

IN THE CIRCUIT COURT OF THE 15TH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO.:

ESTATE OF JOHN W. LARSEN,
BY AND THROUGH ITS
PERSONAL REPRESENTATIVE,
DEBRA B. SCHUMAN,

Plaintiff,

v.

SONATA BOCA RATON, LLC
D/B/A SONATA BOCA RATON,
CREF3 FSLP BOCA RATON OWNER,
LLC D/B/A SONATA BOCA RATON ,
AND LIFESPACE COMMUNITIES, INC.
D/B/A ABBEY DELRAY,

Defendants.

COMPLAINT

COMES NOW, ESTATE OF JOHN W. LARSEN, by and through its Personal Representative, Debra B. Schuman, (hereafter "Larsen"), and hereby sues the Defendants, SONATA BOCA RATON, LLC d/b/a SONATA BOCA RATON (hereafter "SONATA"), CREF3 FSLP BOCA RATON OWNER, LLC d/b/a SONATA BOCA RATON (hereafter "CREF3"), and LIFESPACE COMMUNITIES, INC. d/b/a ABBEY DELRAY (hereafter "ABBIEY DELRAY"), and states as follows:

GENERAL ALLEGATIONS

1. This is an action for damages in excess of \$50,000.00.
2. That at all times material hereto and hereinafter mentioned and at the time of the incidents complained of, John W. Larsen was a resident of Palm Beach County, Florida.
3. That Debra B. Schuman is the natural daughter of the decedent and Personal Representative of the Estate of John W. Larsen.

4. Debra B. Schuman is a survivor under the wrongful death act.
5. Upon information and belief, at all times material hereto and hereinafter mentioned and at the time of the incidents complained of, the Defendant SONATA was duly licensed and authorized to do business as an assisted living facility in Palm Beach County, State of Florida and said Defendant owned and/or operated/managed Sonata Boca Raton, located at 9591 Yamato Road, Boca Raton, Florida 33434, during the time that Larsen was a resident.
6. Upon information and belief, at all times material hereto and hereinafter mentioned and at the time of the incidents complained of, the Defendant CREF3 was duly licensed and authorized to do business as an assisted living facility in Palm Beach County, State of Florida, as principal for SONATA, and said Defendant owned and/or operated/managed Sonata Boca Raton, located at 9591 Yamato Road, Boca Raton, Florida 33434, during the time that Larsen was a resident.
7. Upon information and belief, at all times material hereto and hereinafter mentioned and at the time of the incidents complained of, the Defendant ABBEY DELRAY was duly licensed and authorized to do business as a nursing home in Palm Beach County, State of Florida and said Defendant owned and/or operated/managed Abbey Delray Health Center, located at 2105 SW 11th Court, Delray Beach, Florida 33445, during the time that Larsen was a resident.
8. Defendants SONATA and CREF3 owed a duty to its residents, including Plaintiff, in accordance with Chapter 429, Fl. Stat., and state and federal law and regulations, to treat them according to accepted standards of care.
9. Defendant ABBEY DELRAY owed a duty to its residents, including Plaintiff, in accordance with Chapter 400, Fl. Stat., and state and federal law and regulations, to treat them according to accepted standards of care.
10. The Defendants' responsibilities to Larsen were non-delegable such that the Defendants had direct liability for violations, deprivations and infringement by any person under Defendants' control, direct or indirect, including their employees, agents, consultants and independent contractors whether in-house or outside entities, individuals, agencies or pools, or caused by the Defendants' policies and procedures, whether written or unwritten, or common practices.
11. In or about May, 2022, John W. Larsen was admitted to Sonata Boca Raton Assisted Living and Memory Care after residing at Sonata Delray Beach Assisted Living.
12. Upon admission, John W. Larsen's skin was intact with no pressure ulcers identified. His known medical conditions included: (a) congestive heart failure (CHF); (b) atrial fibrillation; (c) triple coronary artery bypass surgery; (d) implantable cardioverter-defibrillator (ICD) placement in 2016; (e) hypertension; (f) progressive dementia; (g) recurrent falls; and (h) generalized weakness.

13. In or around April 2023, Larsen was transferred to the Memory Care Unit at Sonata Boca Raton.
14. On September 19, 2023, Larsen was found seated on the bathroom floor.
15. On September 21, 2023, he fell again in the bathroom at approximately 5:00 a.m., prompting a 911 response and transfer to West Boca Medical Center, where he was diagnosed with a left hip contusion.
16. On January 10, 2024, Larsen again fell. He suffered a cut to his right hand. A dressing was applied but there was no physician evaluation and no emergency escalation. Five days later, on January 15, 2024, Larsen was found difficult to arouse, weak, and providing incomprehensible verbal responses. Emergency services were activated and he was transferred to Boca Raton Regional Hospital, where he was diagnosed with a chronic hand wound, cellulitis and encephalopathy.
17. On or about January 26–27, 2024, following his hospitalization, Larsen was admitted to Abbey Delray Health Center for skilled nursing care. Upon admission, nursing assessment documented redness to bilateral heels, redness to the buttocks, a closed blister on the right great toe, dry scabs on the toes, and excoriation of the scrotum.
18. During Larsen's stay at Abbey Delray, his condition rapidly deteriorated. By February 10, 2024, his Braden Scale score (14 at admission) had declined to 10 (high risk), reflecting complete immobility, constant moisture, chairbound status, and probable nutritional inadequacy. By February 15, 2024, the Abbey Delray dietitian documented a weight loss of approximately 28 pounds — nearly 12.5% of his body weight — in only 18 days since admission.
19. On or about March 8, 2024, Larsen was discharged from Abbey Delray and transferred to Sonata Boca Raton.
20. Abbey Delray's discharge documentation noted only generalized buttocks and scrotal redness with no staged pressure ulcers.
21. On March 8, 2024, Larsen was admitted to VITAS hospice. The admitting hospice nurse conducted a pre-admission assessment and documented five separate pressure ulcers: right heel, left heel, right coccyx, left coccyx, and sacral spine.
22. On or about March 18, 2024, Larsen's daughter noticed a wound on the right heel.
23. By May 14, 2024, the right heel pressure ulcer had progressed to a Stage 3 wound measuring 10 x 7 cm. The wound was also classified as unstageable with a black necrotic wound bed.
24. On June 11, 2024, Larsen was the victim of a battery/assault while still residing at Sonata Boca Raton wherein he was beaten by another resident.
25. By July 10, 2024, wound assessments documented a coccyx Stage 2 pressure ulcer, a right medial leg Stage 3 wound, and a left heel unstageable ulcer with black eschar — all demonstrating

increased slough and necrosis.

26. John W. Larsen died on August 19, 2024, at Sonata Boca Raton Assisted Living and Memory Care.

27. Plaintiff has complied with all conditions precedent to the filing of this lawsuit including putting the Defendants on notice through the initiation of a presuit pursuant to Chapters 400 and 429, Fl. Stat. Sonata Boca Raton was asked during presuit to produce documents identifying any entity/individual that was responsible for the management of Sonata Boca Raton during the time that Plaintiff resided there, and the correct legal name and correct fictitious name of the Sonata Boca Raton assisted living facility within which John W. Larsen resided. Defendant objected and refused to answer.

COUNT I

CHAPTER 429 SURVIVAL ACTION AGAINST DEFENDANT SONATA

28. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.

29. Defendants SONATA violated the following assisted living facility resident rights of Larsen:

a. The right to live in a safe and decent living environment, free from abuse and neglect — Section 429.28(1)(a), Florida Statutes;

b. The right to receive adequate and appropriate health care and protective and support services consistent with the established and recognized practice standards within the community — Section 429.28(1)(d), Florida Statutes; and

c. The right to be treated with dignity — Section 429.28(1)(m), Florida Statutes.

30. Defendants SONATA was negligent in the following ways including but not limited to:

a. Failing to perform Braden Scale pressure ulcer risk assessments or any equivalent pressure injury risk assessment during Larsen's entire residency;

b. Failing to implement and document a repositioning schedule or pressure relief protocols for a resident known to be at high risk for pressure injury;

c. Failing to perform formal nutritional assessments or obtain dietitian consultations for a resident with documented weight loss, severe anemia, and nutritional risk;

d. Failing to perform adequate and timely skin assessments during the Memory Care residency period;

e. Failing to identify, document, stage, and treat pressure ulcers in a timely manner;

- f. Failing to obtain timely physician evaluation following falls on September 19, 2023, September 21, 2023, and January 10, 2024;
- g. Failing to escalate Larsen's clinical condition to emergency services in a timely manner following the January 10, 2024 fall and subsequent deterioration;
- h. Failing to take adequate and appropriate measures to prevent harm;
- i. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;
- j. Failing to provide and obtain appropriate nursing and medical care;
- k. Failing to perform full and complete assessments of the resident;
- l. Failing to ensure sufficient qualified staff and supervision in the Memory Care Unit; and
- m. Failing to protect the dignity of Larsen.

31. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, and aggravation of existing disease or physical defect.

WHEREFORE, Larsen demands judgment against the Defendant SONATA and further demands costs, and trial by jury.

COUNT II
CHAPTER 429 WRONGFUL DEATH ACTION AGAINST DEFENDANT SONATA

- 32. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.
- 33. Defendants SONATA violated the following assisted living facility resident rights of Larsen:
 - a. The right to live in a safe and decent living environment, free from abuse and neglect — Section 429.28(1)(a), Florida Statutes;
 - b. The right to receive adequate and appropriate health care and protective and support services consistent with the established and recognized practice standards within the community — Section 429.28(1)(d), Florida Statutes; and
 - c. The right to be treated with dignity — Section 429.28(1)(m), Florida Statutes.

34. Defendants SONATA was negligent in the following ways including but not limited to:
- a. Failing to perform Braden Scale pressure ulcer risk assessments or any equivalent pressure injury risk assessment during Larsen's entire residency;
 - b. Failing to implement and document a repositioning schedule or pressure relief protocols for a resident known to be at high risk for pressure injury;
 - c. Failing to perform formal nutritional assessments or obtain dietitian consultations for a resident with documented weight loss, severe anemia, and nutritional risk;
 - d. Failing to perform adequate and timely skin assessments during the Memory Care residency period;
 - e. Failing to identify, document, stage, and treat pressure ulcers in a timely manner;
 - f. Failing to obtain timely physician evaluation following falls on September 19, 2023, September 21, 2023, and January 10, 2024;
 - g. Failing to escalate Larsen's clinical condition to emergency services in a timely manner following the January 10, 2024 fall and subsequent deterioration;
 - h. Failing to take adequate and appropriate measures to prevent harm;
 - i. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;
 - j. Failing to provide and obtain appropriate nursing and medical care;
 - k. Failing to perform full and complete assessments of the resident;
 - l. Failing to ensure sufficient qualified staff and supervision in the Memory Care Unit; and
 - m. Failing to protect the dignity of Larsen.
35. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, aggravation of existing disease or physical defect, and death.

WHEREFORE, Larsen demands judgment against the Defendant SONATA and further demands costs, and trial by jury.

COUNT III
CHAPTER 429 SURVIVAL ACTION AGAINST DEFENDANT CREF3

36. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.
37. Defendant CREF3 violated the following assisted living facility resident rights of Larsen:
- a. The right to live in a safe and decent living environment, free from abuse and neglect — Section 429.28(1)(a), Florida Statutes;
 - b. The right to receive adequate and appropriate health care and protective and support services consistent with the established and recognized practice standards within the community — Section 429.28(1)(d), Florida Statutes; and
 - c. The right to be treated with dignity — Section 429.28(1)(m), Florida Statutes.
38. Defendant CREF3 was negligent in the following ways including but not limited to:
- a. Failing to perform Braden Scale pressure ulcer risk assessments or any equivalent pressure injury risk assessment during Larsen's entire residency;
 - b. Failing to implement and document a repositioning schedule or pressure relief protocols for a resident known to be at high risk for pressure injury;
 - c. Failing to perform formal nutritional assessments or obtain dietitian consultations for a resident with documented weight loss, severe anemia, and nutritional risk;
 - d. Failing to perform adequate and timely skin assessments during the Memory Care residency period;
 - e. Failing to identify, document, stage, and treat pressure ulcers in a timely manner;
 - f. Failing to obtain timely physician evaluation following falls on September 19, 2023, September 21, 2023, and January 10, 2024;
 - g. Failing to escalate Larsen's clinical condition to emergency services in a timely manner following the January 10, 2024 fall and subsequent deterioration;
 - h. Failing to take adequate and appropriate measures to prevent harm;
 - i. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;
 - j. Failing to provide and obtain appropriate nursing and medical care;

- k. Failing to perform full and complete assessments of the resident;
- l. Failing to ensure sufficient qualified staff and supervision in the Memory Care Unit; and
- m. Failing to protect the dignity of Larsen.

39. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, and aggravation of existing disease or physical defect.

WHEREFORE, Larsen demands judgment against the Defendant CREF3 and further demands costs, and trial by jury.

COUNT IV
CHAPTER 429 WRONGFUL DEATH ACTION AGAINST DEFENDANT CREF3

40. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.

41. Defendants CREF3 violated the following assisted living facility resident rights of Larsen:

- a. The right to live in a safe and decent living environment, free from abuse and neglect — Section 429.28(1)(a), Florida Statutes;
- b. The right to receive adequate and appropriate health care and protective and support services consistent with the established and recognized practice standards within the community — Section 429.28(1)(d), Florida Statutes; and
- c. The right to be treated with dignity — Section 429.28(1)(m), Florida Statutes.

42. Defendants CREF3 was negligent in the following ways including but not limited to:

- a. Failing to perform Braden Scale pressure ulcer risk assessments or any equivalent pressure injury risk assessment during Larsen's entire residency;
- b. Failing to implement and document a repositioning schedule or pressure relief protocols for a resident known to be at high risk for pressure injury;
- c. Failing to perform formal nutritional assessments or obtain dietitian consultations for a resident with documented weight loss, severe anemia, and nutritional risk;
- d. Failing to perform adequate and timely skin assessments during the Memory Care residency

period;

- e. Failing to identify, document, stage, and treat pressure ulcers in a timely manner;
- f. Failing to obtain timely physician evaluation following falls on September 19, 2023, September 21, 2023, and January 10, 2024;
- g. Failing to escalate Larsen's clinical condition to emergency services in a timely manner following the January 10, 2024 fall and subsequent deterioration;
- h. Failing to take adequate and appropriate measures to prevent harm;
- i. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;
- j. Failing to provide and obtain appropriate nursing and medical care;
- k. Failing to perform full and complete assessments of the resident;
- l. Failing to ensure sufficient qualified staff and supervision in the Memory Care Unit; and
- m. Failing to protect the dignity of Larsen.

43. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, aggravation of existing disease or physical defect, and death.

WHEREFORE, Larsen demands judgment against the Defendant CREF3 and further demands costs, and trial by jury.

COUNT V

CHAPTER 400 SURVIVAL ACTION AGAINST DEFENDANT ABBEY DELRAY

- 44. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.
- 45. Defendant ABBEY DELRAY violated the following nursing home resident rights of Larsen:
 - a. The right to be adequately informed of his or her medical condition and proposed treatment — Section 400.022(j), Florida Statutes;
 - b. The right to receive adequate and appropriate health care and protective and support services

and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency — Section 400.022(1), Florida Statutes (incorporating by reference, Florida Administrative Code, 59A-4 and for violations of the Federal Nursing Home Administrative Regulations referred to as Subpart B of Part 483); and

c. The right to be treated courteously, fairly and with the fullest measure of dignity — Section 400.022(n), Florida Statutes.

46. Defendant ABBEY DELRAY was negligent in the following ways including but not limited to:

a. Failing to implement adequate pressure ulcer prevention protocols notwithstanding documented high-risk Braden Scale scores declining from 14 to 10 during the skilled nursing stay;

b. Failing to prevent the development and/or progression of pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine;

c. Failing to adequately address Larsen's severe nutritional decline, including a weight loss of approximately 28 pounds in 18 days;

d. Failing to accurately document and stage pressure ulcers at the time of discharge;

e. Failing to take adequate and appropriate measures to prevent harm;

f. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;

g. Failing to provide and obtain appropriate nursing and medical care;

h. Failing to perform full and complete assessments of the resident; and

i. Failing to protect the dignity of Larsen.

47. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, and aggravation of existing disease or physical defect..

WHEREFORE, Larsen demands judgment against the Defendant ABBEY DELRAY and further demands costs, and trial by jury.

COUNT VI

CHAPTER 400 WRONGFUL DEATH ACTION AGAINST DEFENDANT ABBEY DELRAY

48. Plaintiff readopts and reavers all allegations contained in Paragraphs numbered 1 through 27 as if fully set forth herein.
49. Defendant ABBEY DELRAY violated the following nursing home resident rights of Larsen:
- a. The right to be adequately informed of his or her medical condition and proposed treatment — Section 400.022(j), Florida Statutes;
 - b. The right to receive adequate and appropriate health care and protective and support services and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency — Section 400.022(l), Florida Statutes (incorporating by reference, Florida Administrative Code, 59A-4 and for violations of the Federal Nursing Home Administrative Regulations referred to as Subpart B of Part 483); and
 - c. The right to be treated courteously, fairly and with the fullest measure of dignity — Section 400.022(n), Florida Statutes.
50. Defendant ABBEY DELRAY was negligent in the following ways including but not limited to:
- a. Failing to implement adequate pressure ulcer prevention protocols notwithstanding documented high-risk Braden Scale scores declining from 14 to 10 during the skilled nursing stay;
 - b. Failing to prevent the development and/or progression of pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine;
 - c. Failing to adequately address Larsen's severe nutritional decline, including a weight loss of approximately 28 pounds in 18 days;
 - d. Failing to accurately document and stage pressure ulcers at the time of discharge;
 - e. Failing to take adequate and appropriate measures to prevent harm;
 - f. Failing to document the resident's chart in a manner which accurately reflects the resident's condition;
 - g. Failing to provide and obtain appropriate nursing and medical care;
 - h. Failing to perform full and complete assessments of the resident; and
 - i. Failing to protect the dignity of Larsen.
51. As a result of the Defendant's negligence and violation of the resident rights of Larsen, he

suffered injuries including but not limited to multiple pressure ulcers on the bilateral heels, bilateral coccyx, and sacral spine, wound infection, necrosis, progressive peripheral arterial disease, severe malnutrition, significant weight loss, prolonged pain and suffering, loss of dignity, humiliation, bodily injury, disability, physical impairment, disfigurement, inconvenience, loss of capacity to enjoy life, discomfort, expense of hospitalization, medical and nursing care and treatment, aggravation of existing disease or physical defect, and death.

WHEREFORE, Larsen demands judgment against the Defendant ABBEY DELRAY and further demands costs, and trial by jury.

s/ Kenneth R. Segal
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