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 _____	05/01/2025

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, complaint #2025005595, was conducted at Oasis at Boynton Beach Assisted Living on . The facility had deficiencies at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Resident Health Assessment 1823 form was accurately completed and reflective of the resident's current health status and care needs, for 2 of 2 sampled resident (Resident #1 and #2) requiring supervision with activities of daily living (ADL). The findings include: 1. Review of Resident #1's medical record indicated the resident was admitted to the facility on . Further review of the record indicated Resident #1's medical diagnosis' including , , , ( ), , history of , , poor appetite, , , , and was a smoker. Review of Resident #1's physician note dated revealed a medical assessment to include the resident had diagnoses of , functional decline, and .The resident is responsive and remains . The assessment concluded that the resident was unsteady on his , had a history and gait apraxia. Additionally, he had a poor appetite, and need for personal care. The note documents a plan to encourage safe ambulation and recognize and reduce risk. Review of Resident #1's medical record revealed no Resident Health Assessment,1823 form was available for review. In an interview with the Administrator on at approximately 2:30 PM she stated	A 010		

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A 010	Continued From page 5 that Resident #1 was admitted to the facility and required daily supervision for activities of daily living. She stated Resident #1 was ambulatory and paced around the facility. She stated the resident spent most of his time outside on the patio but into other residents rooms. She stated that she could not provide Resident #1' s current 1823 Health Assessment 1823 form. 2. Review of Resident #2's medical record, resident assessment 1823 form dated shows diagnosis including failure, D deficiency, , and . The resident is noted to be independent for all ADLS and requires ( ) as needed. Further review of Resident #2's medical record revealed the resident was admitted to hospice services on . Review of Resident #2's Initial Plan of Care dated indicated the resident was a smoker, and was smoking less than ½ pack cigarettes in 5 days. He was assessed to have , , and saturation on room air measured 97%. Further review of the residents' hospice Plan of Care dated indicated an order for at 2 liters/minute setting via a for . Further review indicated on Plan of Care dated the resident was ordered an increase in to 3 Liters/minute setting for . In an interview with the hospice nurse on at 12:35 PM she stated Resident #2 has , ( ) and requires continuously. She stated Resident #2 is non-ambulatory, weak, has poor appetite, has a decline in condition and requires assistance with all ADL care.	A 010		

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A 010	Continued From page 6 In an interview with the Administrator on at approximately 2:30 PM she confirmed that Resident #2 was admitted to hospice services. She stated that the resident was independent with ADL care. She was unaware of the updated orders for due to changes. She acknowledged the 1823 form does not accurately reflect Resident #2's current condition and care needs. Class III	A 010		
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.	A 025		

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A 025	Continued From page 7 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the level of care, services and oversight required to meet the needs of 2 of 2 sampled residents. This was evidenced by the failure to ensure the physical well-being of Resident #1 and the failure to follow internal policies to effectively communicate	A 025		

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A 025	Continued From page 8 Resident #2 had a change in , condition and decline requiring assistance with Activity of Daily living (ADL)care. The findings include: 1.Review of Resident #1's medical record indicated the resident was admitted to the facility on . Further review indicated Resident #1's medical diagnosis' including , , , ( ), , , history of , , , poor appetite, , , , and was a smoker. Review of Resident #1's physician note dated revealed a medical history to include the resident had diagnoses of , functional decline, and . The resident is responsive and remains . The assessment concluded that the resident was unsteady on , had a history and apraxia. Additionally, he had a poor appetite, and a need for personal care. The note documents a plan to encourage safe ambulation and recognize and reduce risk. Review of Resident #1's medical record revealed no Resident Health Assessment,1823 form was available for review to document the resident's care and oversight needs. Review of facility progress notes dated indicated Resident #1 was observed pacing around the facility. Review of facility progress note dated indicated Resident #1 was seen by the psychiatrist who reported he was experiencing feelings of sadness. Review of facility progress note dated indicated a resident's family reported that	A 025		

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A 025	Continued From page 9 Resident #1 was observed on camera by a family member in another resident's room and had removed items. The note reads when Resident #1 was asked what he wanted and if he needed anything, the resident declined, and staff offered him more food. Review of facility progress note dated indicated resident called police to report Resident #1 had entered her room and removed items. Further review of the note indicated no actions were taken by the facility. Review of facility progress note dated indicated Resident #1 was observed on the patio smoking. Review of facility progress note dated at 8:30 AM indicated Resident#1 appears to be seeking cigarette remnants and may indicate cravings or unmet needs. The note indicated there were no safety concerns observed. Further review of the note indicated no actions were taken by the facility. Review of facility progress note dated at 10AM indicated Resident#1 was found with a lighter, taken from another resident. Resident #1 sustained a injury to his . The note indicated that the was assessed, and first aid applied. Resident #1 was alert and responsive and did not display any signs of discomfort. The note indicated that Resident#1 engaged in unsafe behavior, resulting in self-inflicted injury. Resident#1 required immediate medical attention, 911 was called and transported to hospital for evaluation. In an interview with Wellness Coordinator #1 on at approximately 11:15 AM stated Resident #1 "paced" throughout the facility, but he was not an elopement risk. Resident #1 spent most of his time outside on an enclosed patio.	A 025		

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A 025	Continued From page 10 Coordinator#1 stated that the resident could not sit still and was found numerous times entering other residents' rooms and taking items including, cigarettes, food, and drinks. Staff would attempt to redirect him with this activity. Coordinator #1 stated that the resident was a smoker and had cravings, he would the patio area looking for discarded cigarette butts to smoke. Facility staff would give him cigarettes throughout the day, 2 in the morning, 2 in the afternoon and 1 at night. Coordinator #1 stated that Resident #1 would ask other residents for cigarettes. On at approximately 10AM a caregiver found the resident with a lighter and sustained a injury to his and . Coordinator #1 stated the resident's were assessed and first aid was applied. Resident #1 was observed to be alert and responsive and did not display any signs of discomfort. Resident #1 required immediate attention and 911 was called. The Coordinator stated that the resident refused to give the lighter to facility staff and police had to physically remove the lighter from his . Resident #1 was by police and transported to hospital for evaluation. When asked how Resident #1 had obtained a lighter, Coordinator #1 stated the facility staff believe he found it on the patio, left there by other residents. Coordinator #1 stated that Resident #1 engaged in unsafe behavior, resulting in a self-inflicted injury. Coordinator #1 stated that since the incident the facility staff make attempts to collect the discarded cigarette butts but the residents continue to throw butts on ground. (see photographic evidence) . The facility does not utilize any assessment to determine smoking safety but rely on the health care provider to determine smoking safety risk. Coordinator #1 was questioned about facility staff assignments to ensure residents were receiving the required	A 025		

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A 025	Continued From page 11 personal care and supervision, the coordinator stated there were 8 residents that require assistance with ADL care. Coordinator #1 stated that the facility does not assign individual staff to residents, the staff "all work as a team". Coordinator #1 stated that that morning, 2 day shift caregivers had called out sick, leaving the 2 wellness coordinators and 1 caregiver to provide care to/monitoring of the 54 inhouse residents on . In an interview with Wellness Coordinator #2 on at 1:15 PM she stated a care staff brought Resident #1 to the Nurses Station after the incident on around 10:20 AM. She stated Resident #1's around his , and beard was blackened and the resident's on right were also blackened. She stated she called 911, and police arrived. She stated that Resident #1 refused to give up the lighter, and the police had to physically remove the lighter from his . She stated Resident #1 a lot, walking into other residents' rooms, he was curious and a non-threatening person. She stated Resident #1 never went out of the building, and he paced around the outside patio looking for cigarettes. She stated she is not sure where Resident #1 found the lighter but stated he would pick up discarded cigarette butts on the patio and most likely attempted to light one with the lighter and got . She stated Resident #1 expressed no , or discomfort after the incident. Review of Resident #1's hospital records dated at 10:59 AM indicated the resident presents via under police for his with a lighter. The note indicated the resident has and was apparently at some point, used a flame	A 025		

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A 025	Continued From page 12 and his . Apparent attempt at self-harm. The note indicated the resident stated he was not trying to harm himself but could not explain why he put a to his . The medical assessment revealed a to tip of the with no singeing, no , and no . . . . . . Review of facility Incident Report dated on at 10:08 AM completed by Wellness Coordinator #2 indicated "a resident care staff reported to Wellness Coordinator #2 that Resident #1 was using a lighter and sustained multiple . Resident #1 refused to surrender the lighter to staff. 911 was called. were noted on the and ." Review of facility Incident Report dated on at 10:25 AM completed by Wellness Coordinator #1 indicated "Resident #1 was transported 911 to hospital for treatment of . The lighter was confiscated from Resident#1, and he was counseled on the potential hazards associated with its use." Further review of the incident report revealed no investigation of the incident as to where Resident #1 found the lighter. There was no smoking assessment to evaluate potential safety issues /risks for residents who smoke. In an interview with the Administrator on at approximately 2:30 PM she stated that Resident #1 was admitted to the facility and required daily supervision of activities of daily living. She stated Resident #1 was ambulatory and paced around the facility. She stated the resident spent most of his time outside on the patio but he into other residents rooms. She stated Resident #1 would look for discarded cigarette butts on the ground and smoke them.	A 025		

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A 025	Continued From page 13 She stated the residents who smoke, throw the cigarette butts on the ground even though the facility provided ash trays. (See photographic evidence) When questioned about Resident #1's behavior and how the facility was supervising the resident, she stated that Resident #1 ambulates everywhere in the facility and had been observed/found in other resident rooms. The resident was found with items that he took from other resident rooms, mostly food, soda, and cigarettes. She stated that due to family member complaints about Resident#1's behaviors, entering rooms and taking items, she moved Resident #1 to another wing of the facility, but his _ did not stop. The Administrator confirmed that that morning, 2 day shift caregivers had called out sick, leaving the 2 wellness coordinators and 1 caregiver to provide care to/monitoring of the 54 inhouse residents on . She confirmed that the facility staff do not have specific resident assignments for care and oversight. In an interview with the Department of Children and Families investigator on at 12:16 PM she stated she had observed Resident #1 at a long-term care facility with a to his , and area. The investigator stated that Resident#1 was found with a lighter at the Assisted Living Facility(ALF) and he made an attempt to light cigarettes. She stated her findings were substantiated for inadequate supervision by ALF staff. She stated that she had notified the facility of her recommendations including that staff need to ensure they are rounding and providing adequate supervision and the facility needs to ensure adequate staff levels to promote safety and wellness to the residents. 2. Review of Resident #2's medical record,	A 025		

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	AL11968596	A. BUILDING: _____ B. WING _____	05/01/2025

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A 025	Continued From page 14 Resident Assessment 1823 form dated shows diagnosis including , , failure, , , , , D deficiency, , , , and , . The resident is noted to be independent for all ADLS and requires , , ( ) as needed. Further review of Resident #2's medical record revealed the resident was admitted to hospice services on . Review of Resident #2's Initial Plan of Care dated indicated the resident was a smoker, and smoking less than ½ pack cigarettes in 5 days. He was assessed to have , , , and , , saturation on room air measurement was 97%. The resident requires assistance with ADL care, mobility, bathing, and , . Further review of the Resident #2's hospice Plan of Care dated indicated a physician order for at 2 liters/minute setting via a for , , . The resident is non-ambulatory and wheelchair bound. Further review indicated a Plan of Care dated , Resident #2 was experiencing and was ordered an increase in to 3 liters/minute setting continuously. In an interview with the hospice nurse on at 12:35 PM she stated Resident #2 has , , ( ) and requires continuously. She stated Resident #2 is weak, non-ambulatory, has a poor appetite, has a decline in medical condition and requires assistance with all ADL care. Review of Resident #2's psychiatrist note dated on indicated that the resident was assessed to be depressed, he was , and in his room. Further review of the note indicated that the resident has short term	A 025		

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A 025	Continued From page 15 memory , , , concentration, poor judgement, with increased and decrease . In an observation and interview with Resident#2 on at 10:45 AM the resident was observed sitting in his wheelchair, inside his room doorway facing out to the patio area. The resident was wearing an attached to an concentrator set at 3L/ minute. Resident #2's were wet and crusted with debris. The skin on his upper extremities was observed dry and discolored. Resident#2 was observed very thin, with his bones showing thru his skin. The resident's lower extremities were observed thin with no , the skin was discolored with patches of flaky crusted skin. Resident #2's and were observed bluish, with dry skin, and the toenails were long, with jagged edges. Resident#2 stated that the hospice nurse comes several times a week to check on him but does not apply ordered skin cream. He stated he can no longer apply the cream himself and wishes staff would assist him. Observed on a table next to the resident was a half-smoked cigarette and 2 lighters, when asked if he smoked, Resident #2 stated yes but only outside of his room and he removed his . Directly outside of Resident #2's room hundreds of cigarette butts were observed discarded on the ground (see photo evidence). Resident #2 stated that if the facility management finds you are smoking in the room, you will be thrown out. In an observation on at 1:45 PM, Resident #2 was sitting in his wheelchair, his were outside the open door frame and his roommate was sitting directly outside of the doorway. As the surveyor approached the room, Resident #2 was observed with a lighted	A 025		

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A 025	Continued From page 16 cigarette in his right . The resident was wearing his at this time. Resident #2 was observed to drop his with the cigarette to the right side of his wheelchair and then slide the , cigarette into the opening between the door and door frame. When asked if he was smoking, he stated he was not. In an interview with the Administrator on at approximately 2:30 PM she confirmed that Resident #2 was admitted to hospice services. She stated that Resident #2 was independent with ADL care. She stated that Resident #2 was a smoker but was determined to not be a safety risk, he was aware he could not smoke in his room and with his in place. She stated that she was unaware of the updated orders for , due to , , changes and decline in condition. She acknowledged the 1823 form does not accurately reflect Resident #2's current condition and care needs. She stated that the 3rd party providers are expected to complete a 3rd party provider visit form for each visit to the resident, which informs the facility staff of the resident's medical status. She was informed that with surveyor record review of Resident #2's record, the 3rd party provider forms were incomplete, noting only a "visit was made" with the date and no information was noted about the resident's status, care provided and response. The Administrator provided a copy of the "Third Party Visit Notes" for review. The form instructs the provider to "provide a brief clinical note for resident's chart regarding services received today". Review of the facility's Third-Party Provider policy revealed all parties are to sign in upon entering the facility and upon exiting. Further review of the third-party policy indicated the policy emphasizes	A 025		

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A 025	Continued From page 17 open communication between the facility and third party providers, including regular updates on the resident's condition, care needs and service delivery. The policy requires thorough documentation of all interactions with the third-party providers, including service plans, care coordination and financial arrangements. Further review of the policy reveals no facility plan or expectation of review by the facility staff of the third-party provider communication form. Class II	A 025		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to	A 165		

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A 165	Continued From page 18 which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which	A 165		

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A 165	Continued From page 19 case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to file an adverse incident report with the Agency for 1 of 1 sampled residents, Resident #1 who sustained a injury to the requiring transfer to the hospital for evaluation and treatment. The findings include:: Review of the facility ' s resident record revealed that Resident # 1 sustained a injury to the on from a lighter. The	A 165		

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A 165	Continued From page 20 resident required transfer to the hospital for evaluation and care. Review of the facility Incident Report dated on at 10:08 AM completed by Wellness Coordinator #2 indicated "a resident care staff reported to Wellness Coordinator #2 that Resident #1 was using a lighter and sustained multiple . Resident #1 refused to surrender the lighter to staff. 911 was called. were noted on the and ." Review of Resident #1's hospital records dated at 10:59 AM indicated the resident presents via under police for , his with a lighter. The hospital note further indicated that Resident #1 has and was apparently at some point, used a flame and his . An apparent attempt at self-harm. The note indicated Resident #1 stated he was not trying to harm himself but could not explain why he put a to his . The medical assessment revealed a to tip of the with no singeing, no , and no . A review of the Agency's Incident Report Database revealed that no Adverse Incident Report was filed by the facility regarding Resident #1's transfer to a higher level of care for injury sustained on . In an interview with the Administrator on at approximately 2:45 PM, she confirmed that no Adverse Incident Report had been filed for Resident #1's injury requiring transfer to a higher level of care for treatment. The Administrator stated she was unaware she needed to submit a report.	A 165		

Agency for Health Care Administration

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A 165	Continued From page 21 Refer to A 0025 CLASS III	A 165		