STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105372	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Lake Worth, Inc.	2501 N A St Lake Worth, FL 33460

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat 3 of 3 sampled residents in a dignified manner as evidenced by the failure to honor the request to use a shower bed with subsequent non-dignified comments by staff toward Resident #1; failure to speak to and treat Resident #3 in a dignified manner related to requested assistance and food; and failure to speak kindly about residents in a foreign language as heard by Resident #4 who spoke that foreign language.The findings included:1) Review of the record revealed Resident #1 was admitted to the facility on [DATE] and moved to his current room on the Flamingo unit on 11/14/25. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This MDS also documented the resident had impairment on both sides of his body and was totally dependent upon staff for assistance with all Activities of Daily Living (ADLs).Review of the current care plan dated 10/21/25 documented Resident #1 had an alteration in musculoskeletal status related to quadriplegia (inability to use all four limbs)/paraplegia (inability to use two limbs) and bilateral upper extremity contractures (permanent shortening and hardening of muscles, tendons or ligaments causing rigid, abnormal joint positioning). A second care plan dated 02/26/26 documented the resident had an ADL self-care performance deficit related to limited mobility and musculoskeletal impairment. An intervention documented the resident was totally dependent on one staff to provide bath/shower and totally depended upon two staff for transfers.During an interview on 05/05/26 at 10:56 AM, Resident #1 stated the staff are not nice to me. The nurses don't speak nicely or in English. When asked if the resident preferred the shower chair or shower bed, the resident stated, I want to use the shower bed. They won't let me. The resident further stated his shower days were Tuesday and Friday and that he wanted them around 11 or 11:30 AM.During the continued interview at 11:17 AM, Resident #1 stated he wanted a shower and asked the surveyor to assist. The resident pushed the call light, and it was answered by Staff A, Concierge Certified Nursing Assistant (CNA), who informed him that she would let his CNA know he wanted a shower. Staff A left the room, and the resident immediately pushed the call light again. Staff A again explained she would let his CNA know he wanted a shower. Resident #1 refused to let the CNA turn off the call light, so the light remained on. Staff A proceeded to get the shower chair and brought it to the entrance of the resident's room at 11:31 AM. When asked if that chair reclined like a bed, as it was noted to be reclined at about 45 degrees, the CNA stated it did not. When asked if they had a shower bed, Staff A stated they did, but it was hard to fit into the resident's room. Resident #1 resided in a double occupancy room, but his was the only bed in the room, and there was room to maneuver about the bed and or move the bed as needed. When asked the resident's preference, Staff A stated, He changes his mind every day, but you just have to do what he wants.During the continued observation, Staff A took the shower chair into the resident's room at 11:33 AM, and Resident #1 began yelling over and over again, shower bed, shower bed, shower bed. Staff A attempted to talk him into the shower chair, stating that the resident had used the shower chair in the past and the bed was difficult to get into (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room. At 11:36 AM Staff A stated, You have a choice, the shower chair or no shower again stating the shower bed was too big. At 11:40 AM the Corporate Nurse arrived and spoke with the resident. The Corporate Nurse listened to the resident and agreed to use the shower bed, instructing the staff to obtain the bed. The Corporate Nurse and Unit Manager gave the resident a shower using the shower bed.During an interview outside of the room on 05/05/26 at 11:51 AM, when asked why she told Resident #1 that he had to use the shower chair, Staff A, CNA, denied saying it and stated he previously used the shower bed but had been using the chair recently. When reminded she had told the surveyor that he changes his mind every day, the CNA agreed. When asked again why she would not use the shower bed, the CNA denied the comment.During an interview outside of the room on 05/05/26 at 11:53 AM, the Corporate Nurse volunteered that Resident #1 changes his mind and this was not the only time they had had issues with showers. The Corporate Nurse agreed the CNAs could use either the shower chair or shower bed, depending upon the resident's request. When told the observation of Staff A and the verbal altercation between Staff A and the resident, the Corporate Nurse stated she would do one-on-one education and agreed with the findings.During an interview on 05/05/26 at 1:32 PM, when asked about the shower chair vs. the shower bed for Resident #1, the Unit Manager stated he was quite complicated and which was not a problem, as the CNAs could use either. The Unit Manager stated he likes the bed because he feels he gets cleaned better but that he will also use the chair at times.2) During an interview on 05/05/26 at 3:32 PM, when asked if customer service had improved since her grievance filed on 04/23/26, Resident #4 stated, Nothing has changed. Resident #4 stated the staff speak Creole in front of English-speaking residents, while caring for the resident. The resident explained she speaks both English and Creole, and further stated the staff are not speaking kindly about the residents. Resident #4 further stated the staff are not happy and they have a bad attitude. Resident #4 stated she witnessed a CNA refuse to give a resident a washcloth to wash her own feet.Review of the record revealed Resident #4 had a current BIMS of 11, on a 0 to 15 scale, indicating the resident had mild cognitive impairment.3) During an interview on 05/05/26 at 3:46 PM, when asked if customer service had improved since her grievance filed on 04/06/26, Resident #3 stated it had not. When asked her concerns, the resident stated the staff attitudes are horrible. The resident stated she had recently asked a staff for assistance to wash her feet and the staff responded, I have been here for 14 years and never washed no one's feet and I'm not gonna start now. The resident stated the CNA would not even hand her a washcloth to do her own feet. Resident #3 explained another time she was having difficulty holding a small plastic cup, explaining that it was crumpling up as she lacked motor control. The resident stated she asked a staff to help her with the cup and the staff responded, You can't even hold the f___ing cup? Resident #3 stated the Creole speaking staff talk about the size of other resident's bowel movements or that they are too big to transfer in the mechanical lift. The resident questioned, If they are saying those things about other residents in front of me, what are they saying about me to other residents? Resident #3 finally stated when she calls the kitchen in the evening for a turkey sandwich the staff had responded, This isn't Burger King . you can't get it your way.Review of the current MDS documented the resident had a BIMS score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician ordered medications were provided to 1 of 3 sampled residents, as evidenced by the failure to administer three doses of Medrol 4 mg (milligrams) to Resident #2.The findings included:Review of the record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and diabetes. Review of the admission physician order dated 04/30/26 documented the resident was to receive Medrol 4 mg (milligrams) four times daily starting on 04/30/26 at 6 PM.Review of the corresponding Medication Administration Record (MAR) revealed the nurses failed to administer the medication on 04/30/26 at 6 PM, on 04/30/26 at 9 PM, and on 05/01/26 at 6 AM. The record lacked any reason for the lack of administration.During an interview on 05/05/26 at 10:46 AM, when asked the process for obtaining medications for newly admitted residents, Staff B, Licensed Practical Nurse (LPN) and admission nurse for Resident #2, stated after clarifying the medication orders and entering them into the computer, the medications are delivered in the late afternoon or early morning. When asked if they had an automated system of stock or emergency medication at the facility, the LPN was unsure.During a side-by-side record review and interview on 05/05/26 at 2:07 PM, when asked if Resident #2 should have received the physician ordered Medrol during her stay at the facility, the Unit Manager agreed she should have. When asked if they had an automated system with medications, the Unit Manager confirmed they did. An observation of the inventory at that time revealed the Medrol was available for use by the nursing staff.