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
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 This reports the status of Complaint Inspection #2012000498 survey conducted on [redacted] at Boynton Beach Assisted Living Facility. During the revisit survey conducted on [redacted], the following defieciencies were corrected, specifically: A0032 and A 0092 The following deficiencies remained uncorrected, specifically: A 0010, A 0025, A 0160 and A 0165	{A 000}		
{A 010} SS=G	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7	{A 010}		

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
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 010}	Continued From page 1	{A 010}		

consecutive days.
(b) A resident requiring care of a pressure may be retained provided that:
1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
2. The condition is documented in the resident ' s record; and
3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall 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 the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 010}	Continued From page 2	{A 010}		

the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all residents meet residency requirements for 1 out of 7 sampled residents (Resident #2).

The findings include:

Upon observations during lunch on : at approximately 12:00 PM, Resident #2 was observed sitting at a table in the dining a geri-chair. Further observation revealed the resident was slumped over and drooling, as he sat in the geri-chair. A bed sheet was tied around his waist and around the back of the chair restricting movement and preventing him from rising. During a further observation, it was noted the resident's right eye was a The surveyor attempted to interview the resident, but was unsuccessful. During an interview with a care associate who was standing next to him in the dining at approximately 12:05 PM, she reported when she came on duty at 7 AM, the resident was already tied to the chair. She stated "if we do not tie him to the chair he will out". During an interview with Office Clerk #1 on : at approximately 12:30 PM, she could not verify who tied the resident to the chair and how long the resident has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 010}	Continued From page 3 restrained. Record review revealed Resident #2 was admitted to the facility on . His most recent health assessment dated revealed his diagnosis includes and Parkinson . The health assessment documented the resident requires "supervision" with ambulation, bathing, dressing and transferring and is "independent" with eating, and toileting. During a further interview with Office Clerk #1, it was reported the resident now requires "total" care with all ADL's. Further review of the record revealed the resident has been a recipient of hospice services since . Review of his hospice care plan dated revealed there was no plan of care for the geri-chair the resident was observed sitting in during lunch. The plan of care dated documented the resident requires frequent observations. Review of the facility's communication log, the following two incidents were noted: : "He get out of the bed lot of times. He again at 3:30. We call 9-1-1. He has cut of left eyes". 4:40 PM "Resident was in his CNA found him on the floor with a cut above his right eye; Non-emergency was called and they took him to the hospital for stitches. He's back". There was no documentation within the resident's record in regards to the aforementioned incidents. The only documentation was written within the facility's internal communication log. There was no documentation indicating the residents responsible party, physician and/or	{A 010}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 010}	Continued From page 4 hospice services was notified of the incidents and transfer to the hospital. Class II This is an uncorrected deficiency.	{A 010}		
{A 025} SS=G	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, 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 individual. (c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	{A 025}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 025}	Continued From page 5	{A 025}		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide appropriate supervision to meet the needs of 1 out of 7 sampled residents (Resident #2).

The findings include:

Upon observations during lunch on [redacted] at approximately 12:00 PM, Resident #2 was observed sitting at a table in the dining [redacted] a geri-chair. Further observation revealed the resident was slumped over and drooling, as he sat in the geri-chair. A bed sheet was tied around his waist and around the back of the chair restricting movement and preventing him from rising. During a further observation, it was noted the resident's right eye was [redacted] a [redacted]. The surveyor attempted to interview the resident, but was unsuccessful. During an interview with a care associate who was standing next to him in the dining [redacted] at approximately 12:05 PM, she reported when she came on duty at 7 AM, the resident was already tied to the chair. She stated "if we do not tie him to the chair he will [redacted] out". During an interview with Office Clerk #1 on duty on [redacted] at approximately 12:30 PM, she could not verify who tied the resident to the chair and how long the resident has been restrained.

Record review revealed Resident #2 was admitted to the facility on [redacted]. His most recent health assessment dated [redacted] revealed his diagnosis includes [redacted] and Parkinson [redacted]. The health assessment documented the resident requires "supervision" with ambulation, bathing, dressing and transferring and is "independent" with eating,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILIT\	1708 N.E. 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 025}	Continued From page 6 and toileting. During a further interview with Office Clerk #1, it was reported the resident now requires "total" care with all ADL's. Further review of the record revealed the resident has been a recipient of hospice services since . Review of his hospice care plan dated revealed there was no plan of care for the geri-chair the resident was observed sitting in during lunch. The plan of care dated documented the resident requires frequent observations. Review of the facility's communication log, the following two incidents were noted: . "He get out of the bed lot of times. He again at 3:30. We call 9-1-1. He has cut of left eyes". 4:40 PM "Resident was in his CNA found him on the floor with a cut above his right eye; Non-emergency was called and they took him to the hospital for stitches. He's back". There was no documentation within the resident's record in regards to the aforementioned incidents. The only documentation was written within the facility's internal communication log. There was no documentation indicating the residents responsible party, physician and/or hospice services was notified of the incidents and transfer to the hospital. Class II This is an uncorrected deficiency.	{A 025}		
{A 160} SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written	{A 160}		

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
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 160}	Continued From page 7	{A 160}		

records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.
(1) FACILITY RECORDS. Facility records shall include:
(a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s:
1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure , and
2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of .
Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the

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
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILIT\	1708 N.E. 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 160}	Continued From page 8	{A 160}		

incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.
(e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.
(f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.;
(g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.;
(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.
(j) If the facility advertises that it provides special care for persons with or related , a copy of all such facility advertisements as required by Section 429.177, F.S.
(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate.
(m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILIT\	1708 N.E. 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 160}	Continued From page 9 (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. (q) The facility ' s resident elopement response policies and procedures. (r) The facility ' s documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to conduct a thorough internal investigation in regards to an alleged incident for 1 out of 7 sampled residents (Resident #7). The findings are: During an interview with Office Clerk #2 on [redacted] at approximately 11:15 AM, she reported Resident #7 was allegedly raped at the facility by a former resident " a couple of months ago " . Office Clerk #2 provided a copy of an internal document written on notebook paper in regards to the incident. The internal document dated [redacted] at 12:15 PM read " Case Manager from FACT Team called the police and said that Resident #7 went into the [redacted] a former resident and rapped her last month " .	{A 160}		

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
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 160}	Continued From page 10	{A 160}		

Office Clerk #2 reported that when the police arrived at the facility on Resident #7 declined to provide information to the police in regards the alleged incident. During a further investigation with Office Clerk #2 and the Administrator on at approximately 1:00 PM it was confirmed the facility failed to conducted an internal investigation in regards to the allegation to ensure the safety and well-being of Resident #7 and other residents of the facility.

During the revisit survey conducted on Resident #7's record was reviewed to determine if a thorough investigation was completed in regards to the aforementioned incident. The only documentation of an investigation was documented as follows:

The Administrator called Resident #7 to ask her about the alleged incident. He asked her what happened, if they have a relationship. She reply that he offered her cigarettes and she went into his The Administrator advised her "not going into others

During an interview with Office Clerk #1 on at approximately 1:00 PM, it was revealed the aforementioned conversation between the Administrator and Resident #7 was all that was done in regards to the alleged incident. The facility failed to conducted a thorough internal investigation in regards to the allegation to ensure the safety and well-being of Resident #7 and other residents of the facility. The alleged rapist is no longer a resident of the facility, he discharged himself from the facility on

Class III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 160}	Continued From page 11 This is an uncorrected deficiency.	{A 160}		
{A 165} SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 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. [illegible] or spinal damage; 3. Permanent 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury.	{A 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILIT\	1708 N.E. 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 165}	Continued From page 12	{A 165}		

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States 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, by electronic mail, facsimile, or United States 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 Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 165}	Continued From page 13	{A 165}		

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 Department of Elderly Affairs may adopt rules necessary to administer this section.

Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 165}	Continued From page 14 Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to fulfill adverse incident reporting requirements, specifically: failure to document and submit a 1-day and 15-day adverse incident report, as required for an incident that occurred at the facility. The findings include: During an interview with Office Clerk #2 on at approximately 11:15 AM, she reported Resident #7 was allegedly raped at the facility by a former resident " a couple of months ago ". Office Clerk #2 provided a copy of an internal document written on notebook paper in regards to the incident. The internal document dated at 12:15 PM read " Case Manager from FACT Team called the police and said that Resident #7 went into the a former resident and rapped her last month ". Office Clerk #2 reported that when the police arrived at the facility on , Resident #7 declined to provide information to the police in regards the alleged incident. During a further investigation with Office Clerk #2 and the Administrator on at approximately 1:00 PM it was confirmed the facility failed to conducted an internal investigation in regards to the allegation to ensure the safety and well-being of Resident #7 and other residents of the facility.	{A 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932687	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 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 165}	Continued From page 15	{A 165}		

During the revisit survey conducted on . Resident #7's record was reviewed to determine if a thorough investigation was completed in regards to the aforementioned incident. The only documentation of an investigation was documented as follows:

. . . . . The Administrator called Resident #7 to ask her about the alleged incident. He asked her what happened, if they have a relationship. She reply that he offered her cigarettes and she went into his . . . . . The Administrator advised her "not going into others

During an interview with Office Clerk #1 on at approximately 1:00 PM, it was revealed the aforementioned conversation between the Administrator and Resident #7 was all that was done in regards to the alleged incident. The facility failed to conducted a thorough internal investigation in regards to the allegation to ensure the safety and well-being of Resident #7 and other residents of the facility. The alleged rapist is no longer a resident of the facility, he discharged himself from the facility on

As of the day of the revisit survey, the facility failed to submit the required 1-day and 15-day adverse incident reports.

Class III
This is an uncorrected deficiency.

AH Form Approved

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11932687	A. Building B. Wing	7/9/2012

Name of Facility	Street Address, City, State, Zip Code
BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 4TH STREET BOYNTON BEACH, FL 33435

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0032 Reg. # 58A-5.0182(8) FAC LSC		ID Prefix A0092 Reg. # 58A-5.020(1) FAC LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By ASB	Date: 8-17-12	Signature of Surveyor: A.T. Smith (ACG)	Date: 8-17-12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Boynton Beach Assisted Living Facility
1708 N.E. 4th Street
Boynton Beach, FL 33435

Dear Administrator:

This letter reports the findings of a revisit survey to Complaint 2012000498 conducted on 2012 by representative of this office. Enclosed is the provider's copy of the State Form Revisit Report which identifies the corrected deficiencies found at the time of the revisit. Also enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references uncorrected deficiencies identified during the revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to this agency's representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A. C. Boyles, HFE Supervisor
for Arlene Mayo-Davis
Field Office Manager

AMD/hl
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924