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	

Name of Facility

BOYNTON BEACH ASSISTED LIVING FACILITY

Street Address, City, State, Zip Code

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 **A0010** Reg. # **58A-5.0181(4) 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		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	W. Smith	10/23/12	W. Smith for HOLLY FOSTER	10/23/12
Reviewed By CMS RO				

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of (CMS-2567) Sent to the Facility? ~~YES~~ (circled: YES) NO

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

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BOYNTON BEACH ASSISTED LIVING FACILITY	1708 N.E. 4TH STREET BOYNTON BEACH, FL 33435

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{A 000}	Initial Comments This reports the status of Complaint Inspection #2012000498 survey conducted on at Boynton Beach Assisted Living Facility. During the revisit survey conducted on , the following deficiencies remained uncorrected, specifically: A0010, A0025, A0160, and A0165 During the 2nd revisit survey conducted on , the following deficiency was corrected, specifically: A0010 The following deficiencies remained uncorrected, specifically: A0025, A0160 and A0165	{A 000}		
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	A 025		

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A 025	Continued From page 1	A 025		

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.

This Statute or Rule is not met as evidenced by:
Based on record review and interview it was determined the facility failed to provide adequate supervision to meet the needs of 3 out of 3 sampled residents who all eloped from the facility (Residents #1, #2, and #3).

The findings include:

1) The AHCA Day 1 report indicated Resident #1 was determined to be missing on [redacted] at 7:40 AM. The 7:00 AM - 3:00 PM caregivers were noted to have initiated [redacted] in an effort to find this resident. Further review revealed 911 was called and a missing persons report was filed with the police. The AHCA report reflected that at 10:30 AM (no date noted) an officer informed the facility that this resident was seen walking on Atlantis Drive and was taken to the hospital on [redacted] at 3:00 AM.

Review of a letter from a local mental health center attending psychiatrist for Resident #1, dated [redacted], indicated that this resident "must remain on a closed unit and cannot be allowed to leave on her own or wander outside

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A 025	Continued From page 2	A 025		

the building due to her mental condition " . This letter reflects that " if allowed to leave the facility, she will wander, get lost, and not be able to make her way back " .

Review of Resident #1's health assessment ,dated , noted special precaution as: client likes to wander and will get lost. The medical history and diagnoses reflected and . This health assessment indicated that in the professional opinion of the examining physician that completing this document on , noted that this individual ' s need cannot be met in an assisted living facility which is not a medical, a nursing or a facility.

Subsequent Health Assessment, dated , reflected this resident is in the physician ' s professional opinion a for an assisted living facility. During interview with the Administrator, conducted on beginning at 10:45 AM, he stated that the house physician determined this resident to be appropriate for this non-secured facility.

During interview and record review with the Administrator, conducted on beginning at approximately 11:10 AM, he was asked for the AHCA Day 15 report for review. The Administrative Assistant printed the AHCA Day 15 Report for Resident #1. This report did not contain any further information other than what was documented in the initial AHCA Day 1 Report. There was no investigative information contained in this report. The facility did indicate that they determined this incident to be adverse. The Administrator was asked if there was any further investigative documentation related to this elopement incident for Resident #1. He stated

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A 025	Continued From page 3	A 025		

that there was no further investigative documentation. He was asked if the facility attempted to determine how Resident #1 eloped from the facility. The Administrator stated that this resident probably "strong armed" the door. He stated that if someone pushes hard enough that the door lock releases. He was asked why the documentation did not reflect why this resident was taken to the local hospital and the results of the hospital visit. He could not provide an explanation.

2) Review of the AHCA Day 1 report, with an incident dated of [redacted], reflected that Resident #2 came to the front desk and informed the receptionist that he was going to his Aunt's house for the weekend. The receptionist asked this resident for the Aunt's name and telephone number, however, the resident refused to provide this information. The receptionist was noted to have contacted the case worker. The case worker was noted to have informed the receptionist that she saw Resident #2 at the local mental health center and at that time he asked her to drop him off at the library. Further review revealed the case worker stated Resident #2 indicated that he was going to return to the facility. However, Resident #2 did not return to the facility. The police were informed and a missing person's report was filed.

Resident #2's Health Assessment, dated [redacted], indicated diagnoses of [redacted], poor impulse control, poly [redacted] in remission; and mild mental [redacted]

During an interview with the Administrator on [redacted] at approximately 11:45 AM, he was asked why there was no investigative

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A 025	Continued From page 4	A 025		

documentation to reflect the whereabouts of Resident #2 from the noted date of elopement on _____ through his discharge with his case worker on _____ as well as documentation to reflect the resident's condition. He could not provided an explanation.

3) An incident report, dated _____ indicated Resident #3 "bust open the door and left the facility". The Med Tech was noted to have eventually gone to look for this resident and could not find her. This incident report reflected that after 30 minutes, the police brought Resident #3 back to the facility and told her not to leave the facility without permission.

Resident #3's Health Assessment, dated _____, indicated diagnosis of _____ and _____.

During record review and interview conducted with the Administrator, on _____ at approximately 11:40 AM, he was asked how this resident eloped and if the staff witnessed her "busting open the door". He stated he did not know. He was asked the condition of this resident upon her return to the facility as the incident report did not provide this information. He stated he was not aware and could not provide any further information. He was asked if the facility conducted an investigation as to how this resident eloped. He replied that there was no further investigation as this resident was returned by the police. He was asked if the security of the door was considered to be an elopement concern, as this was not the first resident that had been noted to have "busted" out of the door. He stated that he did not consider the front door to be an elopement concern because in the case of an emergency he would rather the door "give

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A 025	Continued From page 5 way" and open. The Administrator could not provide evidence of any steps taken to prevent recurrence to prevent residents from eloping from the facility. 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 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	{A 160}		

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{A 160}	Continued From page 6	{A 160}		

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 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 s 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.

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{A 160}	Continued From page 7	{A 160}		

(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.
(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 it was determined the facility failed to conduct a thorough internal investigation related to 3 elopement incidents for 3 out of 3 sampled residents (Residents #1, #2, and #3).

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{A 160}	Continued From page 8	{A 160}		

The findings include:

1) The AHCA Day 1 report indicated Resident #1 was determined to be missing on [redacted] at 7:40 AM. The 7:00 AM - 3:00 PM caregivers were noted to have initiated [redacted] in an effort to find this resident. Further review revealed 911 was called and a missing persons report was filed with the police. The AHCA report reflected that at 10:30 AM (no date noted) an officer informed the facility that this resident was seen walking on Atlantis Drive and was taken to the hospital on [redacted] at 3:00 AM.

Review of a letter from a local mental health center attending psychiatrist for Resident #1, dated [redacted], indicated that this resident "must remain on a closed unit and cannot be allowed to leave on her own or wander outside the building due to her mental condition". This letter reflects that " if allowed to leave the facility, she will wander, get lost, and not be able to make her way back ".

Review of Resident #1's health assessment ,dated [redacted] noted special precaution as: client likes to wander and will get lost. The medical history and diagnoses reflected [redacted] and [redacted]. This health assessment indicated that in the professional opinion of the examining physician that completing this document on [redacted], noted that this individual ' s need cannot be met in an assisted living facility which is not a medical, a nursing or a [redacted] facility.

Subsequent Health Assessment, dated [redacted], reflected this resident is in the physician ' s professional opinion a [redacted] for an assisted living facility. During interview with

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the Administrator, conducted on [redacted] beginning at 10:45 AM, he stated that the house physician determined this resident to be appropriate for this non-secured facility.

During interview and record review with the Administrator, conducted on 10/15 [redacted] at approximately 11:10 AM, he was asked for the AHCA Day 15 report for review. The Administrative Assistant printed the AHCA Day 15 Report for Resident #1. This report did not contain any further information other than what was documented in the initial AHCA Day 1 Report. There was no investigative information contained in this report. The facility did indicate that they determined this incident to be adverse. The Administrator was asked if there was any further investigative documentation related to this elopement incident for Resident #1. He stated that there was no further investigative documentation. He was asked if the facility attempted to determine how Resident #1 eloped from the facility. The Administrator stated that this resident probably "strong armed" the door. He stated that if someone pushes hard enough that the door lock releases. He was asked why the documentation did not reflect why this resident was taken to the local hospital and the results of the hospital visit. He could not provide an explanation.

2) Review of the AHCA Day 1 report, with an incident dated of 08/02. that Resident #2 came to the front desk and informed the receptionist that he was going to his Aunt's house for the weekend. The receptionist asked this resident for the Aunt's name and telephone number, however, the resident refused to provide this information. The receptionist was noted to have contacted the case worker. The case

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worker was noted to have informed the receptionist that she saw Resident #2 at the local mental health center and at that time he asked her to drop him off at the library. Further review revealed the case worker stated Resident #2 indicated that he was going to return to the facility. However, Resident #2 did not return to the facility. The police were informed and a missing person's report was filed.

Resident #2's Health Assessment, dated , indicated diagnoses of , poor impulse control, poly in remission; and mild mental

During interview with the Administrator on at approximately 11:45 AM, he was asked why there was no investigative documentation to reflect the whereabouts of Resident #2 from the noted date of elopement on through his discharge with his case worker on , as well as documentation to reflect the resident's condition. He could not provided an explanation.

3) An incident report, dated indicated Resident #3 "bust open the door and left the facility". The Med Tech was noted to have eventually gone to look for this resident and could not find her. This incident report reflected that after 30 minutes, the police brought Resident #3 back to the facility and told her not to leave the facility without permission.

Resident #3's Health Assessment, dated , indicated diagnosis of and

During record review and interview conducted

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{A 160}	Continued From page 11 with the Administrator, on [redacted] at approximately 11:40 AM, he was asked how this resident eloped and if the staff witnessed her "busting open the door". He stated he did not know. He was asked the condition of this resident upon her return to the facility as the incident report did not provide this information. He stated he was not aware and could not provide any further information. He was asked if the facility conducted an investigation as to how this resident eloped. He replied that there was no further investigation as this resident was returned by the police. He was asked if the security of the door was considered to be an elopement concern, as this was not the first resident that had been noted to have "busted" out of the door. He stated that he did not consider the front door to be an elopement concern because in the case of an emergency he would rather the door "give way" and open. The Administrator could not provide evidence of any steps taken to prevent recurrence to prevent residents from eloping from the facility. Class III 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	{A 165}		

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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 spinal damage;
3. Permanent
4. or of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the 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, 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.

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
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(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 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

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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 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 it was determined the facility failed to file an AHCA Day 1 report for 1 of 3 sampled residents (Resident #3) and the facility failed to file an AHCA Day 15 report for 1 of 3 sampled residents (Resident #2) related to elopement incidents.

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The findings include:

1) An incident report, dated , indicated Resident #3 "bust open the door and left the facility". The Med Tech was noted to have eventually gone to look for this resident and could not find her. This incident report reflected that after 30 minutes the police brought Resident #3 back to the facility and told her not to leave the facility without permission.

Resident #3's Health Assessment, dated , indicated diagnosis of and .

During record review and interview conducted with the Administrator, on 10/15 approximately 11:40 AM, he was asked how this resident eloped if the staff witnessed her "busting open the door". He stated he did not know. He was asked the condition of this resident upon her return to the facility as this incident report did not provide this information. He stated he was not aware and could not provide this information. He was asked if the facility conducted an investigation as to how this resident eloped. He replied that there was no further investigation, as this resident was returned by the police. He was asked if the security of the door was considered to be an elopement concern, as this was not the first resident that has "busted" out of the door. He stated that he did not consider the front door to be an elopement concern because in the case of an emergency he would rather the door "give way" and open.

During interview with the Administrator, conducted on 10/15 approximately 11:40 AM, he was asked for an AHCA Day 1 Report for

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this elopement incident. He stated he did not believe that this incident met the criteria of elopement because the resident was not gone for more than 24 hours. The definition of an elopement was reviewed with the Administrator as follows: " elopement means occurrence in which a resident leaves a facility without following facility policy and procedures ". At that time, the Administrator acknowledged that Resident #3 did not follow facility policy and procedures for signing out of the facility. The Administrator instructed the Administrative Assistant to complete the AHCA Day 1 report for this incident.

2) The AHCA Day 1 Report, with an incident date of 08/02. Resident #2 came to the front desk and informed the receptionist that he was going to his Aunt ' s house for the weekend. The receptionist asked this resident for the Aunt ' s name and phone number. However, the resident refused to provide the requested information. The receptionist contacted the case worker. The case worker was noted to have informed the receptionist that she saw Resident #2 at a local mental health center and he asked her to drop him off at the library. Further review revealed the case worker stated the resident indicated that he was going to return to the facility. However, the resident did not return to the facility. The police were informed and a missing person ' s report was filed.

Resident #2 ' Health Assessment, dated 06/27. diagnoses of schizoaffective impulse control; poly substance remission; mild mental retardation; hypoxic brain

entrance to the Administrative Assistant ' s office, on 10/15 approximately 11:45 AM,

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it was discovered that the Administrative Assistant was currently completing the Day 15 report for this resident on her computer. She was asked if she was completing Resident #2 ' s AHCA Day 15 report for the above noted elopement and she confirmed that she was. Upon completion of this report a copy was provided for review. The corrective or proactive action section of this report indicated that Resident #2 came to the facility with his case worker (date and time not noted) stating that he wanted to be discharged from this facility. This resident was noted to have received all of his medication and was discharged on at 12:00 PM. There was no investigative documentation to reflect the whereabouts and well-being of Resident #2 from the noted date of elopement on through his discharge with his case worker on at 12:00 PM (4 days later). There was no investigative documentation to reflect the condition of this resident upon return to the facility.

During interview with the Administrator, conducted at the time of the above noted observation and interview (on at approximately 11:45 AM), he was asked if this resident was considered to have followed the facility's policy and procedure for signing out or was this incident considered to be an elopement. He acknowledged that the facility considered this incident to be an elopement. He was asked why an AHCA Day 15 report had not been filed until now. He could not provide an explanation.

Class III
This is an uncorrected deficiency.

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 **second Complaint Inspection #2012000498 revisit** survey was conducted on , 2012 by a representative from this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies and/or new deficiencies, identified during the revisit.
All deficiencies shall be corrected no later than , 2012.

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 the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Monica Thurman-Smith

for Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

BBT7

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2727 Mahan Drive
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