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
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 Licensure Complaint survey (#2023008069, #2024000840, #2024001103, #2024001595) and Generator Monitoring survey were conducted on through and at The Atrium of Boca Raton. The facility had deficiencies identified related to the Complaint survey (#2023008069 and #2024001595) at the time of the visit.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	A 025		

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
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 1 (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility for 2 of 8 Residents (Resident #1, #5). The facility failed to offer personal supervision as appropriate for the resident, daily observation of the activities of the resident and awareness of the general health, safety and physical and emotional well-being of the resident.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 2 The findings include: Record review of the facilities policy and procedures on titled, " Policy" revealed: 1. To provide proper intervention and follow through in the event of a Resident . 2. Any identified risk and appropriate interventions will be determined, put in place, and documented on each Resident's care plan. 3. In the event of a an internal investigation will be completed to determine cause of and appropriate interventions for safety. 4. Care plan will be updated for each , or adverse action and referrals made to . 5. 72 hours follow up that Resident stability is maintained. Record review of the facilities policy and procedures on titled, " Risk Assessments" revealed: 1. To determine the Resident's risk for . 2. An evaluation of the Resident's risk will be completed during the move-in process and repeated upon a significant change of condition and with each routine reassessment. 3. Any identified risk and appropriate interventions will be determined, put in place, and documented on each Resident's care plan. A) Review of Resident #1's chart on revealed a prescription written by the Resident's provider on for / to strengthen gait and balance. Record review on of Resident #1's Agency for Health Care Administration Resident Health Assessment Form (AHCA form 1823) dated revealed Resident was determined to be risk and independent with	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 3 ambulation, toileting, and transferring. Record review on of Resident #1's 1823 dated revealed Resident was determined to be a risk and required assistance with ambulation, toileting, and transferring. Record review of facility incident log on revealed Resident #1 had documented on the following dates: - 8:08 AM - 1:37 PM - 9:40 AM - 5:40 AM - 12:21 AM - 12:31 PM Record review of Resident #1's chart on revealed no evidence of interventions documented on incident reports, progress notes or care plans to prevent further occurrences. B) Record review on of Resident #5's Agency for Health Care Administration Resident Health Assessment (1823) dated revealed Resident ambulates with wheelchair and needs assistance with ambulation, toileting, and transferring. Record review on of Resident #5's chart revealed a prescription dated for a care consult DX(history): Frequent , decline in function and advanced . Record review on of Resident #5's AHCA form 1823 dated revealed the resident was determined to be a risk and required supervision and assistance with ambulation, toileting, and transferring.	A 025		

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
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 4 Record review of facility incident log on revealed Resident #5 had documented on the following dates: - 6:37 AM - 4:36 AM - 4:30 AM - 12:30 PM - 1:57 PM - 4:00 AM Record review of Resident #5's chart on revealed no evidence of interventions documented on incident reports, progress notes or care plans to prevent further occurrences. Interview with Wellness Director (Staff B) on at 2:30 PM, she stated that nursing on floor will do each new Residents intake evaluation and document each Resident's risk to their progress notes. Stated when a Resident is identified at risk for , they will increase rounds, update care plan. Staff training and Inservice are done monthly and Nurse Practioner would also do staff education. Record review of training attendance records on revealed a prevention/Pendant response time training conducted on for 21 of 40 patient care staff as listed on the Agency for Health Care Administration clearing house roster. Interview with Administrator (Staff A) on at 3:30 PM, she stated she understands the concerns and importance of Resident safety. Class III	A 025		

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
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 152	Continued From page 5	A 152		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not	A 152		

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
	AL11912132	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM AT BOCA RATON (THE)	1080 NORTHWEST 15TH STREET BOCA RATON, FL 33486

(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 152	Continued From page 6 be . This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to maintain a safe and decent living environment. The findings included: Observation on found carpeting in front of Resident #8's # to be stained and discolored with excessive signs of wear. (Photographic evidence obtained). Observation on found resident common hallways on the 4th floor and 3rd floor to be stained and discolored throughout the carpeted area of the corridors. (Photographic evidence obtained). Interview with Administrator on 3:00 PM, she stated the facility keeps the carpet clean and recently purchased two carpet scrubbers, but the facility recognized the carpeting on the 3rd and 4th floor needs to be replaced. Quote has already been obtained and sent to corporate office for approval. Class III	A 152		