

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2025
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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 000	Initial Comments An unannounced Complaint survey (2024015930, 2025000600, 2025001567) was conducted on 02/11/2025 and 02/12/2025 at Oasis at Boynton Beach Assisted Living. The facility had no deficiencies at the time of the survey. NOTE: The facility has uncorrected deficiencies related to the Relicensure and Complaint survey revisit (2024001225, 2024003802, 2024007021, 2024010116) conducted on 02/12/2025. Please see separate report for findings.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) DATE