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
	AL11970275	A. BUILDING: _____ B. WING _____	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSCAPE BOCA RATON	22501 BOCA RIO RD BOCA RATON, FL 33433

(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 Relicensure, Complaint (#2025012474) and Generator Monitoring survey was conducted on at Sunscape Boca Raton. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of	A 032		

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A 032	Continued From page 1 at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide documentation of staff participation in elopement drills for the calendar year 2024 for 3 of 4 sampled Staff. (Staff A, B, and C). The findings include:	A 032		

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A 032	Continued From page 2 During an interview conducted on at 11:41 AM with the acting Administrator, the facility's elopement drills were requested for 2024 and 2025. At this time, the acting Administrator stated that the facility did not have any record of elopement drills on file at the time of the survey. Review of the facility records confirmed that no elopement drills were conducted in 2024, Class III	A 032		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by	A 036		

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A 036	Continued From page 3 multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation, record review and interview, the facility failed to follow appropriate control techniques for 3 of 5 sampled residents (Resident #10 and Resident #5 and Resident #6) observed during a Resident Self-Administration Medication Observation. The findings included: Review of the facility policy titled Medication Management provided by the "interim" Administrator revised documented in the Policy Statement: ....Medications are administered as prescribed in accordance with good principles and practices ...3. All medication will be handled in accordance with the community policies, State regulatory requirements ....and all other applicable State or Federal regulations. 4. All staff handling medications will comply with required training ... Review of the facility policy titled, Assisting with Oral Medications Policy provided by the "interim" Administrator revised documented in the Policy Statement: ....Tablets and Capsules ...when assisting with tables or capsules, try not to touch the medication with your .... Review of the facility policy titled, Self-Administration Medication Management Policy provided by the "interim" Administrator revised documented in the Policy Statement: ...All medications must be pre-poured, packaged, or provided in accordance with State	A 036		

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A 036	Continued From page 4 regulations ...Medications are pre-poured according to the system established ... Review of the facility policy titled, Control Guidelines Policy provided by the "interim" Administrator revised documented in the Policy Statement: The AgeWell Solvere Living Managed Community has defined a set of guidelines to prevent the spread of from one Resident to another, to protect Community staff from , to prevent the transfer of communicable , and to prevent the spread of through and body .....1. Handwashing is the most important method of control. 2. must be washed between direct contact with any Residents, after doing cleaning tasks, after using the restroom, or after performing any other task that provides opportunity for ... Review of the facility policy titled, Handwashing Policy provided by the "interim" Administrator revised documented in the Policy Statement: It is the policy of the AgeWell Solvere Living Managed Community to support employee handwashing throughout the community to reduce the incidence of and .... 1) Resident #10 moved into the facility on with diagnoses which included , Sleep and of the . She had a Brief Mental Status (BIM), indicative of intact cognition. During a Resident Self-Administration Medication Observation conducted on at 9:43 AM with Staff E Medication Technician, was observed	A 036		

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A 036	Continued From page 5 donning a pair of clean gloves, reaching in medication cart #1, touching and taking out two (2) bottles of supplement capsule bottles and placing them atop the medication cart. Then, Staff E was observed separately touching, picking up and opening the two (2) over-the-counter (OTC) capsule supplement bottles. Next, Staff E was then observed reaching inside each separate bottle and directly touching the capsules, during each of the two (2) separate supplemental capsule preparations; after having touched multiple other surfaces prior, to include the top of medication cart #1. And, finally Staff E then directly placed the supplemental capsules into their separate prospective cups, with her gloved ; without first placing the supplement capsules in their bottle caps, prior to "pouring or placing" them into the individual medication cups for administration to the resident. An interview was conducted with Staff E in which she stated that she only sometimes does it this way. However, Staff E acknowledged, after the fact, that she should not have directly touched the resident's supplement capsules directly with her gloved , and she added that she should have either placed the supplemental capsules into the bottle cap first, or directly in the medication cup. On the Physician's Order documented, " ( ) Cranberry tablets, take one (1) daily by " for diagnosis of: Supplement for , Tract health. On the Physician's Order documented, "Tumeric 500mg take one (1) capsule by daily" for diagnosis of: Supplement for , and properties. For the month of , the	A 036		

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A 036	Continued From page 6 Medication Observation Record (MOR) documented both the ( ) Cranberry tablets, take one (1) daily by , as well as the Tumeric capsules, take one (1) daily by , as initialed as being provided by the facility staff. During consecutive interviews conducted on at 2:15 PM, both the "interim" Administrator and the Director of Health & Wellness (DHW) further recognized and acknowledged that appropriate control protocol should have been followed in that the resident's capsule supplement medication should not have been touched directly, during the staff member's observation of the resident's self-administered medication. 2) Record review revealed Resident #5 was admitted to the facility on with diagnosis that included ( ), ( ), ( ), Review of the Resident #5's Health Assessment (AHCA Form 1823) dated revealed the resident requires assistance with self-administered medications. Observations during Resident #5's self-administration medication observation conducted on at 10:00AM with the Medication Technician (Staff F), she did not clean her with soap and water or sanitize her prior to assisting the resident with her medications. The Medication Technician (Staff F) was observed reaching in a drawer on the medication cart, touching and taking six (6) prepackaged medications out placing them a top the cart. Next Staff F was observed dispensing	A 036		

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A 036	Continued From page 7	A 036		

each medication from the pre packaged bubble wrap into a small plastic cup for administration to the resident.

Interview with Staff F on at 10:45AM, she acknowledged that she should have sanitized her , and that she usually uses the sanitizer.

For the month of , , the Medication Observation Record (MOR) documented:
- 40mg take 1 tablet by daily
- , 5mg take 1 tablet by daily,
- , 75mg take 1 tablet by daily
- , 300mg take 1 capsule by twice daily
- 400 mg take 1 tablet by daily
- 10mg take 1 tablet by twice daily

Record review revealed Resident #6 was admitted to the facility on with diagnosis that included , , mix , , , , ( ), , ( ).

Review of Resident #6's Health Assessment (AHCA Form 1823) dated revealed the resident requires assistance with self-administered medications.

Observations during Resident #6's self-administration medication observation conducted on at 10:20AM with the Medication Technician (Staff F), she did not clean her with soap and water or sanitize her

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A 036	Continued From page 8 prior to assisting the resident with her medications. The Medication Technician (Staff F) was observed reaching in a drawer on the medication cart, touching and taking eleven (11) prepackaged medications out placing them a top the cart. Next Staff F was observed dispensing each medication from the bubble wrap packaging into a small plastic cup for administration to the resident. Interview with Staff F on at 10:45AM, she acknowledged that she should have sanitized her , and that she usually uses water and soap before exiting the resident's room. For the month of , the Medication Observation Record (MOR) documented the following prescribed medications: - , 10mg take 1 tablet by once daily - , 325mg take 1 tablet by daily, - , 25mg take 1.2 tablet by once daily, -DOC SOD100mg take 1 capsule by twice daily -Iron 65mg take 1 tablet by daily - , 10mg take 1 tablet by daily - 400mg take 1 tablet by twice daily - HIPP 1 gm take 1 tablet by twice a day - , DR 20mg take 1 capsule by daily - 30mg, take 1 tablet by daily - D2 take 1 capsule by every week. Class III	A 036		

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A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on observations and interviews the facility	A 075		

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A 075	Continued From page 10 failed to maintain a functioning automated external defibrillator ( ) for 2 of 2 machines. The findings include: Record review revealed the facility had a census of 104 on . During a tour of the facility on at 11:00 AM two (2) automated external defibrillator ( ) machines were observed in the building, located by the elevator on the first floor and the 2nd floor. During an interview on at 1:45 PM with the Administrator she stated the machine is maintained by the Maintenance Director. During a tour on at 2:30 PM with the Maintenance Director to verify the machine were in working order. Observations of the machine and the accessories on the 2nd floor revealed the maintenance inspection had expired, a inspection sticker noted the date ; Valid: 1 year and the electrode pads revealed an expiration date of , Class III	A 075		