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 _____	11/25/2025

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 survey, #2025002648 and #2025008359 was conducted on and at Sunscape Boca Raton. The facility had deficiencies identified related to the Relicensure and Complaint survey #2025002648 and #2025008359 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. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 1 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 staff interviews, the facility failed to ensure that four of four sampled residents (Residents #1, #2, #3, and #4) received adequate supervision to prevent repeated . This failure resulted in ongoing occurrences without evidence of effective interventions implemented by the facility. The findings included: a) Record review showed Resident #1 was admitted to the facility on with multiple	A 025		

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A 025	Continued From page 2 diagnoses including: , , , , and wasting. A health assessment dated documented that the resident required assistance with all ADLs, including ambulation. An undated updated 1823 documented the resident ambulated independently but continued to require assistance with , transferring, bathing, grooming, and toileting. Review of the incident log revealed multiple : - - in bathroom - - Found on floor in room - - Observed with unsteady gait and documented to have twice in the dining room; sustained a left - - in dining room; transferred to hospital - - Discharged to another facility During an interview on at 11:30 AM, the Administrator stated Resident #1 frequently and experienced multiple . He reported that one-on-one supervision was arranged by the family through a Private Duty Aide (PDA), but supervision hours were later reduced. The facility did not implement its own enhanced supervision plan. b) Record review showed Resident #2 was admitted to the facility on and required assistance with ADLs. She was wheelchair-bound, alert to name only, and receiving hospice services. Diagnoses included ' s , lower extremity lymphedema, , , and . Incident logs documented the following :	A 025		

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A 025	Continued From page 3 - - Hallway - - Dining room - - Resident ' s room - - Resident ' s room - - Resident ' s room There was no documentation of additional supervision or interventions implemented by the facility to reduce recurrent . c) Record review showed Resident #3 was admitted to the facility on with diagnoses including , , , , , history of , and Lymphedema. She used a walker and required supervision for ambulation and grooming, and assistance with bathing, , and toileting. Incident logs documented multiple : - - Hallway - - During activities - - Hallway - - Activity room - - Additional There was no evidence of facility-implemented prevention interventions despite repeated incidents. d) Record review showed Resident #4 was admitted to the facility on with diagnoses including , , Overactive , , , , gait instability, decreased endurance, and history of , placement. She required assistance with all ADLs and had documented limitations in ambulation, balance, and transfers.	A 025		

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A 025	Continued From page 4 Incident logs showed the following : - - Hallway - - Hallway - - Dining room - - Dining room - - Hallway - - Dining room - - Location not recorded - - Location not recorded No documentation showed that the facility implemented reduction strategies after repeated incidents. On at 11:30 AM, the Administrator stated that all four residents resided in the Memory Care Unit. He reported that when residents in the unit , families are typically expected to provide Private Duty Aides for supervision. The Administrator did not provide evidence of facility-driven interventions to prevent or reduce . He and the Director of Nursing reported they would implement a new monitoring system to ensure more frequent and documented supervision. Class III	A 025		