings Include: On at 11:27 AM a request was made to the Administrator for the facility's Comprehensive Emergency Management Plan (CEMP) letter from the Palm Beach County Emergency Management Division. She stated in the interview that they were told by the Emergency Management Division that they needed a Broadband System, but Local Fire prevention stated they don't need that. She stated Corporate is still waiting for someone to come and perform the survey. She further stated that in communications with the Local County, they still tell her that they needed the Broadband system. She stated that once the people come out, they can tell them whether it is needed or not.	CZ830		

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CZ830	Continued From page 5 In an interview with Maintenance Director on at 11:06 AM, a request was made for the facility's current Fire Inspection Report. He brought 4 binders into the office where the surveyors were working and stated they should be in one of those. A review of the binders was conducted with the Maintenance Director and this surveyor, which revealed an Inspection report dated . A request was made to him for the most recent inspection report, and he stated they just had one, and left to go find it. The Maintenance Director came into the room at 11:20 AM and showed this surveyor a letter from the Local Municipality (City) dated for their Grease Management Program Inspection. He was informed that it was not a Fire Inspection Report. He then accessed his cell phone an stated the only other thing he had was a letter from the Local City's Fire Department and showed it to this surveyor. He printed a copy of the letter to this surveyor. In an interview with the Maintenance Director on at 1:23 PM he was informed that the Fire Inspection Report from the Local City Fire Department was still needed. This surveyor provided him with an explanation of what it was as he expressed, he did not to know about such letters. A review of the facility's CEMP submittal packet revealed a Fire Plan review/approval letter dated , but no Annual Fire Inspection Report from the Local City's Fire Rescue dated (copy obtained). No additional information was provided during the survey. In an interview with the Administrator and Assistant Administrator on 11/12/2024 at 3:23 PM, she restated that the Local City's Fire Bureau	CZ830		

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CZ830	Continued From page 6 Chief stated that they needed a "Broad-System" which annunciates a warning should a fire starts at the facility. She stated they needed the original plans from the building and is not sure where they would get that as the building is old. She stated the Local County Emergency Management Division informed them that they don't need it, so it's confusing. A review of the CEMP binder provided to this surveyor by the Administrator revealed a letter from the Local County Emergency Management Division dated . , informing the facility that their Comprehensive Emergency Management Plan (CEMP) could not be approved in its current state (copy obtained). In an interview with the Administrator and Assistant Administrator on 11/12/2024 at 3:27 PM the Administrator stated this was their first time doing a CEMP, and that they went to the training at the Local County's Emergency Management Division's office, and that they reached out to her sister facilities for assistance. A second review of the facility's CEMP binder on revealed a receipt from the Local County Emergency Management Division dated acknowledging receipt of information from the facility (copy obtained). A second review of the facility's CEMP submittal packet revealed a Fire Plan review/approval letter dated , , but no Annual Fire Inspection Report from the Local City's Fire Rescue dated . (copy obtained). No other documentation was provided during the survey. Class III	CZ830		

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CZ841	Continued From page 7	CZ841		
CZ841	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an	CZ841		

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CZ841	Continued From page 8	CZ841		

essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care.
(c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:
1. End-of-life situations.
2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support.
3. The resident, client, or patient is making one or more major medical decisions.
4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently .
5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
6. A resident, client, or patient who used to talk and interact with others is seldom speaking.
7. For hospitals, childbirth, including labor and delivery.
8. patients.
(d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures.
(e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request.

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CZ841	Continued From page 9 (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the provider failed to meet the Visitation Policy requirements, or have such policy posted on their website. The facility also failed to produce a visitation policy upon request. The Findings Include: Observations of the facilities website and written policies on revealed the facility failed to have any visitation documents, records, or other such data, either in electronic or paper format that addresses: 1). Visitation requirements for an Assisted Living Facility 2). control education for visitors, including screening, PPE, essential caregiver designations, visit length, consensual physical contact and designation of a person responsible for ensuring staff adhere to the policies and procedures 3). Allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects to End-of-life situations, a resident, client, or patient who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support, the resident, client, or patient is making one or more major medical decisions resident, client, or patient is experiencing emotional distress or grieving the	CZ841		

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CZ841	Continued From page 10 loss of a friend or family member who recently , a resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver, a resident, client, or patient who used to talk and interact with others is seldom speaking. In an interview with the Administrator on at 11:35 AM she acknowledged the facility does not have a visitation policy and stated she believed it was not necessary after the Covid restrictions were lifted. She stated the facility will have a visitation policy that will meet the Florida State requirements. No policy was provided during the survey. Class	CZ841		

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A 000	Initial Comments An unannounced Relicensure, Complaint (#2023018460, #2024001225, #2024003802, #2024007021, #2024010116) and Generator Monitoring survey was conducted on - at Oasis at Boynton Beach Assisted Living. The facility had deficiencies related to the Relicensure and Complaint surveys (#2024001225, #2024003802, #2024007021, #2024010116) at the time of the 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.	A 025		

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A 025	Continued From page 1 (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, 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 interviews, observations and record review, the facility failed to provide daily observation by designated staff of the activities provided to residents while on the premises, or an awareness of the general health, safety, physical and emotional well-being of residents residing in the facility. The Findings Include:	A 025		

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A 025	Continued From page 2 During an interview with Resident #27 on at 12:00 PM she stated she was lying in her bed on at approximately 2:00 AM, when another Resident (#30) entered her unlocked room and began to grab her inappropriately and tried repeatedly to kiss her on the . She stated she screamed for several minutes until Resident #30 left the room. She stated no staff responded to her screams and she does not feel safe in the facility. She stated she has informed the Administrator numerous times that she does not have a key to her apartment and is unable to lock it. In an interview on with an officer from the Local Police Department, he stated that on he was called to the facility and Resident #30 for Resident #27. Observations on by the surveyor revealed Resident #27's room does not lock, which provided unabated access into the Resident's room by Resident #30. On the Administrator provided this surveyor with the Immediate Discharge letter dated that was given to Resident #30. A review of the letter documented Resident #30's lease was immediate terminated following the incident with Resident (#27), stating it was in the best interest, safety and well-being of all Residents in the facility. In an interview with the Administrator (Staff A) on at 11:30 AM she stated she is aware of the incident involving Residents #27 and 30. And that she was informed that the Local Police Department did respond to the facility and Resident #30 for his role in the incident with Resident #27. She stated no staff members on duty the night of the incident reported hearing the	A 025		

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	AL11968596	A. BUILDING: _____ B. WING _____	11/14/2024

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 025	Continued From page 3 screams of Resident #27. She also acknowledged that Resident #27 has requested a key to her room several times and that is something the facility is working on. As of the survey that room remained unlocked with no key provided to the Resident. As such, Resident #27 room remains with unimpeded access by other residents, visitors and all staff. Class III	A 025		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to offer supervision of/or assistance with activities of daily living as needed for Resident #8 resulting in numerous un-addressed Resident The findings include: Record review on revealed a facility policy which states: It is the policy of the facility to ensure that every effort is made to provide every Resident adequate supervision as needed and to protect the resident from and injuries: 1). Administrator to monitor the effectiveness of	A 028		

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A 028	Continued From page 4 the policy. 2). Physicians and family are notified of all . 3). Steps to prevent will be implemented immediately or as soon as feasible by Director of Nursing and Administrator. 4). The Administrator will determine after 2 if Resident is appropriate for the ALF. 5). A new health assessment (1823) will be completed. 6). Staff will conduct a non-formal investigation. 7). All will have a completed facility incident report and what can be done to prevent reoccurrences. During review of the Resident's files and documents, observation was made of progress notes and incident reports. A review of the documents revealed documented for Resident #8 as follows: - documented on observation notes. No incident report. - documented on observation notes. No incident report. - documented on observation notes. No incident report. - Resident returned from hospital/rehabilitation center. - Resident observation notes document Resident acting unstable. - documented on observation notes. No incident report. - documented on observation notes. No incident report. - documented on observation notes. No incident report. - Incident report prepared. - documented on observation notes. No incident report. - Incident report prepared.	A 028		

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A 028	Continued From page 5 Record review of Resident #8's chart also revealed there was no Health Assessment form (AHCA form 1823) updated or incident reports completed which documented actions taken to prevent reoccurrences. In an interview with Resident #8 on at 1:30 PM she stated she in the courtyard last month and had to go to the hospital. She stated she has had several and no staff from the facility has ever put any procedures in place to prevent further . She further stated she , and the staff would just help her up. In an interview with the Administrator (Staff A) on at 11:30 AM she stated she is aware of the Resident and her history. However she could not produce any documentation of any prevention protocols put in place for Resident #8 during the survey implementing. Class III	A 028		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure	A 030		

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A 030	Continued From page 6 for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical .	A 030		

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A 030	Continued From page 7 (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.	A 030		

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A 030	Continued From page 8 (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255	A 030		

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A 030	Continued From page 9 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or	A 030		

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A 030	Continued From page 10	A 030		

explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of

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A 030	Continued From page 11 such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a procedure for receiving and responding to resident complaints. The facility also failed to follow grievance policy and was unable to demonstrate that such procedure was implemented upon receipt of a complaint for 4 of 7 Residents interviewed (6, 7, 9 and 27). The Findings Include: Record review of facility grievance policy and procedure revealed the following: 1). Administrator will bear and attempt to resolve all grievances in a fair and timely manner. 2). A written summary of the formal grievance heard by the Administrator will be recorded, which includes the nature of the grievance and remediation correction plan. 3). If the facility is unable to resolve any of the concerns of the Resident, they will be directed to contact the Ombudsman, phone number to be provided. In an interview with Resident #8 on 1:30 PM she stated she made a complaint to the Administrator in and regarding her clothes being missing from her room. She stated she never got a response or any resolution. A Review of the grievance log provided revealed no documented grievance	A 030		

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A 030	Continued From page 12 regarding Residents #8's missing clothes. . In an interview with Resident #6 on at 9:50 AM he stated he has made multiple requests for his own dresser in his room and that his closet door is broken. Review of the grievance log provided revealed no documented grievance regarding Resident's dresser or closet repair. In an interview with Resident #7 on at 10:00 AM, he stated he continues to have issues with his air conditioning not working well. He stated he informed the Administrator and maintenance. Review of grievance log revealed provided revealed no documented grievance regarding Resident 7's air conditioner. In an interview with Resident #9 on at 10:15 AM, she stated she informed the Administrator and other staff of the facility of having roaches and mice in her room. She stated she asked several times if her complaint is being addressed, as has had no communication from the Administrator of Maintenance regarding her complaint. A review of the grievance log provided revealed no documented grievance regarding roaches or mice observed by Resident #9. In an interview with Resident #27 on at 12:00 PM, she stated she has made multiple requests to the Administrator for a key to her apartment so she can lock her door as she does not feel safe. She stated the Administrator informed her that she has to make copies of keys but has not gotten around to it as of yet. A Review of the grievance log provided revealed no documented grievance regarding Resident 27's request for a door key. In an interview with the Administrator (Staff A) on	A 030		

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A 030	Continued From page 13 at 11:30 AM, she stated she is aware of the facility grievance log and that it needs to be updated and staff in-serviced on documenting Residents grievances and complaints. No additional information or documentation was provided during the survey. Class III	A 030		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations.	A 036		

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A 036	Continued From page 14 This Statute or Rule is not met as evidenced by: Based on record review, observation and interview it was revealed the facility failed to provide services in a manner that reduces the risk of transmission of for 96 out of 96 residents. Findings Include: Record review on revealed the facility had no policy or procedure for control for staff to follow. This surveyor was presented a document by the Administrator, Staff A on which she stated was their control policy. A review of the document revealed it was a 1-page flyer from their food vendor titled food safety and documented the process for washing your . (copy obtained) Record review of three facility staff members (F, G, H) revealed 2 of 3 staff (F, G) did not have the required 1-hour control training within 30 days of hire, which is required prior to providing direct care to Residents. Staff F and G are Resident Care Aides. In an interview on at 1:30 PM with the Administrator, Staff A and Assistant Administrator, Staff C, the Administrator stated Resident Care Aides have direct contact to Residents. A discussion during the interview regarding the implementation of a hygiene program for staff before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or . The Administrator stated the facility does not train staff for control. Nor could the Administrator and Assistant Administrator what the facilities policy or procedures are for standard precautions which	A 036		

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A 036	Continued From page 15 includes hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. Interview with Administrator on 11/14/2024 at 6:00 PM, she stated she understood the facility needs an control procedure and training for staff and she stated she will work on implementing immediately. No additional information or documentation was provided during the survey. Class III	A 036		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and	A 052		

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(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 052	Continued From page 16 must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment	A 052		

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	AL11968596	A. BUILDING: _____ B. WING _____	11/14/2024

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A 052	Continued From page 17 on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.	A 052		

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A 052	Continued From page 18 (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.	A 052		

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A 052	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure and document that prescribed medications were provided to residents as ordered by the physician. And that such medications were available, and the assistance with medications were conducted in a safe/or sanitary manner for sixty-nine (69) of sixty-nine (69) residents reviewed (Residents .). The Findings include: A review of the facility's undated Medication Policy provided to the survey team documented the following: 1). Documentation should be completed on a MAR sheet, either provided by the facility or by the pharmacy. 2). There should be no absence of days without explanation. During the survey a medication audit was conducted which include a review of Medication Observation Records (MORs) and medications. Review of the facility's Resident MORs revealed the facility was not/or fully documenting the medication indicated on the MORs, and stated to have been provided to residents. A sample of the findings that existed for all sixty-nine (69) residents reviewed revealed the following: A) A review of Resident #31's Medication Observation Record (MOR) for and revealed his medications as follows: - , , Tab 50MG; Take 1 by at bedtime	A 052		

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A 052	Continued From page 20 - Tab 3.12MG; Take 1 T by twice daily (12:00 PM and 5:00 PM). - Tab 1MG; Take 1 tablet by three times daily. - Tab 75MG; Take 1 T by once daily. - Tab 500MG; Take 1 T by in the evening W/Evening meal. -Rabegron Tab 50MG ER; Take 1 T by once daily. - SUL Tab 60MG ER; Take 1 tablet by twice daily for non-acute - Cap 20MG; Take 1 C by once daily. - Tab 15MG; 1 tablet by three times daily for non-acute -Prochlorper Tab 10MG; by three times daily DX: - Tab 50MG; Take 1 T by once daily for - Tab 20MG; Take 1 T by at bedtime. - Tab 80MG; Take 1 T by once daily Further review of Resident #31s and MOR revealed no documentation that the resident had received the medication listed as prescribed. Review of the Medication Notes section (of MOR) also contained no documentation explaining why the resident had not received the medication. B) A review of Resident #33's Medication Observation Record (MOR) for and revealed his medications as follows: -Lodipine Yab 10MG: 1 Tablet by once	A 052		

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A 052	Continued From page 21 daily - , Low CHW 81 MG; 2 tablets (162MG) by once daily - Tab 20 MG; 1 tablet by once daily - Tab 10MG; 1 tablet by twice daily -Clondine Tab 0.1MG, 1 tablet by twice daily. - , Tab 10MG, 1 tablet by twice daily. -Ferosul 325MG(RED BT#100), 1 tablet by at bedtime. - Tab 1MG, 1 tablet by once daily. -Dralazine Tab 50MG;1 tablet by three times daily with food. - Tab 2.5MG-HD; 1 tablet by weekly DX: - , Tab 15MG; 1 tablet by at bedtime. -OLM Med/HCTZ Tab 15MG; 1 tablet by once daily DX: -POT Tab 20MEQ ER: 1 tablet by once daily with food DX: Further review of the MOR revealed that with the exception of and , there was no daily documentation indicating the resident had received the medication as prescribed. Review of the Medication Notes section (of MOR) also contained no documentation explaining why the resident had not received the medication. C) A review of Resident #32's Medication Observation Record (MOR) for and revealed his medications as follows:	A 052		

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A 052	Continued From page 22 - Tab 20 MG; 1 tablet by at bedtime Dx - SOD CAP 100MG; 1 Capsule by twice daily for , -Ferosul 325MG (RED BT#1000); 1 tablet by twice daily with meals - , Tab 10MG: 1 tablet by once daily Dx - SOL Tab 10GM/15; 30ML (20 Grams) by once daily for , - SOL Tab 10GM/15; 30ML by once daily for 30 Days -Levothyroxin Tab 50MCG; 1 tablet by every morning on empty - , SUC Tab 25MG ER; 1 tablet by once daily Dx - , Tab 30MG; 1 tablet by at bedtime Dx - Tab 8.6MG; 1 tablet by once daily for , - Tab 50MG; 1 Tablet by every morning for , - , 7.5MG CAPS-HD; 1 Capsule by at bedtime for - C Tab 500MG; 1 tablet by once daily - D3 CAP 5000 Unit; 1 Capsule by once daily Additionally, review of Resident #32s MOR revealed PRN (as needed) the following medications documented on the MOR was not available in the medication cart at the time of the Medication Audit: - , Tab 325MG; 2 tablets (650 MG) by every 4 hours as needed for general discomfort -Diphen/Atrop Tab 2.5MG; 1 Tablet by	A 052		

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A 052	Continued From page 23 every 6 hours as needed for - , AC SUP 25MG; , , , , every 24 hours as needed for , , -Mintox SUS MAX ST 30ML; By every 4 hours as needed for indigestion Further review of the MOR(s) revealed no/or no consistent documentation that the resident had received the medication as prescribed. Review of the Medication Notes section (of MOR) contained no documentation explaining why the resident had not received the medication. D): A review of the MORS (current to) for the additional sixty-three (66) sampled residents of the facility who a receiving medication, revealed the same pattern of no daily documentation of medications provided to residents/or inconsistencies with documenting daily dosages of medications to be given (copies obtained). In an interview with the Assistant Administrator, Staff A and Staff E (Wellness Coordinator) on at 11:11 AM, they stated they recently changed their pharmacy about two months ago. Staff E stated the computer MORs do not match their electronic MORs. She stated that they are currently using the paper MORs and logging it into the computer as the pharmacy does not have a system. She stated they have to send the MORs out three times to get it accurate. She also stated she has an application on her phone to track all meds, which she showed to the surveyor. During the interview on that began at 11:11 AM, a lengthy discussion ensued regarding the process they are using, and the behind what they are doing. This surveyor pointed to the MORs that were presented and called their	A 052		

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A 052	Continued From page 24	A 052		

attention to the fact that they were blank and had no entries. As such, it could not be determined whether the Residents received their medication or not. Staff E stated they give them to them. But to have the MedTech's document each sheet (MOR) would be too much work. She also stated that she audits the carts, and she communicates with the pharmacies if there's a problem. This surveyor asked how she would verify that any given resident actually received their medications. She stated they are not tracking when the medications were given. This surveyor shared with her the practices with paper MORs observed in other facilities (small and large). And that medications given to must be documented. They stated they understood.

E) In an interview with the nurse from a third-party Home Health provider on at 12:29 PM, she stated the MORs for Resident #28 is not the same as the units of he is getting. She stated he sees an outside doctor (Endocrinologist). She stated on she changed his morning from 40 units to 36. She stated she asked the Resident's mom to request the endocrinologist have the dosage changed to update the MOR, but she hasn't. As such, the MOR from the Pharmacy do not reflect the current units he is getting, and that the MOR has not been updated.

In an interview with the Assistant Administrator, Staff E on at 5:38 PM this surveyor asked her about Resident #28's mom administering his . She stated the Resident's mom will come in and sign the medication out for the Resident if the nurses don't' move as fast as she wasn't them to. This surveyor asked for the sign-out sheet documenting that the medications are being

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A 052	Continued From page 25 signed-out when they are said to be administered by the resident's mother. Staff E left the room and came a few minutes later with a file folder and handed out of it a document dated . This surveyor asked if she had any other documents, specifically for the administration on . She stated that was the only one she had. And there was no documentation of the administrations on the MORs, or any additional information provided during the survey. Further observations of the facility's medications system for all Residents (Residents#1-#69) revealed the medications were being administered(assisted) in a random unsafe method. Specifically, observations of Residents' medication (Bingo) packets revealed several packs were present for the same physican prescribed medication for a resident, in which each staff member would use a different bingo packet, resulting in the medications packets and system being handled in an unorganized manner and in consistent manner. During an interview with Staff E and the Administrator between 12 PM and 4 PM on it was revealed that each resident has an overflow of medications in which the pharmacy is sending extra medications for each resident. It was revealed that instead of staff separating the excess from the current use packets, they are getting mixed up. This is resulting in each Med-tech staff using a different bingo packet for each medication assistance instead of using the same packet until completion. They stated, they have tried to notify the pharmacy but have had no luck in resolving the problem.. As a result of aforementioned medications concerns, and the facility not documenting the	A 052		

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A 052	Continued From page 26 assistance or medications being provided to the Residents of the facility on a timely, daily basis, they are unable to ensure/or verify that residents receive their medications as ordered/prescribed. Class II The facility will be required to secure the services of a Pharmacy Consult.	A 052		
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 055		

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A 055	Continued From page 27 a safe manner as described in this paragraph; 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	A 055		

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A 055	Continued From page 28 prescribed by the resident's health care provider. (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, record review and interview the facility failed to ensure Medications that have been abandoned or have expired were disposed of within 30 days of being determined abandoned or expired. And that the medication was kept in a locked cabinet, locked cart or other locked storage receptacle, and the disposal documented in the resident's record for sixty-nine (69) of sixty-nine (69) Residents reviewed (Residents). The Findings Include: A review of the facility's undated Medication Destruction Policy documented the following:	A 055		

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A 055	Continued From page 29 Medication(s) that are no longer active on the medication list of the residents should not be on the cart(s). If a prescriber or doctor has discontinued, changed or altered the order of that medication, that medication needs to be addressed to supervisor(s) admin(s) attention immediately. Medications can only be destroyed by the following: Administrator, Director of nursing and or with two eyewitnesses. Signatures must be made by signed by ADMIN. If the medications cannot be destroyed in the facility the medications need to be sent to pharmacy. You must call a pharmacy for the need-be destroyed meds to be retrieved. NO STAFF WITHOUT A WITNESS AND APPROVAL OF ADMIN CAN DESTROY MEDICATIONS. During a tour of the facility's medication room and Wellness Area on 11/13/2024 and , the following concerns were noted: 1) On at 11:13 AM observation was made of two (2) white soiled 5-gallon plastic buckets (unsecured) with lids located on the floor of the West wall of the Nurses Station facing the parking lot. Observation of the buckets revealed they are/were used for disposal of medications and materials (photo obtained). Further observations through a large cup size hole on the lid of each bucket revealed each contained an extremely large volume of pills (hundreds of pills), some melted down and others still in whole format. In an interview with the Administrator on	A 055		

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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

(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 055	Continued From page 30 at 3:17 PM, she stated they place medications for destruction in the buckets but was not sure when they were last emptied. She also confirmed that many of the pills were still in orginal format and could easily be pulled by a resident or staff from the container. 2) In an interview with Resident #34 on at 11:26 AM he states he gets his orders from the doctor, personally calls the pharmacy for fills/refills, he self-medicates and that the facility has nothing to do with his meds. Observation of the room revealed Bingo packs banded together with a rubber , and a small black metal box located on the floor of the left side (facing the headboard) of his bed in which he stated he keeps his . There was no lock observed on the small metal box, which was exposed to his roommate and any person(s) entering the room. 3) In an interview on at 11:46 AM with a third-party (Home Health Agency) provider, she informed the surveyors of an incident that occurred at the facility on Saturday , . She stated she came to the facility on to see her patients and noticed the large plastic bins that she keeps her supplies (, care, logbook, etc.) inside, was missing from the Wellness room (located adjacent to the Nurses' Station). She stated she asked staff about the bins, but no one knew what happened to them. She stated the Maintenance Director went from Resident room - to resident room asking if they had seen anything. She stated that when he went to Resident #26's room, he noticed the bins in her room. She further stated that the Maintenance Director told her that he observed Resident #26's shoes and clothing items in the bins and asked her about it and what	A 055		

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A 055	Continued From page 31 she did with the supplies that was in it. She is stated to have told him that she threw everything in the garbage. Because of the incident, the 3rd party nurse stated she had to re-stock the bins and reconstruct her logbook. Observation by this surveyor on of the Wellness Center door that allows entry into the room from the hallway was observed to have a lock. However, the rear door in the room that leads to the outside does not lock as it has no locking mechanism, which allows for unabated entry into and exit out of the room. (Photo taken). 4) On at 5:18 PM this surveyor observed the Wellness room located next to the Nurse Station. Observation revealed the door was unlocked and no staff was present. Observation was made of the small black dorm-sized refrigerator located by front door had medication ( ) in it. Observation also revealed plastic clear bins that contained medical supplies (, care, gauze, etc.) were present as well. And the two-door cabinet located on the West wall of the room was observed to have supplies in it as well. As the door was unlocked, it provided anyone (i.e. staff, residents, visitors, 3rd party providers) unabated access to the medication and supplies kept in the room. No safety protocols were put in place for securing the room during the survey. Class III	A 055		
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	A 078		

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A 078	Continued From page 32 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 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	A 078		

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A 078	Continued From page 33 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 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 have evidence for 2 of 4 staff sampled (A, G) of a onetime statement from a health care provider within 30 days of hire, documenting that they are free of communicable /or ( ) on an annual basis. The Findings Include: A record review on revealed Staff A and G did not have a onetime statement within 6 months prior to being hired or 30 days of hire that they are free of communicable . The review also revealed Staff A and G facility files did not have an annual statement documenting they are free from ( ).	A 078		

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A 078	Continued From page 34 Record review on of Staff A's file she was hired on , provides direct care to residents. Review of the file also revealed a document indicating she was free from communicable including . However, the filed did not include an updated/current annual statement that she was free of , and no additional documentation was provided during the survey. A review of Staff G's facility file revealed she was hired on and provides direct care to residents. Review of the file also revealed a document dated which revealed a positive status. Staff G's chart revealed no follow up documentation that she was free from . No additional information or documentation was provided during the survey. In an interview with the Administrator on 11/14/24 at 6:00 PM, she confirmed that the employee records did not have a current/annual statement from a healthcare provider documenting Staff A and G was free of ( ). She stated she will ensure that all staff have their one-time statement by a health care provider for communicable and freedom of moving forward. No further documentation was provided at time of survey. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by	A 081		

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A 081	Continued From page 35 the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously	A 081		

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A 081	Continued From page 36 completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including	A 081		

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A 081	Continued From page 37 chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 38	A 081		

This Statute or Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure that all staff attend in-service training provided or arranged by the facility administrator or manager to facility staff before interacting with residents. The facility failed to have a certificate of completion that covers all required in-service training topics signed that the employee completed the required in-service in the employee's personnel record for 2 out of 4 Staff reviewed (Staff F, G).

The Findings include:

a) A record review on of Staff F's file revealed a date of hire of and no evidence or documentation that she completed the required in-service training topics within 3 months of hire:

1). Control 1-hour training prior to providing direct care to Residents.
2). ADL and behavioral needs 3-hour training.
3). Elopement policy training.

b) A record review on of Staff G's file revealed a date of hire of and no evidence or documentation that she completed the required in-service training topics within 3 months of hire:

1). ADL and behavioral needs 3-hour training.
2). Reporting major incidents, adverse incidents, facility emergency procedures and incident reporting training.
3). Elopement policy training.

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A 081	Continued From page 39 Interview with the Administrator on 11/14/2024 at 6:00PM, she acknowledged the findings and stated she will work to make sure all staff files contain the required trainings. No additional information or documentation was provided during the survey. Class III	A 081		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that facility staff had	A 083		

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A 083	Continued From page 40 documentation of a current valid First Aid and for 4 of 4 sampled staff (Staff A, F, G, H). The Facility also failed to ensure that at least 1 staff member holding current certification in First Aid and ( ) was in the facility at all times. Findings Include: Record review of Staff A personnel file on revealed no documentation of a current valid or a First Aid card documenting the completion of the courses. Record review of Staff F personnel file on revealed no documentation of a current valid or a First Aid card documenting the completion of the courses. Record review of Staff G personnel file on revealed an expired card as of with no documentation of a current valid or a First Aid card documenting the completion of the courses. Record review of Staff H personnel file on revealed no documentation of a current valid or a First Aid card documenting the completion of the courses. In an interview with the Administrator (Staff A) on at 6:00 PM she acknowledged that herself, Staff A, and Staff F, G and H did not have current/valid or a First Aid certification. The Administrator was also unable to provide documentation of any staff members who had current/valid certification in First Aid and that worked the same shift as the staff previously noted.	A 083		

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A 083	Continued From page 41 Class III	A 083		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a	A 084		

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A 084	Continued From page 42 training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;	A 084		

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A 084	Continued From page 43 l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , rate, temperature, and , , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training	A 084		

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	AL11968596	A. BUILDING: _____ B. WING _____	11/14/2024

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

(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 084	Continued From page 44 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 5 out of 7 current unlicensed staff members (Staff I, M, N, P and L) whose job descriptions included assisting residents with their medications, had evidence of completing the required/or updated medication management training. The findings include: Review of Staff I's personnel record on revealed she was hired at the facility as a med-tech, whose duties include providing direct care to residents and assisting residents with self-administration of medications. Review of Staff I's personnel file revealed no evidence that she had completed the 6-hour medication training provided by a registered nurse or licensed pharmacist. Review of Staff M's personnel record on revealed she was hired at the facility as a med-tech, whose duties include providing direct care to residents and assisting residents with self-administration of medications. Review of Staff M's personnel file revealed no evidence that she had completed the 6-hour medication training provided by a registered nurse or licensed pharmacist. Review of Staff N's personnel record on revealed she was hired at the facility as a med-tech, whose duties include providing direct care to residents and assisting residents with self-administration of medications. Review of Staff N's personnel file revealed no evidence that she had completed the 6-hour medication training provided by a registered nurse or licensed	A 084		

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A 084	Continued From page 45 pharmacist. Review of Staff P's personnel record on revealed she was hired at the facility as a med-tech, whose duties include providing direct care to residents and to assist residents with self-administration of medications. Review of Staff P's personnel file revealed no evidence that she had completed the 6-hour medication training provided by a registered nurse or licensed pharmacist. Review of Staff L's personnel record on revealed she was hired at the facility as a med-tech, whose duties include providing direct care to residents and assisting residents with self-administration of medications. Review of Staff L's personnel file revealed no evidence that she had completed the 6-hour medication training provided by a registered nurse or licensed pharmacist. In an interview with the Administrator on at 11:30 AM, she stated that she was not aware Staff I, M, N, P and L did not have the required medication training documented in their chart, which included the initial 6-hour medication training. The Administrator acknowledged the findings and that Staff members I, M, N, P, and L should undergo the 6-hour medication training provided by a registered nurse or licensed pharmacist prior to assisting residents with self-administration of medications. Class III	A 084		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other	A 152		

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A 152	Continued From page 46 (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 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 observation, record review and	A 152		

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A 152	Continued From page 47 interview, the facility failed to make needed repairs or provide sanitary supplies to ensure a safe/sanitary living environment for 96 of 96 Residents (Residents) residing in the facility. The Findings Include: Observations made on at 9:45 AM of the exterior of the facility revealed unkept shrubbery obstructing the sidewalk located directly in front of the facility. The sidewalk was observed to be broken in several places causing a tripping hazard (photo obtained). On at 10:02 AM observation was made of a small wall unit Air-conditioner (AC) that was installed with translucent plastic to cover the gaps between the AC and the wall. There is no frame around the AC, allowing bugs and pest to enter the room (photo obtained). On at 9:53 AM observation was made of the TV/Recreation room in the Northeast section (wing) of the facility. Observation revealed a wall AC (PTAC) in the upper section of the South wall which had no cover and wires exposed. Also observed a brown leather-like 2-seater couch that was stained/soiled. The door leading out to the courtyard was damaged, dirty and had large gaps in the bottom of it, which could allow insects and rodents to come into the facility (Photos obtained). Interview with Resident #7 on at 10:00 AM revealed the residents room air-conditioned does not work, as observed by the surveyor during the interview. He stated he has informed the management many times and no one has come to repair it.	A 152		

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A 152	Continued From page 48 Observations made by this surveyor on revealed had broken closet doors, clogged shower drain and a non-working room air conditioner (photo obtained). Observations made on revealed had broken closet doors (photo obtained). Observation of on at 10:11 AM revealed that the toilet was leaking around the bottom and the floor was wet. The bathroom sink cabinet is rotted. The shower also has a constant leak, and the room has a mold-like smell (Photos obtained). During observation of on at 10:13 AM by this surveyor, observation revealed the toilet leaks around the bottom and had water on the floor (photo obtained). And the room had a loud foul smell. On at 10:21 AM observation by this surveyor of the common bathroom located in the Northeast section of the facility near the TV/Activity room, which revealed the drywall that has been patched with spackle needs painting (Photo obtained). On at 11:11 AM observation was made by this surveyor of the laundry room located in the Southwest section of the facility, just beyond the dining room. Observation revealed two residential washers and two residential dryers (photos obtained) for a population of 96. The Maintenance director turned each of them on to demonstrate that they work. 1 of the residential washers was not working. Observation of the room also revealed a large commercial dryer which was not working. The Maintenance Director stated that he has	A 152		

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A 152	Continued From page 49 been requesting updated equipment, and for someone to come out and repair the large dryer, but nothing has happened yet. At this time, the Administrator and Maintenance Director both confirmed the residential washers and dryers are not sufficient for the census. And that the residential appliances are not capable of handling the laundry needs of the facility. On at 12:44 PM observation was made by this surveyor of located in the Northwest section of the facility, a few doors East of the Nurses' Station. Observation revealed the wall Air-conditioner unit did not have any framing around it, which could permit roaches, insects, rodents, etc.) to enter the room through the gaps/openings at the bottom of the AC (photo obtained). Observations made on of the central air conditioning vent located in the ceiling outside the main dining area to be dirty and contain large amounts of dust. (Photo obtained) On the main lobby and dining corridor of the facility was observed with live and roaches in various locations. Floors noted to be dirty and sticky. Observation of by this surveyor on at 10:13 AM revealed clothing scattered all over the room; the bathroom had clothing items, and other debris on the floor and was generally unclean. The resident has a large cat and has cat food in paper plates on the floor. The door in her room (leading to the courtyard), was stained and needed to be painted, and the wall to the left of it had been patched and unpainted. The wall air-conditioner's framing was rotted and the vents dirty. The resident had a	A 152		

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A 152	Continued From page 50 lamp with the light bulb exposed (no lampshade) sitting on the air conditioner (AC) approximately 2 from the floor, which if knocked over, could on her bed and cause a fire (Photos obtained). Observations by this surveyor made during tour of the facility's South section on at 11:25 AM, revealed a loud -like smell in the TV/Activity room. Observation by this surveyor on of the Emergency exit door located in the North-side section across from the Nurses Station, revealed it is old, stained and had cigarette butts on the ground outside of it (Photo obtained). On at 10:21 AM observations by this surveyor revealed the emergency door located across from the main dining room was unsecured with no latching device. Observation of the door also revealed that sandbags were being used to keep the door from opening. Observation of the outside of the door revealed the sandbags had been moved of the way from the door to allow it to open. Observation revealed there are no locking mechanisms in the holes where locks are supposed to be (video obtained). On at 11:37 AM observation by this surveyor was made of the outside gutter on the roofline on the North unit just above the overhang covering the entry/exit door leads to the inside by the Wellness room/Nurses' station. The Gutter was hanging, secured with duct-tape and water running from the section that was disconnected from the other section revealing rotted wood damage (photo obtained). The condition poses a potential danger to residents who access the courtyard/or re-enters the facility using the door	A 152		

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A 152	Continued From page 51 located in that section. In an interview on at 3:41 PM with Staff U she stated to this surveyor that the white washer wasn't working, and the large commercial dryer has never worked as far as she knows. Observation of the dryer (again by this surveyor) revealed it did not work and did not latch properly. Clothes were observed in the commercial dryer, but Staff U stated she didn't know why they were in there. Observations throughout the facility revealed live and pests (ants and roaches, noted in common areas and in resident rooms. The dining room area was noted to be extremely dirty; chairs and tables noted to be extremely dirty and discolored, with an abundance of food particles and sticky. Multiple resident doors observed with no mechanism to secure and/or lock the room for privacy and protection. Interview with the Administrator on 11/14/2024 at 6:00 PM, she acknowledged the findings and stated she is aware of the numerous physical plant concerns/problems at the facility. She stated she she will work with the Owners to try to resolve. Class II	A 152		