

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Avante at Lake Worth, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interview, the facility failed to assess for self-administration of medication for 1 of 35 sampled residents, as evidenced by no assessment was completed for Resident #68 to self-administer medication.</p> <p>The findings included:</p> <p>Review of the policy titled Self-Administration of Medication Program revised: 06/26/2024, documented in part, It is the policy of the facility to allow the resident the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. Resident's preference will be documented on the appropriate assessment in the medical record. The results of the interdisciplinary team assessment are recorded in the resident's medical record.</p> <p>Record review revealed Resident #68 was admitted to the facility on [DATE]. The most recent comprehensive 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 no cognitive impairment.</p> <p>During an interview on 05/27/25 at 10:42 AM, in Resident #68's room, a tube of ointment with a prescribed date of 12/19/24 was observed on the bedside table. When asked what the ointment was for, the resident stated It's for my feet. The nurse put it there and I put it on myself. This is the second tube I've had. When asked have the nurses ever applied the ointment, the resident stated No, I can do it myself. Photographic evidence obtained.</p> <p>Further review of the record revealed an order dated 12/19/24, that instructed the staff to apply Ciclopirox Olamine External Cream 0.77 % (antifungal cream) to the bottom of both of Resident #68's feet every shift.</p> <p>Review of the Treatment Administration Record (TAR), on 05/27/25, for the month of May, revealed that the staff had documented on every shift administration of the antifungal cream for Resident #68.</p> <p>During further review of the record, there was no documentation of an assessment completed by the interdisciplinary team for Resident #68 to self-administer medication.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a resident choice for showers, for 1 of 35 sampled residents (Resident #103).</p> <p>The Findings included:</p> <p>A review of facility's policy titled, Quality of Care, revised on 03/02/19, revealed facility ensures that each resident receives, and the facility provides the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, in accordance with State and Federal Regulations.</p> <p>Resident #103 was admitted on [DATE] with diagnoses that included Central Cord Syndrome, Quadriplegia, Neuromuscular Dysfunction of the Bladder and Major Depressive Disorder.</p> <p>A review of the Minimum Data Set (MDS) under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 15 indicating Resident #103 had good cognitive function. Section GG revealed Resident #103 was dependent on the ability to bathe self, including washing, rinsing, and drying self.</p> <p>Record review of the Nursing care plan initiated on 04/24/25 revealed Resident #103 was dependent on staff for meeting emotional, intellectual, physical and social needs related to immobility. One of the care plan goals for Resident # 103 was to improve the current level of function with the intervention to provide bath/shower as necessary, since resident is totally dependent on showering, dressing, toilet use, and transfer.</p> <p>In an interview with Resident #103 on 05/28/25 at 10:15 AM and on 05/29/25 at 12:00 PM, she stated that she has been in the facility for 5 weeks. When asked about her stay, she responded, she was so uncomfortable with her bad smelling, dirty hair and neck. Resident #103 pointed to a cervical collar around her neck area.</p> <p>She added that she had been requesting showers since she arrived at the facility, but staff did not frequently provide her the choice of showers whenever she requested. She received 2 showers in the past 5 weeks. She added the staff stated they will come back and give her showers, but it happened only twice in the past 5 weeks. She told staff multiple times that she desperately needed assistance in showering and did not prefer bed baths.</p> <p>In an interview with Staff O, Certified Nursing Assistant, (CNA) on 05/28/25 at 11:00 AM, she stated she will put the shower schedule on the board for today. She added that the shower schedule must be posted as early as possible so staff can give showers per residents' requests. When asked about the usual time she provides shower to her assigned residents, she stated, It depends on when the resident likes to have one. When asked how many residents' showers she provides during her shift, she responded, It depends, sometimes 2 and 3. When asked if she documents the showers she provides residents, she responded, We have a shower log binder.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with Staff C, a CNA on 05/30/25 10:00 AM, when asked how other staff would know that she already provided a shower to her assigned residents, she responded, We document them in the shower log. When asked if she documented the showers, she provided for Resident #103, she stated she never had this resident. When asked if she could provide a copy of the shower log of her assigned residents, she stated she would ask the Unit Manager. When asked if she could show this surveyor the shower log, she stated, It is at the Nursing station.</p> <p>During an inspection of a binder called the shower log found at the Nursing station, Staff C, a CNA verified that the shower log for residents was not updated. There were no residents' names and shower times documented. This Staff kept on turning pages, but she could not show the surveyor any showers provided to residents.</p> <p>When the Assistant Director of Nursing (ADON) was asked regarding a copy of a shower log for Resident #103 on 05/28/25 at 11:45 AM, she stated it would be provided. But until the last day of the survey no copy of the shower log was provided.</p> <p>In an interview with the Flamingo Unit Manager on 05/29/25 at 10:00 AM, when she was asked about shower schedule, she responded, Shower is scheduled every other day. Each member of the CNA staff is assigned to a resident. The CNA Staff provide residents' showers during day and afternoon, but not during the night shift. She stated any resident can ask for an extra shower but it must be scheduled by staff. When asked if she checks the shower log binder, she responded, Yes. When asked who is responsible for checking the shower log binder, she responded, It is the ADON. When asked to show the shower log for Resident #103, she stated I will print you a copy. Until the last day of survey, no shower log for Resident #103 was provided to the surveyor.</p> <p>In an interview with the Corporate Administrator on 05/29/25 at 11:24 AM, she was asked to print a shower log for Resident #103. She stated she would ask the Director of Nursing (DON) to print a copy. Until the last day of survey, no copy of the shower log for Resident #103 was provided to the surveyor.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, interview and observation, the facility failed to identify and notify of a change in condition for 1 of 35 sampled residents (Resident #91) as evidenced by no documentation of a change in condition in the medical record.</p> <p>The findings included:</p> <p>Review of the policy titled Change in Condition Process revised 3/2/19, documented in part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification. Situations requiring notification include: an accident involving the resident which result in injury, potential to require physician intervention. Upon identification of a change in condition in a resident the nurse will complete an evaluation of the resident's status and document findings on the Change in Condition in the residents' electronic medical record</p> <p>Review of the record revealed Resident #91 was admitted to the facility 11/12/24. The quarterly assessment dated [DATE], documented the resident had a Brief Interview for Mental Status score of 03, on a scale of 0 to 15, indicating severe cognitive impairment.</p> <p>During an observation on 05/27/25 at 12:03 PM, Resident #91 was sitting in the Dolphin dining area being assisted with eating lunch, scratches were observed on her nose. The scratches had dried blood and scabs. Resident's fingernails appeared short and well groomed.</p> <p>During a brief interview on 05/27/25 at 12:05 PM, when asked if she was aware of how Resident #91 received the scratches on her nose Staff C, Certified Nursing Assistant, stated No, she had them when I came, so I'm not sure.</p> <p>During a interview on 05/27/25 at 12:30 PM, when asked if she was aware of how Resident #91 got scratches on her nose Staff A, Licensed Practical Nurse (LPN), stated No, maybe she scratched or picked at her own nose.</p> <p>Review of a Skin assessment completed on 05/27/25, documented Resident #91 had no new skin areas and there was no documentation of the scratches to the nose.</p> <p>During an interview with the Unit Manger on 05/28/25 at 9:59 AM, when asked if she was aware of the scratches to Resident #91's nose, the Unit Manager stated Yes, and the family and doctor was notified. The family said the resident had a habit of scratching herself. When asked if she documented the conversation she had with the family or doctor, the Unit Manager, stated No. When asked if the behavior of Resident #91 scratching herself was care planned, the Unit Manager stated No.</p> <p>Further record review did not reveal any documentation of progress notes of communication to the family or doctor regarding Resident #91's change in condition. There was no change in condition evaluation completed for the scratches on Resident #91.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/25 at 9:50 AM, when asked are you aware of how Resident #91 got the scratches on her nose, the Activities Assistant stated No, when I came a few days ago, I asked the same thing, and no one seems to know.</p> <p>During an interview on 05/29/25 at 9:58 AM, when asked what is your process when a resident sustains a new injury or has a change in condition, the Unit Manager stated, I usually call the family and notify the doctor. When asked did you document that you notified the family or doctor for Resident #91, the Unit Manager stated No, the family was actually here in the facility, and they saw the scratches on her nose. When asked who was the family that was here to visit, the Unit Manger stated, It was two people I'm not sure who they were, you can look on her face sheet. When asked did you do a change in condition assessment for Resident #91, the Unit Manager stated No. When asked does the facility have a change in condition assessment in the computer, the Unit Manager stated Yes. When asked why a progress note or assessment was not completed, the Unit Manager stated I don't know. I should have completed one.</p> <p>During an interview on 05/29/25 at 11:01 AM, when asked what do you do when you notice a resident has a new skin tear or condition, Staff A, Licensed Practical Nurse (LPN) stated, I would ask the nurse I'm relieving what happened and if there is any documentation. When asked what if the incident happened on your shift, Staff A, LPN stated, I would have the wound care nurse see the resident and I will do an incident report. When asked what was done when you noticed the scratches on Resident # 91's nose, Staff A, LPN stated, I asked other nurses what happened, and they said she scratched herself.</p> <p>During a telephone conversation on 05/30/25 at 11:45 AM, with Resident #91's son, when asked when did you last visit with your mother at the facility where she resides, the son stated, I was there about a week and half ago. When asked if he had a conversation with any staff regarding the scratches on his mother's nose, the son stated No, I did not have a conversation with anyone about the scratches on my mother's nose. I don't recall her having any scratches on her nose. The only conversation I had was regarding where the remote was, because she was just lying in the bed staring at the ceiling. When asked if there was anyone with you when you visited your mother the son stated, My wife was with me, she is the one who helped me take care of my mother before we put her in the facility. When asked, did you discuss with any staff about your mother having a habit of scratching herself, the son stated No, I'm not aware of her having a habit of scratching.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a PRN (as needed) psychotropic medication was addressed in a timely manner for 1 of 5 sampled residents reviewed for unnecessary medications, as evidenced by an anti-anxiety medication prescribed to Resident #36 did not have a discontinue date.</p> <p>The findings included:</p> <p>Review of the record revealed Resident #36 was admitted to the facility on [DATE]. The comprehensive assessment documented that the resident had a Brief Interview for Mental Status (BIMS) score of 03 on a 0 to15 scale, indicating severe cognitive impairment.</p> <p>Review of the record revealed an order for Resident #36, dated 03/26/25, for Lorazepam 0.5 milligrams (mg) every four hours as needed for anxiety (excessive worry) without a date to discontinue.</p> <p>Review of the April and May Medication Administration Record (MAR) for Resident #36, revealed administration of Lorazepam 0.5mg by staff.</p> <p>A pharmacy consultation report dated 04/16/25 and 5/12/25 for Resident #36, recommended that Lorazepam (anti-anxiety medication) be tapered down and discontinued or documentation of a specific diagnosis and indication with a rationale for use be provided, because it had been prescribed for greater than 14 days. The pharmacy consultation reports for 04/16/25 or 5/12/25 were not addressed or signed by the physician.</p> <p>During an interview conducted on 05/29/25 at 4:30 PM with Staff S, the Consultant Pharmacist (CP), she stated she had been working with the facility for years. When asked about Resident #36, Staff S, the Consultant Pharmacist stated, In April the resident was on Lorazepam PRN (as needed) with no stop date and the recommendation was to taper the dose as necessary and add a stop date. In May, the pharmacy recommendation for Resident #36 documented the resident had a PRN order for anxiety medication, which has been in place for greater than 14 days without a stop date, Lorazepam 0.5mg take 1 tablet by mouth every 4 hours as needed for anxiety.</p> <p>During an interview on 05/30/25 at 10:29 AM, the DON stated he had been working at the facility for almost 10 years. When asked if Lorazepam is considered a psychotropic medication, the DON stated, Lorazepam is for anxiety. When asked do you agree that Lorazepam is a psychotropic, the DON stated Yes. When asked how often the physician comes in the facility to review the pharmacy consult recommendation, the DON stated Usually monthly, but I did not know that the family did not want Resident #36 to be seen by psych doctor. I called hospice yesterday, regarding the Lorazepam. When asked who wrote the order for the PRN Lorazepam, the DON stated, It was probably from the hospital. When asked why the physician didn't sign the pharmacy recommendation, the DON stated, The assigned doctor didn't sign the recommendation, because the resident should have been seen by the psych doctor, but the family did not want the resident to be seen. When asked why the recommendation from April by pharmacy to get a stop date for the Lorazepam was not followed through, the DON stated, I've already told you, because the family didn't want the psych doctor to see the resident so that's why I called hospice to review, and they will be in today.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to investigate an allegation of abuse thoroughly for 1 of 35 sampled residents (Resident #307).</p> <p>The findings included:</p> <p>A review of the facility's policy on Abuse, Neglect, Exploitation and Injuries of Unknown Origin, effective 03/01/17, clarified that residents must not be abused by anyone, including facility staff, other residents, consultants, volunteers, family members, visitors, or other individuals. It stated that alleged violations involving mistreatment, neglect, or abuse must be immediately reported to the facility administrator and to other officials in accordance with state and federal law and through established procedures. The detailed investigation and reporting procedure for abuse mandated a thorough investigation, and a grievance form for an allegation of physical abuse without evidence of physical injury. [NAME]</p> <p>A review of the medical records for Resident #307 revealed that he was admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of larynx, tracheostomy status, and muscle wasting. A review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed that Resident #307 had a Brief Interview for Mental Status score of 12, which indicated that he was cognitively intact.</p> <p>A review of the medical records of Resident #85 (he was the roommate of Resident #207) revealed he was admitted [DATE] with diagnoses including Schizophrenia, Brief Psychotic disorder, anxiety, and bipolar disorder. Per Minimum Data Set assessment dated [DATE], Resident #85's BIMS score was 5. This indicated severe cognitive impairment. Resident #85 had behavior problems. His care plan dated 04/03/25 noted that he yelled obscenities in facility hallways, and he hit another resident during a smoke break which was related to poor impulse control.</p> <p>During an initial screening interview with Resident #307, on 05/27/25 at 12:43 PM, when asked if he was ever abused at the facility, he described an incident when his roommate, Resident #85, threw a television remote control at him which hit him in the forehead. Resident #307 said that Resident #85 also lifted up the bottom of the privacy curtain that hung between the beds and threw it over the table. Resident #307 wrote on his communication board that the curtain hit him in the chest. Resident #307 had a trach in place with an exposed open area in between the trach and the surrounding skin (stoma). The surveyor asked him to show with his hands where the curtain hit him, and Resident #307 moved his hands from the bottom of his rib cage to his face while he mouthed the words from my chest to all over my face. When Resident #307 was asked if he reported it to anyone, he said that he told the nurse manager that he wanted Resident #85 arrested, but they only moved him down the hallway. He explained that Resident #85 used awful defamatory language towards nursing every day, and he still heard him from his room. He said they should have moved Resident #85 further away from his room. When Resident #307 was asked if Resident #85 came into his room and threw things at him after his room changed, Resident #307 answered no. Resident #307 mouthed words and wrote full sentences with a stylus on his communication board to communicate effectively.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the administrator in her office, on 05/27/25 at 1:48 PM, the surveyor reported the incident. The administrator told the surveyor that she knew about the incident that occurred with Resident #307 and his roommate. The surveyor requested all documents that related to that incident.</p> <p>A review of the Resident #307's medical record showed no documentation about the incident.</p> <p>On 05/27/25 at 2:52 PM, the administrator entered the conference room and explained that Staff D, an RN, observed the incident on Saturday. She said that Resident #85 had a diagnosis of tardive dyskinesia and that Resident #85 accidentally moved the curtain into Resident #307. The administrator said that the remote control fell off the table and landed on the resident. She said it was an accident and that Resident #307 agreed with that.</p> <p>On 05/27/25 at approximately 4:00 PM, the administrator provided the surveyor with a Witness Statement signed by Staff D. Staff D wrote that when she was doing rounds on May 24 (2025), at 9:00 AM, she went to the room of Resident #307 and asked the residents if they were ok. Resident #307 reported to her that his roommate hit him with the remote control. She wrote that she discussed the incident with both residents and we conclude(d) it was an accident. She wrote that the roommate tried to pick up his stuff from the floor and the curtain was wrapped around the table. She wrote that's how the remote fell on him. She ended the statement with a note about changing the room of the other resident to prevent more accidents. There was no mention of the name of the roommate in the Witness statement. There was no statement from Resident #307 provided to the surveyor.</p> <p>During an interview with Resident #307 on 05/29/25 at 8:29 AM, the resident said that the top nurse (who he reported the incident to) came to him and spoke about the incident. The surveyor asked Resident #307 if the nurse referred to it as an accident and he answered yes. When asked if he agreed with the nurse that it was an accident, Resident #307 answered: I told her that was bullshit. When Resident #307 was asked how the incident affected him, Resident #307 said that when he saw Resident #85 in the hallway he was horrified. Resident #307 said that the facility should have called the police right away. He said he should have been able to fill out a police report. Again, Resident #307 spoke about the awful defamatory language used by Resident 85 and he asked the surveyor if she heard it.</p> <p>In an interview with Staff D on 05/29/25 at approximately 12:30 PM, the nurse clarified that she did not observe the incident. She also said that the incident was a misunderstanding.</p> <p>An interview on 05/29/25 at 6:31 PM with the administrator, who also holds the position of risk manager, revealed that Staff D texted her on Saturday (05/24/25) to see if she thought it was abuse, neglect, exploitation, or misappropriation. The administrator was asked under what circumstances she interviewed residents herself. The administrator said that she interviewed residents when she was made aware of ongoing concerns. Per the administrator, there weren't any ongoing concerns mentioned. The administrator said she did not have any statements from Resident #307 or Resident #85.</p> <p>During an interview with the Administrator/Risk Manager on 05/30/25 at 9:31 AM, she said she spoke to Resident #307 last night, and that she reported the incident to the police and to the DCF. Per the administrator, DCF didn't accept the case, and the police came out and spoke to Resident #307. Resident #307 declined to press charges, and the police did not take the case. The administrator reported the incident to AHCA (the State Agency) on 05/29/25. This was 5 days after the incident occurred.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #307 on 05/30/25 at 10:39 AM confirmed that the police came to the facility and spoke with him on 05/29/25. When asked how he felt after the discussion with the police, Resident #307 said good. When Resident #307 was asked if Resident #85 came to his room after the incident, he answered no.		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3). Resident #56 was admitted on [DATE] with diagnoses that included Metabolic Encephalopathy, Alcohol Dependence with Alcohol-Induced persisting Dementia, Unspecified Psychosis, Major Depressive Disorder, and other Persistent Mood Disorders.</p> <p>A record review of Minimum Data Set (MDS) under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 7 indicating Resident #56 had impaired cognitive function. Section N revealed a yes response to antidepressant.</p> <p>A review of physician orders dated 03/05/25 revealed Trazodone Hydrochloride 50 milligram (mg), to give 0.5 tablet by mouth, two times a day for depression. An additional review of orders revealed the behavior code monitoring every shift as needed for behavior.</p> <p>An additional order revealed Memantine Hydrochloride 5 mg, to give 2 tablets by mouth, two times a day for Dementia.</p> <p>A review of psychiatry progress notes dated 05/08/25 revealed the following This resident struggled with alcohol use resulting in negative consequences on his life. The resident also suffers from psychotic symptoms that are long and lasting. Additional notes revealed to continue Memantine for dementia, Trazodone to treat depression, and Valproic Acid for mood disorder.</p> <p>During a record review of Level I PASARR (Preadmission Screening and Resident Review) dated 08/26/24 , it was found incomplete with no pages 2 and 4. There was no Level II PASARR found on Resident #56's electronic medical record under miscellaneous records.</p> <p>In an interview with the Director of Social Services on 05/30/25 at 2:45 PM, when asked why Resident #56's PASARR Level I was incomplete, she responded, I had been out for a while and was not able to check . When asked if Level II PASARR is indicated for Resident #56, she responded, I agree, but I never found a time to request for one since I had no help, and just came back from being off.</p> <p>Based on policy review, record review, and interviews, the facility failed to ensure that PASRR (Preadmission Screening and Resident Review) Level 1 was documented completely for 2 of 35 sampled residents as evidenced by the PASRR Level 1 for Resident #56 and Resident #91 was not completely filled out, and failure to ensure that the PASRR Level 2 was completed for 1 of 35 sampled residents, as evidenced by the results of the PASRR Level 1 screening for Resident #86.</p> <p>The findings Included:</p> <p>Review of the Policy titled Coordination-Preadmission Screening and Resident Review (PASSR) Program revised 3/2/19, documented in part It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-admission Screening and Resident Review, in accordance with State and Federal regulations. The facility will coordinate assessments with the pre-admission screening and resident review practicable to avoid duplicative testing effort. Incorporating the recommendations from the PASRR level 2 determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1). Record review revealed Resident #86 was admitted to the facility on [DATE]. The quarterly assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 07 on a 0 to 15 scale indicating severe cognitive impairment. Review of Resident #86 medical diagnosis indicated that she had a history of dementia (impairment of mental function that affect daily function) with mood disturbance, major depressive disorder (persistent feelings of sadness), and schizophrenia (mental health condition where people experience a disconnect from reality).</p> <p>Review of the record revealed a PASRR Level 1 dated, 09/20/24 for Resident #86 with documentation in section four of the PASRR Level 1 that indicated that a Level 2 PASRR should have been requested due to her diagnosis of Serious Mental Illness.</p> <p>Review of the care plan dated 3/25/25 for Resident #86 documented the resident has impaired cognitive function/dementia or impaired thought processes related to impaired decision making, diagnosis of Schizophrenia with a goal that the resident will maintain current level of cognitive function through the review date and the resident has a communication problem related to schizophrenia with a goal that the resident will be able to make basic needs known on a daily basis through the review date.</p> <p>Review of a progress note dated 05/16/25, by staff documented that the patient was observed to be highly agitated and upset. Very restless, pacing the hallway and yelling incoherently. Patient reports seeing people in the room with her and in the hallway.</p> <p>Review of physician orders dated 04/25/25, revealed that Resident #86 is prescribed Seroquel (antipsychotic) 50 MG, 1 tablet by mouth at bedtime related to Schizophrenia. A second order dated 05/19/25 revealed that Resident #86 is prescribed Trazodone (antidepressant) 50 MG, 1 tablet by mouth at bedtime for depression related to major depressive disorder.</p> <p>During an interview on 05/28/25 at 8:21 AM, when asked what is your process for making sure the PASRR are filled out accurately, the Social Worker stated Unfortunately a lot of the residents are coming in without the PASRR filled out properly, so I'm having the psychiatrist to evaluate them and then I redo the PASRR after they are seen. I am trying to catch up. I know a lot of them are triggering for needing a PASRR Level 2. When asked if she was aware of Resident #86, the Social Worker stated, I will go and review hers right now.</p> <p>2). Record review revealed Resident #91 was admitted to the facility on [DATE]. The quarterly assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 03 on a 0 to 15 scale indicating severe cognitive impairment. Review of Resident #91 medical diagnosis indicated that she had a history of bipolar (episodes of mood swings) disorder, dementia (impairment of mental function that affect daily function) with other behavioral disturbance, anxiety (excessive worry).</p> <p>Further record review revealed a PASRR Level 1 dated, 10/11/24 for Resident #91 that was not accurately filled out. The document failed to indicate the resident's mental illness diagnosis but indicated that dementia was the resident's primary diagnosis.</p> <p>Review of the care plan dated 3/5/25 for Resident #91 documented that the resident had self-care performance deficit related to confusion, psychosis and required assistance with activities of daily living with a goal that the resident will maintain current level of function in activities of daily living through the review date.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/28/25 at 8:21 AM, when asked what is your process for making sure the PASRR are filled out accurately, the Social Worker stated Unfortunately a lot of the residents are coming in without the PASRR filled out properly, so I'm having the psychiatrist to evaluate them and then I redo the PASRR after they are seen. I am trying to catch up. I know a lot of them are triggering for needing a PASRR Level 2. When asked if she was aware of Resident #91, the Social Worker stated, I will go and review hers right now.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the medications were timely administered for 2 of 6 residents observed for medication passes (Resident #80 and Resident#409). The facility also failed to follow the physician ordered and prescribed medications for 3 of 38 sampled residents (Resident # 41, Resident #8, and Resident #68).</p> <p>The Findings included:</p> <p>A review of facility's policy titled, General Dose Preparation and Medication Administration, with a recent revision date of 11/15/24, it was revealed the following: to administer the medication within timeframes specified by facility policy or manufacturer's information (proc. 5.4; pg. 97); prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including confirming that the Medication Administration Record (MAR) reflects the most recent medication order (proc. 3- 3.4; pg. 97).</p> <p>1). Resident #80 was admitted on [DATE] with diagnoses that included Paroxysmal Atrial Fibrillation, Essential Primary Hypertension, Aphasia following Cerebral Infarction, and Hemiplegia/ Hemiparesis following Cerebral Infarction.</p> <p>A review of admission Minimum Data Set (MDS) under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 5 indicating Resident #80 had severely impaired mental cognition.</p> <p>During a medication pass observation on 05/29/25 at 11:42 AM, with Staff B, a Licensed Practical Nurse (LPN), she stated that she is going to administer the 9:00 AM medication for the resident.</p> <p>She prepared the following medications: Aspirin 81 milligrams (mg), 1 tablet, with an expiration date of 11/26; Atorvastatin 80 mg tablet, 1 tablet, 1time a day, with an expiration date of 02/28/26; Carvedilol 12.5 mg, 1 tablet, 2 times a day, with an expiration date of 12/25; Lisinopril 40 mg, 1 tablet, 1 time a day with an expiration date of 12/31/25; and Zolof 25 mg, 1 tablet, 1 time a day with an expiration date of 05/10/26. All these medications were administered after 12:00 PM.</p> <p>A review of Resident #80's MAR revealed all the above medications were administered at 9:00 AM.</p> <p>In an interview with Staff B, LPN, when she was asked what the documented administration time of the above medications for Resident #80 was, she responded, 9:00 AM. When asked why she did not document the accurate time of after 12:00 PM, she responded, I do not know how.</p> <p>2). Resident #409 was admitted on [DATE] with diagnoses including Absence of Epileptic Syndrome Intractable without Status Epilepticus, Metabolic Encephalopathy, Hyperlipoidemia and Obstructive and Reflux Uropathy.</p> <p>A review of the admission Minimum Data Set (MDS) under Section C revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating Resident #409 had good mental cognition.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a medication pass observation using Flamingo Medication cart 1 with Staff E, a Registered Nurse (RN) on 05/28/25 10:45 AM, it was observed that her computer screen produced a pink color on the 9:00 AM medications for Resident #409. When Staff E , an RN was asked what the pink color meant, she responded, I am administering the medications later than the scheduled time. She added that medications must be administered one hour before and one hour after the scheduled time. She added, I think it is still ok.</p> <p>She administered the following medications: Cefuroxime 250 milligrams (mg), 1 tablet, 2 x a day with an expiration date of 04/08/26. This medication was taken by Resident #409 at 11:08 AM; Sertraline 25 mg, 1 tablet, once a day, with an expiration date of 04/30/26. This medication was taken by Resident #409 at 11:05 AM; Keppra 750 mg, 2 tablets by mouth, 1 time day, with an expiration date of 02/31/25. This medication was administered at 11:02 AM.</p> <p>A review of Resident #409's Medication Administration Record (MAR), it was revealed the above medications were documented administered at 9:00 AM, with check marks and 3 letter initials .</p> <p>2)The findings included:</p> <p>Review of the record revealed Resident #8 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the resident had a Brief Interview Mental Status (BIMS) score of 13 on a 0 to 15 scale, indicating no cognitive impairment.</p> <p>During an Interview on 05/27/25 at 11:11 AM, with Resident #8, in his room, two tubes of cream in a zip lock bag were sitting on the bedside table. One of the tubes was dated as prescribed on 12/19/24 and the other tube, that had never been opened, was dated 4/24. When asked if the cream was being applied by the nurses the resident stated No. When asked are you capable of applying the ointment yourself, the resident stated No. When asked do you have a fungus on your feet, the resident stated Yes. (photographic evidence obtained)</p> <p>Record review revealed an order for Resident #8 dated 12/19/24, that instructed the staff to apply Ciclopirox Olamine External Cream 0.77 % (antifungal cream) to the bottom of both feet two times a day for fungus.</p> <p>Review of the Medication Administration Record for the month of May revealed that the staff had documented on record indicating that the treatment had been provided to Resident # 8. (photographic evidence obtained)</p> <p>During an interview on 05/28/25 at 11:34 AM, when asked was the cream applied to your feet today, the resident stated No. When asked has anyone on any shift asked you if you wanted the cream on your feet the resident stated No. There were 2 tubes on cream in a zip lock bag observed on Resident #8's bedside table. (photographic evidence obtained)</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/25 at 1:06 PM, the Unit Manager was taken to Resident #8's room and two tubes of cream in a zip lock bag were observed sitting on the bedside table. When asked where the medication should be stored the Unit Manager stated, It should be on the medication cart. At this time, the Unit Manger was made aware that the cream had been observed on Resident #8's bedside table since 05/27/25 and the unit manager was told that the resident said that he had not been receiving the medication. At this time, the Unit Manager took the zip lock bag with the cream out of the resident's room.</p> <p>3)The findings included:</p> <p>Record review revealed that Resident #41 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15 on 0 to 15 scale, indicating no cognitive impairment.</p> <p>During an interview 05/27/25 @ 11:28 AM, Resident # 41 stated I can't sit on my bottom because it hurts. When asked have you talked to the wound doctor regarding your wound, the resident stated Yes, but she says I'm diabetic and it will take time to heal. The doctor says it's not open anymore and the ridges on my buttocks will be there. I have a cream they put on the wound. When asked how often the cream is applied, the resident stated, Every time I get changed.</p> <p>Review of the care plan dated 05/07/2025 indicated that Resident #41 has impaired skin related to decreased bed mobility, obesity (overweight), diabetes (increase in blood sugar), Hemiplegia (paralyzed limbs), incontinence and generalized weakness. The areas: the left ischium (hip) shear, right ischium shear, left buttock shear, and right buttock shear, with a goal that the resident will have intact skin, free of redness, blisters or discoloration provided that the staff administer medications as ordered, observe and document side effects and effectiveness of medication, administer treatments as ordered and observe for effectiveness.</p> <p>During an interview on 05/28/25 at 10:25 AM, Staff O, (Certified Nursing Assistant (CNA) observed providing incontinent care for Resident #41. The skin on both buttocks and ischium area was observed to have ridges, excoriation and redness. When asked do you notice any drainage from the wounds on her buttock, Staff O, CNA stated No. There was some white cream observed in a plastic drinking cup with a tongue compressor sitting inside of it. When asked are you applying this cream on Resident # 41 buttocks Staff O, (CNA) stated, Yes.</p> <p>Review of an order dated 3/17/25 for Resident #41 instructed licensed nurse to cleanse left buttock shear and right ischium shear with wound cleanser, pat dry, apply Silver Sulfadiazine (antibiotic cream to treat and prevent wound infection in burns wounds) and leave open to air every day and evening shift for lesion/shear.</p> <p>During an interview on 05/28/25 at 11:52 PM, when asked are you familiar with Resident #41's wounds on her buttocks area, the Wound Care Nurse stated, Yes, but it's not a wound anymore because there's no depth. The resident was recently discharged from the wound care doctor seeing for her. Now, there is an order to apply Silvadene cream to the resident's buttocks area. When asked how often the cream is supposed to be applied, the Wound Care Nurse stated, I will have to look. It's twice a day. When asked who normally applied the cream, the Wound care nurse stated, I apply it in the daytime and on the other shift the evening nurse is to apply the cream.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/28/25 at 4:06 PM, when asked if she provided the wound care treatment for Resident #41, the Wound Care Nurse stated, I went to put the cream on the resident, but Staff N, Licensed Practical Nurse (LPN) said that she had just applied the cream 10 minutes prior after she cleaned the resident.</p> <p>Record review on 05/29/25 at 2:22 PM, revealed that the silver sulfadiazine cream was discontinued by the wound care nurse and a new order written dated 05/28/27 for zinc oxide.</p> <p>During an interview on 05/29/25 at 3:12 PM, when asked why the silver sulfadiazine cream was discontinued for Resident #41, the Wound Care Nurse stated, after having the conversation with you I decided to call the nurse practitioner in regard to changing the treatment since we have been using the silver sulfadiazine cream on Resident #41 for a long period of time. Also, the wound care doctor will evaluate her again on next Monday</p> <p>4)The findings included:</p> <p>Record review revealed Resident #68 was admitted on to the facility on [DATE]. The quarterly comprehensive 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 no cognitive impairment.</p> <p>During an interview on 05/27/25 at 10:42 AM, in Resident #68's room, a tube of ointment with a prescribed date of 12/19/24 was observed on the bedside table. When asked what the ointment was for, the resident stated It's for my feet. The nurse put it there and I put it on myself. This is the second tube I've had. When asked do you have a fungus on your feet, Resident #68 stated Yes, I put on gloves when I put it on my feet. When asked do the nurses ever applied the ointment, the resident stated No, I can do it myself. (photographic evidence obtained)</p> <p>Further review of the record revealed an for Resident #68, dated 12/19/24, that instructed the staff to apply Ciclopirox Olamine External Cream 0.77 % (antifungal cream) to the bottom of both feet every shift.</p> <p>Review of the Treatment Administration Record (TAR), on 05/27/29, for the month of May revealed that the staff had documented that the antifungal cream was administered for Resident #8 on every shift. (photographic evidence obtained)</p> <p>During review of the TAR, on 05/29/25 at 12:15 PM, Staff M, Registered Nurse (RN) had signed the record acknowledging that she administered the cream for Resident #68.</p> <p>During an interview on 05/29/25 at 12:19 PM, when asked what cream you applied for Resident #68's feet, Staff M, RN, went to the treatment cart to find the cream but was having difficulty finding the cream. After a couple of minutes of allowing Staff M, RN to look for the cream, the cream was pointed out to her. The cream was in a box which was dated as ordered on 05/27/25.</p> <p>During a brief interview on 05/29/25 at 12:23 PM, when asked if the nurse applied the cream to his feet, Resident # 68 stated No, not today. I do not want it today.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/25 at 1:07 PM, The Unit Manager was made aware of Resident #68 stating that he did not receive or want the antifungal cream on his feet today, but Staff M, RN documented and acknowledged during conversation that she administered the cream for Resident #68.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to follow their Safe Smoking policy to reassessa resident quarterly and after a change in condition and failed to update the smoking care plan for 1 of 1 resident reviewed for smoking (Resident #72).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Safe Smoking with a revised date of 01/11/19 included in part the following: Screening - A safe smoking screen is performed on admission for a resident who wishes to smoke. Reassessment of the resident occurs annually and/or after a significant change in condition.</p> <p>Record review for Resident #72 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part Generalized Anxiety Disorder. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response.</p> <p>Review of the MDS for Resident #72 revealed Significant Change dated 08/22/24.</p> <p>The Care Plan for Resident #72 dated 09/19/23 with a focus on the resident is a smoker and is noncompliant with facility's smoking policy. The goal was for the resident to safely smoke at designated times , in designated areas with supervision of staff and have no smoking injuries or incidents x90 days. The interventions included in part the following: Smoking assessment to be completed on admission, quarterly and with any significant change in condition. Smoking will be supervised by staff members.</p> <p>Review of the Smoking Assessments for Resident #72 revealed the following:</p> <p>A Smoking assessment dated [DATE] documented May smoke but must be supervised by staff volunteer or family? answered Yes.</p> <p>A Smoking assessment dated [DATE] documented May smoke but must be supervised by staff volunteer or family? answered No.</p> <p>In summary there was no smoking reassessment performed after the resident had a significant change in condition on 08/22/24 and the facility failed to perform smoking assessment quarterly as documented in the intervention of the resident's care plan with a focus on smoking.</p> <p>On 05/27/25 at 4:30 PM an observation was made of Resident #72 smoking on the smoking patio. Staff member seen through the window observing/monitoring the residents who were on the smoking patio.</p> <p>During an interview conducted on 05/27/25 at 4:32 PM with Resident #72 who was asked if she has always smoked while at the facility, she said yes. The resident said the staff hold her cigarettes and lighter and they provide them to her when she comes to the smoking patio. The resident stated she comes several times a day to smoke on the patio.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 05/29/25 at 10:30 AM with the Director of Nursing (DON) who was asked when smoking assessments are completed and by whom, the DON stated they are done by nursing on admission and then quarterly if the resident is a smoker. When asked about Resident #72, the DON acknowledged the resident was admitted to the facility on [DATE] and had only 2 smoking assessments (09/14/23 and 12/12/24). The DON stated the smoking assessment should have been done in March of 2025 and was overdue.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, policy review, and review of professional standards of practice, the facility failed to maintain acceptable parameters of nutrition status for 1 of 4 residents investigated for nutrition (Resident #307).</p> <p>The findings included:</p> <p>A review of the facility's policy on Weight Management last revised on 03/02/19 stated that residents were to be weighed on a monthly basis unless otherwise ordered by the physician or deemed necessary by the dietitian and or the interdisciplinary team.</p> <p>Current professional standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss.</p> <p>A review of the policy on modified consistency diets provided by the Dietary Manager (DM) described the mechanical soft diet as a diet used for patients/residents with limited chewing ability. The foods included on the mechanical soft diet included ground moist meats, poultry and fish (without bones), canned fruits and vegetables, well-cooked soft vegetables, finely chopped fresh fruits and vegetables as tolerated, soft breads, and desserts. The pureed diet consisted of pureed, homogenous, and cohesive foods. Foods were described as pudding like, with no coarse textured foods allowed.</p> <p>A review of the medical records for Resident #307 revealed that he was admitted to the facility on [DATE]. His diagnoses included Malignant Neoplasm of Larynx, Unspecified Protein-Calorie Malnutrition, and Muscle Wasting. A wound assessment performed on 05/12/25 documented that Resident #307 had a stage 4 pressure ulcer to his coccyx. A review of the Minimum Data Set (MDS) admission assessment dated [DATE] revealed that Resident #307 had a Brief Interview for Mental Status score of 12. This indicated that he was cognitively intact.</p> <p>During an initial resident screening interview on 05/27/25 at 12:43 PM, Resident #307 expressed his concern about weight loss. He said he used to weigh 180 pounds and now he weighed close to 130 lbs. The resident was wearing a hospital gown while lying down in bed. Severe muscle wasting to his clavicles was observed. Resident #307 ate the dessert and drank the 4 ounce carton of Mighty shake, which accompanied his lunch meal. He didn't eat any of the food on the meal plate which contained sweet potato, green beans, pureed chicken/gravy. He didn't eat the peanut butter and jelly sandwich that was served on the side. The resident said he didn't want the peanut butter and jelly (PB&J) sandwich because he was tired of it. He said they sent a PB&J sandwich to him three times a day. Resident #307 said that he asked for a tuna fish sandwich once since he was admitted and he never received it.</p> <p>A record review revealed that Resident #307's diet order since 05/08/25 was a diet with No Added Salt, Mechanical Soft (L3), Pureed Meat (L1) texture, with Thin consistency Fluids. The diet order included directions to provide a soft sandwich with lunch/dinner meals, and whole milk with all meals.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of the dinner meal on 05/28/25 at approximately 5:30 PM, the resident's tray of food included a PB&J sandwich on the side. The tray of food rested on the tray table next to the resident's bed. Resident #307 was asleep. During an observation of Resident 307's breakfast meal on 05/29/25 at 8:47 AM, the surveyor saw that the resident did not eat any of the foods from his breakfast tray. The breakfast foods served to Resident #307 did not comply with the mechanical soft diet with pureed meat. The kitchen sent 1 slice of well-done toast with a piece of cheese on it, 1 slice of well-done toast with scrambled eggs, and ground ham. The crust of the toast was cooked to a brown/black color. Photographic evidence obtained. The bread was not soft as described in the policy for the mechanical soft diet, and the ham should have been pureed, not ground. Resident #307 was on a diet with pureed meat. He was served 2% reduced fat milk instead of the whole milk specified to be served with all meals per Resident #307's diet order. The PB&J sandwich from the night before remained on the resident's tray table. The sandwich had a small insect flying in between the sandwich and the plastic wrap that covered it. The sandwich was dated 05/28/25. Photographic evidence obtained. Resident #307 placed the wrapped sandwich under the plastic dome covering his breakfast and he said he didn't want anything.</p> <p>The surveyor offered to let the kitchen know that he didn't eat his breakfast, and that he would appreciate a soft sandwich. Resident #307 was receptive. The surveyor went to the kitchen and requested a tuna sandwich from the cook. The cook said that there was no tuna available at that time, and that he had some ready-made sandwiches available in the refrigerator. He offered PB&J or turkey/cheese sandwiches. The surveyor requested a turkey /cheese sandwich to be delivered to the resident. The Regional Certified Dietary Manager delivered 2 turkey and cheese sandwiches to Resident #307, and per the resident, he ate 1 sandwich.</p> <p>An observation of the lunch meal on 05/29/25 at 12:57 PM revealed that Resident #307 received a PB&J sandwich with his meal, and then he threw the PB&J out into the garbage. Photographic evidence obtained.</p> <p>During an interview on 05/30/25 at 7:06 AM, the Dietary Manager and the Regional Certified Dietary Manager were shown a photo of the breakfast meal with the identifying meal ticket on the tray that was served to Resident #307 on Thursday, 05/29/25. They agreed that the resident was served ground meat instead of the required pureed meat as specified in his diet order.</p> <p>A record review of Resident #307's medical records revealed that his weight on 05/09/25 was 126.2 lbs. There were no other recorded weights for Resident #307 at the start of the survey. Resident #307's Body Mass Index (BMI) was 15.8. This indicated that he was severely underweight. On 05/29/25 the surveyor requested a current weight for Resident #307. The surveyor observed the nurse zero the scale. Then she assisted Resident #307 to stand-up on the platform scale. On 05/29/25 at 3:44 PM, his weight was 118.4 lbs. His weight decreased 7.8 lbs (6.1%) in 20 days. This weight loss was significant.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #307's Nutrition comprehensive risk screen revealed that it was initiated on 05/13/25, and it was signed (locked) on 05/27/25. Concerns noted in the assessment included the diagnosis Severe Protein-Calorie Malnutrition, the resident appeared cachectic, he was on a mechanical soft diet with puree meat, and he had 4 skin wounds. The assessment included a list of skin impairments: a Coccyx stage 4 wound, a left buttock deep tissue injury, a right buttock stage 4 wound, and a right heel deep tissue injury. A high calorie supplement was recommended and initiated on 05/09/25 to provide additional nutrition support. A protein supplement was recommended and initiated on 05/13/25. The Nutrition assessment included a plan to monitor weights weekly for four weeks.</p> <p>During an interview with the Diet Tech Registered (DTR), when asked how many days to do the nutrition assessment, she said that the assessment was input within 5 days of the resident's admission, and she believed it needed to be completed within 7 days. The assessment was signed 19 days after Resident #307 was admitted . The DTR said that the assessments that she wrote were in collaboration with the RD. The nutrition assessment summary note included the signature of the RD with a note that the documentation was reviewed and approved; and that the RD will continue to collaborate on resident care with the DTR. When the DTR was asked how she decided who should be weighed weekly for 4 weeks, the DTR said that it was our plan for this resident based on his plan of care. The DTR and the surveyor searched Resident #307's medical records for a nutrition care plan and there was no care plan in place for nutrition. The surveyor asked the DTR why the Resident was not weighed weekly, and she said she didn't know and that she will have to look into that. The DTR recommended increases in the high calorie supplement and the protein supplement on 05/30/25 following her review of Resident's weight loss since admission. Interventions for weight loss could have been made sooner if the resident was weighed weekly for four weeks post admission as per recommended professional standards of practice, and per the recommendation of the DTR and RD in the Nutrition Risk assessment.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, policy review, and review of professional standards of practice, the facility failed to provide the appropriate treatment for enteral feeding to decrease the risk of complications including weight loss and dehydration, for 1 of 7 sampled residents on enteral feeding (Resident #92).</p> <p>The findings included:</p> <p>The facility's policies and procedure for Nutrition/Hydration Status Maintenance revised on 03/02/19 stated that a resident who is fed by enteral means must receive the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>A review of current professional standards of practice to promote the safe provision of enteral feeding recommends that the components of the feeding be included in the doctor's order. These include the following: the kind of feeding and its caloric value, the volume of the formula, the mechanism of administration (e.g., gravity or pump), and the volume and frequency of water flushes. Nurse driven enteral nutrition protocols for volume-based feedings are recommended. The reference for these protocols is the American Society for Parenteral and Enteral Nutrition (ASPEN) 2016: ASPEN Safe Practices for Enteral Nutrition Therapy.</p> <p>Current professional standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss. These standards of practice were summarized from the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities.</p> <p>A record review of Resident #92's medical record revealed that he was admitted to the facility on [DATE]. He was hospitalized on [DATE] and then readmitted to the facility on [DATE]. Resident #92's diagnoses included: Dysphagia following Cerebral Infarction, Dysphagia Oropharyngeal Phase, Gastrostomy Status, Muscle Wasting and Atrophy. Resident #92 was dependent on enteral feeding to provide adequate nutrition, and there was a doctor's order to provide nothing by mouth. This resident's Brief Interview for Mental Status (BIMS) score, per Minimum Data Set (MDS) assessment dated [DATE] was 10. This indicated that Resident #92 had cognitive impairment.</p> <p>A record review of Resident #92's weights revealed that his admission weight on 03/12/25 was 129 lbs. His Body Mass Index, (BMI) was 18.5 which indicated he was underweight for his age. The Nutrition admission assessment dated [DATE] noted that Resident #92 appeared cachectic. On 04/04/25, his weight was 118 lbs. There were no weekly weights recorded following his admission. Resident #92's weight decreased 11 pounds in 23 days. On 05/19/25 Resident #92's weight was 114 lbs. His BMI was 16.4. This indicated that he was severely underweight.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of a dietary progress note written on 05/27/25 said Resident #92's weight loss 11.6% since admission, was likely related to recent hospitalization. The resident was hospitalized on [DATE] when he weighed 111.6 lbs (04/21/25). His weight decreased 17.4 pounds, 13.4% prior to being sent out to the hospital.</p> <p>A record review of Resident #92's enteral feeding orders dated 05/01/25 were: two times a day Jevity 1.5 or Isosource 1.5 80ml/hr x20 hours via G-tube. On 2pm, off 10am. A review of the enteral feeding order revealed that the total amount of the formula of Isosouce 1.5 to be administered daily was not included in the order. In addition, a 20-hour feeding every day could not be administered two times per day.</p> <p>An observation of the Kangaroo Omni pump, that was used to administer the enteral feeding formula for Resident #92 on 05/29/25 at 5:30 PM, revealed that the pump was active. The rate of administration of the Isosource 1.5 formula was 80 milliliters per hour. This agreed with the doctor's order. The display on the monitor showed that 272 milliliters was administered since the 2:00 PM start of the feeding. Photographic evidence showed the 1000 ml bag of Isosource and the monitor. The plastic bag of Isosource was dated 05/29/25 with a black marker. Since the doctor's order was for 80 milliliters to be administered for 20 hours, the total volume of the Isosource formula to be administered was 1600 milliliters (per day). At approximately 2:30 AM, the 1000 milliliters bag of formula should have been used up, except for time off for activities of daily living, and second bag of formula was needed to complete the balance of 600 milliliters to complete the volume of the feeding.</p> <p>An observation of the Kangaroo Omni pump, that was used to administer the enteral feeding formula for Resident #92 on 05/30/25 at 8:25 AM revealed that the pump was inactive. Observation of the 1000 ml bag of Isosource 1.5 revealed that approximately 150 milliliters was administered since the start of the feeding. Photographic evidence shows the bag of Isosource was dated 05/30/25, and approximately 850 milliliters of formula remained in the bag.</p> <p>An observation of the Kangaroo Omni pump, that was used to administer the enteral feeding formula for Resident #92 on 05/30/25 at 9:04 AM, revealed that the pump was inactive. An observation of the Kangaroo Omni pump, that was used to administer the enteral feeding formula for Resident #92 on 05/30/25 at 9:48 AM, revealed that the pump was inactive. Observation of the 1000 ml bag of Isosource 1.5 revealed that approximately 150 milliliters was administered since the start of the second bag (dated 05/30/25) needed to complete the desired volume of the feeding. Photographic evidence shows the bag of Isosource had approximately 850 milliliters of formula in the bag. A complete feeding of 1600 milliliters from 2 bags of 1000 milliliters each, would have left 600 milliliters remaining, not 850 milliliters. During this feeding, the resident received 250 milliliters less Isosource 1.5 than the order specified (80 milliliters for 20 hours).</p> <p>A record review of Resident #92's medical record progress notes revealed no notes explaining the reason for the inactive pump from 8:25 AM through 10:00 AM. The scheduled time of administration was to administer the formula from 2:00 PM until 10:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Staff D, on 05/30/25 at 10:05 AM, the surveyor requested that she view the enteral feeding pump for Resident #92. The surveyor made the nurse aware that the pump was observed inactive since 8:25 AM. When the nurse was asked how she managed the resident's enteral feedings, she answered that they follow a schedule. When asked how she knew if he received enough formula, the nurse answered that they weigh him monthly. When asked how much Isosource 1.5 formula he required daily, she said she needs to see the order. The surveyor and the nurse went to the cart and the nurse said that the order was for 80 milliliters per hour times the time of feeding. The surveyor asked the nurse to calculate the amount of each feeding, and the nurse calculated 1600 milliliters per day. The volume of the Isosource 1.5 formula to be administered daily was not included in the order.</p> <p>The surveyor and the nurse went back into Resident #92's room. The surveyor pointed to the bag of formula that showed approximately 150 milliliters of formula was administered. The nurse agreed with this finding. The surveyor asked the nurse if she could look at the history of administration on the pump's display monitor to see how much formula was administered. The nurse was unaware that this was a function of the pump. The surveyor explained how to view the history for the past 3 days, and Staff D pressed the history button and entered 3 days. The display monitor revealed that Resident #92 received 2938 milliliters in the past 3 days. At 10:00 AM, with 1600 milliliters ordered per day, Resident #92 should have received 4800 milliliters; 2938 milliliters was 61.2% of the amount of formula that was prescribed. The facility administered less nutrition than was ordered. This put Resident #92 at an increased risk for complications related to enteral feeding such as weight loss and dehydration.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide tracheostomy care and services consistent with the professional standards of practice for 1 of 1 sampled for tracheostomy care (Resident #64); failed to obtain oxygen orders for 2 of 6 residents (Resident #408, and Resident #308); and failed to follow orders for oxygen therapies for 3 of 11 residents receiving oxygen (Resident #7, Resident #23, and Resident #66).</p> <p>The Findings included:</p> <p>A review of facility's policy titled, Policies and Procedures: Respiratory/Tracheostomy Care and Suctioning, with a revision date of 03/26/21, revealed the following: the facility will ensure that residents who need respiratory care including tracheostomy care, and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences; the facility, in collaboration with the attending practitioner, must perform a comprehensive assessment of the respiratory needs: and based upon the resident assessment, attending physician orders, and professional standards of practice, the facility in collaboration with the resident/resident's representative will develop a care plan that includes appropriate interventions for respiratory care.</p> <p>1). Resident # 64 was admitted on [DATE] with diagnoses that included Non-traumatic Subarachnoid Hemorrhage from Unspecified Intracranial Artery, Encephalopathy, Type 2 Diabetes Mellitus with Hyperglycemia, and Respiratory Failure.</p> <p>A review of the current Minimum Data Set (MDS) dated [DATE] revealed Section C was not completed due to severely impaired cognition.</p> <p>A record review of physician orders dated 01/03/25 revealed to provide tracheostomy care every day and as needed. Change tracheostomy tie daily and as needed, every evening and night shift for tracheostomy care.</p> <p>During an observation on 05/28/25 at 9:14 AM, 2 pink saline containers were at bedside table together with an open tracheostomy care kit. There was no tracheostomy obturator observed.</p> <p>During another observation on 05/28/25 at 12:07 PM, there was no tracheostomy obturator observed at bedside of Resident #64.</p> <p>During another observation on 05/29/25 at 2:47 PM, there was no tracheostomy obturator observed at Resident #64's bedside.</p> <p>During a tracheostomy care observation with the Assistant Director of Nursing (ADON) and Staff F, Licensed Practical Nurse (LPN), who were both asked about the inner cannula or tracheostomy obturator, both stated that they keep a box of extra tracheostomy tubes at bedside because the Respiratory Therapist used to change the tracheostomy tubes every day when needed. When they were asked if changing the tracheostomy tube is included in facility's tracheostomy care policy, the ADON responded, I will provide you a copy. They both did not show where the obturator is kept for Resident # 64.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2). Resident #408 was admitted on [DATE] with diagnoses that included Surgery of the Circulatory System, Presence of Cardiac Pacemaker, Hypertensive Heart Disease with Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>A review of Minimum Data Set (MDS) revealed it was not completed due to recent facility admission.</p> <p>During an observation on 05/27/25 at 2:00 PM, there was no oxygen signage on Resident #408's door. During the following days until the last day of the survey, oxygen signage was not observed on Resident #408's door.</p> <p>During an observation on 05/27/25 at 2:30 PM, Resident #408 was observed with a oxygen concentrator at bedside infusing through resident's nasal cannulae at 3 Liters (L) per minute (min). An additional observation on 05/28/25 at 12:13 PM revealed Resident #408 was wearing nasal cannulae on both nares infusing at 3 L/min. There was also an oxygen tank on a standing cart next to the door.</p> <p>A review of physician orders dated 05/27/25 and 05/28/25 revealed no oxygen orders for Resident #408.</p> <p>In an interview with Staff E, Registered Nurse (RN), on 05/28/25 at 9:10 AM, when asked if Resident #64 is receiving oxygen, she responded, Yes</p> <p>A record review of physician orders revealed an order for oxygen, continuous at 3 L/min via nasal cannula, every shift related to COPD. It was dated 05/29/25 at 11:00 PM</p> <p>3) Resident #308 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure with Hypoxia, and Cardiac Pacemaker. This resident's Brief Interview for Mental Status (BIMS) score, assessed on 05/28/25 was 14. This indicated that Resident #308 was cognitively intact. His care plan for COPD dated 05/27/25 included an intervention that listed oxygen settings per MD order.</p> <p>During an observation on 05/27/25 at 5:22 PM, Resident #308 was sitting in a wheelchair in his room and a nasal cannula was situated to deliver oxygen into his nose. The oxygen concentrator was set at 4 liters per minute. There was no order for oxygen in the electronic medical records. During an observation on 05/28/25 at 5:24 PM, the resident was in his room and receiving oxygen at 4 liters per minute.</p> <p>On 05/29/25 at 11:55 AM, Resident #308 was sitting in the wheelchair in his room. He was receiving oxygen from the concentrator which was set at 3.5 liters per minute.</p> <p>During an interview with Staff G on 05/29/25 at 4:20 PM, the surveyor requested that the nurse to look for an oxygen order for Resident #308 and she didn't see an order. The surveyor and Staff G went to Resident #308's room. On 05/29/25 at 4:38 PM, the surveyor and Staff G observed that the resident received oxygen at 3.5 liters per minute. Staff G agreed with this finding. Staff G was asked if it's important to have an order for oxygen, and she responded, yes. Staff G said that the doctor's order is necessary to know what the resident needs. Staff G called the doctor to follow up accordingly. Photographic evidence obtained.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4). A record review revealed that Resident #23 was admitted to the facility on [DATE]. Her diagnoses included CVA, Tracheostomy status, Dementia, Aphasia, and Acute and Chronic Respiratory Failure. A significant change assessment dated [DATE] showed that Resident #23 had severe cognitive impairment. Her care plan for tracheostomy related to impaired breathing mechanics included an intervention to provide oxygen per MD orders. The doctor's order for oxygen dated 01/20/25 stated oxygen 28%/2 liters via trach collar.</p> <p>During observations on 05/28/25 at 10:55 AM, 05/28/25 at 5:35 PM, and 05/29/25 at 9:35 AM, Resident #23 was in bed receiving oxygen from the concentrator that was set on 4 liters per minute.</p> <p>During an interview with Staff G on 05/29/25 at approximately 4:45 PM, the surveyor and Staff G went to Resident #23's room. The surveyor and the nurse observed the oxygen concentrator, and it was set on zero. Staff G acknowledged observation. The nurse left the room to get another concentrator, and she returned quickly with another oxygen concentrator. The nurse set the replacement concentrator on 2 liters per minute, per the doctor's order. Photographic evidence obtained.</p> <p>5). A record review revealed that Resident #66 was admitted to the facility on [DATE]. His diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Tracheostomy Status. Per the Minimum Data Set (MDS) significant change assessment dated [DATE], the resident rarely understood and was rarely understood. He had memory problems.</p> <p>Resident #66's had a care plan dated 05/10/23, which focused on his tracheostomy that was related to impaired breathing mechanics, surgery, and respiratory failure. The intervention listed was to administer respiratory treatments as ordered.</p> <p>A record review of the doctor's order for oxygen for Resident #66 was dated 01/20/25. It stated: for Trach - Encourage and assist resident with use of humidified oxygen 28%/2 liters via trach collar every shift for Trach O2 (oxygen).</p> <p>An observation during the initial resident screening, on 05/27/25 at 5:52 PM, revealed Resident #66 lying down in his bed. He received oxygen via the trach collar, and the oxygen concentrator was set on 3 liters per minute. Observations on 05/28/25 at 5:32 PM, and on 05/29/25 at 9:30 AM revealed the oxygen concentrator was set on 3 liters per minute.</p> <p>During an interview with Staff G on 05/29/25 at approximately 4:36 PM, the surveyor and Staff G went to Resident #66's room. The surveyor and the nurse observed the oxygen concentrator, and it was set on 3 liters per minute. Staff G agreed with this finding, and she corrected the oxygen setting to follow the doctor's order to be set at 2 liters per minute. Photographic evidence obtained.</p> <p>6). A record review revealed that Resident #7 was admitted to the facility on [DATE], and he was readmitted to the facility on [DATE]. His diagnoses included Malignant Neoplasm of the Colon, Morbid (Severe) Obesity, Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, (COPD) and Pleural Effusion. This resident's Brief Interview for Mental Status (BIMS) score, per the Minimum Data Set (MDS) assessment dated [DATE] was 14. This indicated that Resident #7 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #7's care plan for COPD last revised on 11/06/23 listed the intervention for oxygen settings to be administered per MD order. The Doctor's order per the electronic medical record was dated 01/08/2025. It said to administer oxygen continuous at 4 liters per minute via nasal canula for the medical diagnosis of shortness of breath.</p> <p>During observations on 05/28/25 at 10:11 AM, 05/28/25 at 6:32 PM, and on 05/29/25 at 9:47 AM Resident #7 was in bed while he received oxygen via nasal canula. The oxygen concentrator was set on 7 milliliters per minute. On 05/29/25 at 9:58 AM, Resident #7 requested that Staff B fill the water bottle that provided humidification via oxygen concentrator. A few minutes later, Staff B and the ADON entered the room and they explained the process while they added water into the bottle. On 05/29/25 at 11:41 AM, the oxygen concentrator was set to 7 liters per minute. The nurses who added water to the bottle on the oxygen concentrator failed to change the oxygen setting to 4 liters as per the Doctor's order.</p> <p>During an interview with Staff G on 05/29/25 at 4:52 PM, the surveyor and Staff G went to Resident #7's room. The surveyor and Staff G observed that the resident received oxygen at 7 liters per minute. Staff G agreed with this finding. The surveyor asked Resident #7 if he changed the setting on the oxygen concentrator and he responded that he never adjusted the setting for the oxygen. When the nurse approached the concentrator to lower the volume of the oxygen administered to 4 liters per milliliter as per the Doctor's order, Resident #7 adamantly protested. Resident #7 explained that it's been that high for a very long time. He said he needed it that high because without it that high he feared he would get pneumonia. He told the nurse to leave it at 7 milliliters per minute. Staff G said she would speak to the Doctor. Photographic evidence obtained.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to maintain completed dialysis communication records for 1 of 1 resident sampled for dialysis (Resident #90).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Dialysis with a revised date of 03/02/19 included in part the following: Nurses will educate the resident and/or family/resident representative on risks of non-compliance and document in the resident's clinical record as needed. The facility and the dialysis center should maintain regular communication and should a change in condition occur before or during dialysis treatment the sending facility should communicate the changes in needs to the receiving facility.</p> <p>Record review for Resident #90 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: End Stage Renal Disease, and Dependence on Renal Dialysis. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 13 indicating a cognitive response.</p> <p>Review of the Dialysis Communication Sheets (DCS) for Resident #90 from 05/07/25 to 05/23/25 documented in part the following:</p> <p>The DCS dated 05/07/25 was incomplete.</p> <p>The DCS dated 05/14/25 did not have the resident or the dialysis center name.</p> <p>The DCS dated 05/21/25 was incomplete</p> <p>The DCS with no date no resident or the dialysis center name. was incomplete</p> <p>Review of the progress notes for Resident #90 from 05/07/25 to 05/23/25 documented in part the following:</p> <p>There was no note dated 05/07/25</p> <p>There was no note dated 05/14/25</p> <p>There was no note dated 05/21/25</p> <p>Review of the Physician's Orders for Resident #90 revealed an order dated 02/04/24 for Resident is a dialysis patient with a MWF schedule resident chair time is 1pm and is to report for dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan for Resident #90 dated 02/11/25 with a focus on the resident needs hemodialysis related to renal failure Monday, Wednesday, Friday 1:00 PM chair time. Pickup at 12:00 PM. The goals were for the resident to have immediate intervention should any signs/symptoms of complications from dialysis occur and the resident will have no signs/symptoms of complications from dialysis through the review date. The interventions included in part the following: Encourage resident to go for the scheduled dialysis appointments on days the resident receives dialysis.</p> <p>An interview was conducted on 05/27/25 at 10:10 AM with Resident #90 who stated he goes out to dialysis Monday, Wednesday and Fridays. When asked how they give him the dialysis, he said it is through a port in his chest, when he pulled down his gown to show it to surveyor.</p> <p>during an interview conducted on 05/29/25 at 9:45 AM with Staff M Registered Nurse (RN) who was asked about the dialysis communication sheets she said they fill out the top of the form and send the form with the resident to dialysis, the dialysis center fills out their portion in the middle of the sheet and return it with the resident. When the resident returns to the facility they put the vital signs directly into the resident's electronic medical record and the dialysis communication form gets filed into the dialysis book for the specific resident.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure discontinued controlled medications were removed from the medication carts, and initials and time matched on the MAR and control sheet, for 3 of 10 residents reviewed for controlled medication storage (Residents #91, #20, #97).</p> <p>The findings included</p> <p>1) Resident #91 was admitted on [DATE] with diagnoses including Primary Hypertension, Unspecified Mood Affective Disorder, Anxiety Disorder, Unspecified Dementia, and Behavioral Disturbances.</p> <p>A review of Minimum Data Set (MDS) dated [DATE], under Section C, revealed a Brief Interview of Mental Status (BIMS) score of 3 indicating Resident #91 had severely impaired mental cognition.</p> <p>A review of Physician orders dated 11/06/24 revealed Lorazepam 0.5 mg, 1 tablet by mouth twice a day for 7 days.</p> <p>A review of Resident #91's Narcotic sheet revealed 12 counts of Lorazepam 0.5 mg tablets were received on 11/16/24. The medication is to be discontinued on 11/23/24 per physician order.</p> <p>A further review of Resident #91's narcotic sheet revealed that on 12/01/24 at 1:45 AM, 1 tablet was given. On 12/04/25, 1 tablet was administered at 02:05 AM. On 12/20/25, 1 tablet was given at 2 PM.</p> <p>A further record review revealed that Lorazepam 0.5 mg was given on 01/26/24 (typographical error for the year 2025) at 5 :00 PM. On 03/02/24 (typographical error for 03/02/25), 1 tablet was given, but there was no documentation of the time it was given to Resident #91.</p> <p>A further review of Resident #91's narcotic sheet for Lorazepam 0.5 mg revealed there were 6 tablets left which was also the same number on the Bingo medication dispenser.</p> <p>In an interview with the Director of Nursing (DON) on 05/30/25 12:33 PM, he stated that he is responsible for checking that the discontinued medications are removed from the medication carts. He added that Nurses help to make sure unused and discontinued medications are removed from the medication carts, but the ultimate responsibility falls on him.</p> <p>In an interview with the visiting Regional Director on 05/30/25 at 12:30 PM, she stated that upon review of Resident # 91's records, she found that Lorazepam was administered even after it was ordered discontinued. She asked the DON to contact the resident's family and notify resident's attending physician. When was asked why it took 5 months to check Resident # 91's discontinued medication orders, she did not respond. When she was asked who is responsible for verifying discontinued medications are removed from the medication carts, she responded, The facility Nurses and the Director of Nursing.</p> <p>2) Resident #20 was admitted on [DATE] with diagnoses including Gastro-Esophageal Reflux Disease Type 2 Diabetes Mellitus Anxiety disorder and Major Depressive disorder.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of current Minimum Data Set (MDS) dated [DATE] under Section C of the Brief Interview of Mental Status (BIMS,) revealed a score of 5 indicating Resident #20 had severely impaired cognition.</p> <p>A record review of Physician orders dated 03/04/25 revealed Lorazepam 0.5 mg, 1 tablet every 24 hours as needed for anxiety for 14 days.</p> <p>A review of Resident #20's Narcotic sheet revealed 13 counts of Lorazepam 0.5 mg were received on 03/16/25 with the Nurse's signature. The medication was ordered to be discontinued on day 14 (03/30/25).</p> <p>A further review of Resident #20's Narcotic sheet, it revealed Lorazepam 0.5 mg, 1 tablet was given, and was removed from the Bingo dispenser card on 05/12/25 at 5:00 PM and at 10:00 PM, with the same Nurse's signature.</p> <p>In an interview with Staff A, an LPN on 05/29/25 at 3:50 PM, who was asked who received the medications and who signed out the medication from Resident #20's Narcotic sheet on 05/12/25 at 5:00 PM and at 10:00 PM, responded she does not know whose Nurse's signatures are on the Narcotic sheet.</p> <p>A record review of May 2025 MAR for Resident #20 revealed no documentation for Lorazepam 0.5 mg .</p> <p>3) Resident #97 was admitted on [DATE] with diagnoses that included Metabolic Encephalopathy, Dysphagia following Cerebral Infarction, and Chronic Kidney Disease.</p> <p>A review of the current Minimum Data Set (MDS) under Section C revealed a Brief Interview of Mental Status (BIMS) score of 8 indicating Resident #97 had impaired mental cognition.</p> <p>A review of physician orders revealed Oxycodone-Acetaminophen, 10-325 milligrams (mg), 1 tablet by mouth every 6 hours as needed for pain.</p> <p>A review of Medication Administration Record (MAR) dated 05/27/25, it revealed the Oxycodone-Acetaminophen 10-325 mg was administered at 11:34 AM by Staff B, Licensed Practical Nurse (LPN).</p> <p>When compared with Resident #97's narcotic sheet, it was revealed Oxycodone -Acetaminophen 10-325 mg, 1 tablet was administered at a different time from the documentation in MAR. The medication was administered at 4:34 PM on 05/27/25 with a squiggly m signature.</p> <p>Resident #97's narcotic sheet had documented 5 tablets were left and it was the same number left on the Bingo medication dispenser.</p> <p>In an interview with Staff A, LPN on 05/29/25 at 3:50 PM, who was asked who signed out the medication in the Narcotic sheet on 05/27/25 at 4:34 PM, responded she does not know whose Nurse's signatures are on the Narcotic sheet. When asked if that was the same nurse who documented in MAR, she did not respond.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure a medication cart was secured for 1 of 5 medication carts (Flamingo unit). The facility also failed to ensure medications are secured at bedside for 2 of 35 samplef residents (Resident #68 and Resident #8).</p> <p>The findings included:</p> <p>A review of facility's policy titled, General Dose Preparation and Medication Administration with revision date of 11/15/24, revealed the following: the facility staff should not leave medications or chemicals unattended ; and the facility should ensure that medication carts are always locked when out of sight or unattended.</p> <p>1). Resident #97 was admitted on [DATE] with diagnoses that included Metabolic Encephalopathy, A review of Minimum Data Set under Section C revealed a Brief Interview of Mental Status (BIMS) score of 8 indicating impaired mental cognition.</p> <p>During a medication pass observation on 05/27/25 at 4:31 PM, Staff R, Registered Nurse, (RN), who stated he has been working in the facility for one year, and he will administer the scheduled medications for Resident #97.</p> <p>Staff R, RN unlocked Flamingo medication cart 1 and searched for the medication Cyclobenzaprine 10 mg (milligram), which he stated is scheduled for 3 times a day. After searching the medication drawers for a few minutes, Staff R, RN stated he could not find the medication. He added the medication has been ordered from the Pharmacy. On 05/27/25 at 4:31 PM, after checking Resident#97's blood sugar, Staff R RN stated he would go inside the storage room to check if the medication was delivered there. Staff R, RN left the Flamingo medication cart #1 unattended and unlocked.</p> <p>In an interview with the Director of Nursing (DON) on 05/27/25 at 4:41 PM, he was shown Flamingo medication cart #1 was left unattended and unsecured when the surveyor opened the first 2 top drawers. Staff R, RN came back from the storage room and the DON told him the medication cart was unlocked.</p> <p>2) Record review revealed Resident #68 was admitted on to the facility on [DATE]. The quarterly comprehensive 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 no cognitive impairment.</p> <p>During an interview on 05/27/25 at 10:42 AM, in Resident #68's room, a tube of ointment with a prescribed date of 12/19/24 was observed on the bedside table. When asked what the ointment was for, the resident stated It's for my feet. The nurse put it there and I put it on myself. This is the second tube I've had. Photographic evidence obtained.</p> <p>Further review of the record revealed an order dated 12/19/24, that instructed the staff apply Ciclopirox Olamine External Cream 0.77 % (antifungal cream) to the bottom of both of Resident #68 feet every shift.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/25 at 1:09 PM, the Unit Manager was made aware that a tube of Ciclopirox Olamine External Cream 0.77 % (antifungal cream) was observed at the Resident #68's bedside on 05/27/25 at 10:42 PM.</p> <p>3)Review of the record revealed Resident #8 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the resident had a Brief Interview Mental Status (BIMS) score of 13 on a 0 to 15 scale, indicating no cognitive impairment.</p> <p>During an Interview on 05/27/25 at 11:11 AM, with Resident #8, in his room, two tubes of cream in a zip lock bag were sitting on the bedside table. One of the tubes were dated 12/19/24 and the other tube, that had never been opened, was dated 4/24. When asked if the ointment was being applied by the nurse the resident stated No. When asked are you able to apply the ointment yourself, the resident stated No. Photographic evidence obtained.</p> <p>Record review revealed an order for Resident #8 dated 12/19/24, that instructed the staff to apply Ciclopirox Olamine External Cream 0.77 % (antifungal cream) to the bottom of both feet two times a day for fungus.</p> <p>During an interview on 05/29/25 at 1:06 PM, the Unit Manager was taken to Resident #8's room and two tubes of cream in a zip lock bag were observed sitting on the bedside table. When asked where the medication should be stored the Unit Manager stated, It should be on the medication cart. At this time, the Unit Manger was made aware that the cream had been observed on Resident #8's bedside table since 05/27/25 and the unit manager was told that the resident said that he had not been receiving the medication. At this time, the Unit Manager took the zip lock bag with the cream out of the resident's room.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to store and prepare food in accordance with professional standards for food service safety. This had the potential to affect 103 residents who were on oral diets.</p> <p>The findings included:</p> <p>On 05/27/25 at 8:45 am, an initial tour of the kitchen was conducted. The Dietary Manager was present, and the following observations were made:</p> <ol style="list-style-type: none"> 1. The backsplash of the Vulcan stove top was laden with dark black residue. 2. The Vulcan double oven had dried on white crusty sediment, and thick black residue in the area just beneath the hinge of the oven door. 3. The Dean fryer had light brown flaky sediment along the upper rim of the fryer. When the cook was asked if the fryer was used today, he said that it was not used today. It was last used yesterday at the dinner meal. 4. The American Dish Service dishwasher rinse cycle temperature was 114' F, not the required 120' F as stated on the metal tag affixed to the oven. <p>The plastic crates used to place dishes into the dishwasher, and to carry clean dishes out of the dishwasher, had an accumulation of a thick, white, flaky debris. The DM took his fingernail to it and some of it broke up and flaked off.</p> <ol style="list-style-type: none"> 5. A stack of sheet pans was laden with black residue. 6. The hood over the ovens/cooking area had brown and white residue on it. 7. The floor under the shelves of the walk-in refrigerator had the following food items: a plastic bottle of T.G. [NAME] 8 oz milk, several individual use creamers, 2 pieces of green lettuce, plastic wrapping, 2 slices of deli meat, 1 yogurt, dried white residue, brown residue. <p>The Dietary Manager agreed with these findings, and photographic evidence was obtained of the the above findings.</p> <p>A follow-up tour of the kitchen was conducted with the Regional Certified Dietary Manager on 05/27/25 at 3:45 PM. The following was observed:</p> <ol style="list-style-type: none"> 8. The entrance to the walk in freezer had a build-up of ice near the door. When asked why there was a build-up of ice, the DM said that there was a problem with air leakage at the doorway and that a work order was put in. The temperature of the freezer was 0' F. The foods were frozen solid. There was a buildup of ice on the floor and an open space along the inside door that was not sealed. 9. The walk-in refrigerator was observed to have a loose gasket. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Regional Certified Dietary Manager agreed with these finding. Photographic evidence obtained.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2). Resident #409 was admitted on [DATE] with diagnoses including Absence of Epileptic Syndrome Intractable without Status Epilepticus, Metabolic Encephalopathy, Hyperlipidemia and Obstructive and Reflux Uropathy.</p> <p>A review of the admission Minimum Data Set (MDS) under Section C revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating Resident #409 had good mental cognition.</p> <p>During a medication pass observation on Flamingo Medication cart 1 with Staff E, a Registered Nurse (RN) on 05/28/25 10:45 AM, it was observed that her computer screen produced a pink color on the 9:00 AM medications for Resident #409. When Staff E, an RN was asked what the pink color meant, she responded, I am administering the medications later than the scheduled time. She added that medications must be administered one hour before and one hour after the scheduled time. She added, I think it is still ok.</p> <p>She administered the following medications: Cefuroxime 250 milligrams (mg), 1 tablet, 2 x a day. This medication was taken by Resident #409 at 11:08 AM; Sertraline 25 mg, 1 tablet, once a day. This medication was taken by Resident #409 at 11:05 AM; Keppra 750 mg, 2 tablets by mouth, 1 time day, This medication was administered at 11:02 AM.</p> <p>A review of Resident #409's Medication Administration Record (MAR), it was revealed the above medications were documented administered at 9:00 AM, with check marks and the 3- letter Nurse's initials.</p> <p>During an additional review of MAR, it was revealed that the Nurse who administered the 9:00 AM medication for Resident #409 was not the same Nurse who documented in the medication administration for Resident #409's MAR.</p> <p>In an interview with Flamingo Unit Manager on 05/28/25 11:41 AM, when asked about Staff E's initials for MAR documentation, she stated, I think it is a 2 letter initials. When she was asked the name of the nurse whose initials were 3 letters, she did not respond.</p> <p>In an interview with Staff E, an RN on 05/28/25 at 1:00 PM, who when asked what initials she uses for MAR documentation, responded, I think they were 2 letter initials. When she was asked whose initials were the 3 letters, she did not respond. When she was asked if she documented the medications, she administered for Resident #409 under her initials, she did not respond. When she was asked what the documented time for Resident #409's medication administration, she responded at 9:00 AM.</p> <p>In an interview with the facility Administrator on 05/28 25 at 3:00 PM, when she was asked about the Staff who was using the 3- letter initials, she responded, she will try to find out.</p> <p>In an interview with the Director of Nursing (DON) on 05/30/25 at 12:30 PM, he stated that whoever administered the medication is also the same Nurse whose initials were documented in resident's MAR.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of medication time stamped documentation submitted by the Administrator on 05/30/25 revealed the above medications were administered on 05/28/25 after 11:00 AM by Staff D, RN.</p> <p>Based on policy review, record review, observation and interviews, the facility failed to accurately document who provided the wound care for 1 of 1 sampled residents with skin condition, as evidenced by falsifying documentation of care provided to Resident #41, and failed to accurately document who administered medication during medication pass observation for 1 of 6 sampled residents as evidenced by not accurately documenting who administered the medication to Resident #409.</p> <p>The findings included:</p> <p>Review of the policy titled Wound Prevention revised 03/2/19, documented in part The purpose of this program is to assist the facility in the care, services and documentation altered to the occurrence, treatment, and prevention of pressure as well as non-pressure wounds. Weekly skin checks will be conducted by licensed nurse.</p> <p>1). Record review revealed that Resident #41 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15 on 0 to 15 scale, indicating no cognitive impairment.</p> <p>During an interview 05/27/25 at 11:28 AM, Resident # 41 stated I can't sit on my bottom because it hurts. When asked did you talk to the wound doctor regarding your wound, the resident stated yes, but she says I'm diabetic and it will take time. The doctor says it's not open and the ridges will be there. I got an ointment they put on the wound. When asked how often the cream is applied, the resident stated, Every time I get changed.</p> <p>Review of the care plan dated 05/07/2025 indicated that Resident #41 has impaired skin r/t decreased bed mobility, obesity (overweight), diabetes (increase in blood sugar), Hemiplegia, Incontinence and generalized weakness. Left Ischium (hip) shear, Right Ischium shear, left buttock shear with a goal that the resident will have intact skin, free of redness, blisters or discoloration provided that the staff administer medications as ordered, observe and document side effects and effectiveness of medication, administer treatments as ordered and observe for effectiveness.</p> <p>Review of an order dated 3/17/25 for Resident #41 instructed staff to cleanse left buttock shear and right ischium shear with wound cleanser, pat dry, apply Silver Sulfadiazine (a antibiotic cream use to treat and prevent wound infection in burn wounds) and leave open to air every day and evening shift for lesion/shear.</p> <p>Review of a progress note dated 05/19/25, written by the Wound Care Nurse documented, during wound care rounds with the wound care doctor this morning, 5/19/25, it was noted that the right & left ischium & left buttocks wounds have greatly improved, since there is no measurable depth. Just redness remains. The wound care doctor has discharged Resident #41 from their care. The resident is aware of this and was educated on ways to avoid further breakdown. The resident verbalizes understanding. Silvadene cream remains as the preventive treatment.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/28/25 at 10:25 AM, Staff O, (Certified Nursing Assistant (CNA) was observed providing incontinent care for Resident #41. The skin on both buttocks and ischium area was observed to have ridges, excoriation and redness. When asked do you notice any drainage from the wounds on her buttock, Staff O, CNA stated No. There was some white cream observed in a plastic drinking cup with a tongue compressor sitting inside of it. When asked are you applying this cream on Resident # 41 buttocks Staff O, (CNA) stated, Yes.</p> <p>During an interview on 05/28/25 at 11:15 AM, When asked if the wound care nurse sees you for wound care. Resident #41 stated The Wound Care Nurse doesn't see me anymore. She used to apply ointment.</p> <p>During an interview on 05/28/25 at 11:52 PM, when asked are you familiar with Resident #41's wounds on her buttocks area, the Wound Care Nurse stated, Yes, but it's not a wound anymore because there's no depth. The resident was recently discharged from the wound care doctor seeing her. Now, there is an order to apply Silvadene cream to the resident's buttocks area. When asked how often the cream is supposed to be applied, the Wound Care Nurse stated, I will have to look. It's twice a day. When asked who normally applied the cream, the Wound care nurse stated I apply it in the daytime and on the other shift the evening nurse is to apply the cream. When asked, have you seen Resident #41 today, the wound care Nurse stated no have you applied the cream to Resident # 41 buttocks today, the Wound Care Nurse stated No, I haven't seen her yet. When asked when the last time you applied the cream to Resident #41 buttocks, the Wound Care Nurse stated, I saw her yesterday. When asked if she knew who gave the cream to the Staff O, CNA this morning to apply on Resident #41 buttocks, the Wound Care Nurse stated, I'm not sure, she must have got it from the night nurse. When asked so the day shift CNA got it from the night nurse, the Wound Care Nurse stated, Well, I'm not sure, I didn't give it to her.</p> <p>During an interview on 05/28/25 at 4:05 PM, when asked where did you get the cream that you applied on Resident #41 this morning during care, Staff O, CNA stated, The nurse gave it to me. When asked which nurse, Staff O, CNA stated Staff N, LPN gave it to me.</p> <p>During an interview on 05/28/25 at 4:06 PM, when asked if she provided the wound care treatment for Resident #41, the Wound Care Nurse stated, I went to put the cream on the resident, but Staff N, Licensed Practical Nurse (LPN) had just applied the cream 10 minutes prior.</p> <p>During an interview on 05/28/25 at 4:08 PM, when Resident #41 was asked if Staff N, LPN applied the cream to her buttocks, the resident stated, No the aide applied the cream, but when the Wound Care Nurse came to apply the cream I had just went to the bathroom again, so I told the wound care nurse that I was dirty and had to be cleaned first. When asked what time the Wound Care Nurse came to see you, Resident #41 stated This was around 2:45 PM, because she said she had to go to a meeting at PM.</p> <p>During an interview on 05/28/25 at 4:21 PM, when asked if the wound care nurse came to see Resident #41, Staff N, LPN stated, Yes, but the resident refused, because she said she needed to be changed.</p> <p>During a record review on 05/28/25 at 5:10 PM, an initial and time stamp verification of the Medication Administration Record of the wound care treatment administered to Resident #41 by staff was requested. Review of the initial and time verification document provided revealed that the Wound Care Nurse had signed that she administered treatment to Resident #41 on 05/27/25 at 10:02 AM and again on 05/28/25 at 7:32 AM.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During further record review on 05/28/25 05:54 PM, the skin assessment for Resident #41 was not completed in the record, as scheduled for 05/27/25. There were no documented progress notes on 05/27/25 or 05/28/25 entered by wound care nurse regarding Resident #41 skin status.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow Enhanced Barrier Precaution (EBP) guidelines for a resident with sacral wounds and failed to initiate a care plan for a resident on EBP for 1 of 25 residents on EBP (Resident #408). The facility also failed to follow the manufacturer's recommendation for disinfection and storage of glucometer (Resident #73 and failed to follow the professional standards regarding glucose strip storage for 1 of 2 observation of glucose monitoring (Resident # 97).</p> <p>The findings included:</p> <p>A review of facility's policy titled, Enhanced Barrier Precautions issued on 04/01/24, revealed the following: all staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions; Personal Protective Equipment (PPE) for EBP is only necessary when performing high-contact care activities.</p> <p>A review of Center for Disease Control and Prevention (CDC)'s EBP poster revealed the following: everyone must clean their hands, including before entering and when leaving the room; providers and staff must wear gloves and a gown for high-contact care activities including transferring, changing briefs and assisting with toileting, wound care, with any skin opening requiring a dressing.</p> <p>An additional review of facility's policy titled, Policies and Procedures: Blood Glucose Monitoring, with a revision date of 03/02/19, revealed the following: the nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions; the nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer's instructions (3).</p> <p>A review of the user's guide booklet for Medline Even Care G2 glucometer with a reference number of MPH 1540, provided by the Director of Nursing (DON), revealed the recommended disinfecting products included and Medline Micro- Kill bleach germicidal bleach wipes.</p> <p>An additional review revealed Medline Micro-Kill bleach germicidal bleach wipes (purple top container) have a 3-minute drying time to be effective against various microorganisms.</p> <p>1) Resident # 408 was admitted on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Encounter for Surgical after care following surgery on the Circulatory System, and Acute and Chronic Respiratory Failure with Hypoxia.</p> <p>A review of Minimum Data Set (MDS) revealed it was in progress.</p> <p>A review of orders dated 05/29/25 revealed EBP for chronic wounds and Multiple Drug-Resistant Organisms (MDRO) precautions.</p> <p>A record review of nursing care plan did not include EBP and interventions related to MDRO.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 05/29/25 at 9:26 AM, Resident #408's outside wall had PPE supplies and a CDC poster for EBP, while inside the room, two staff were assisting the resident to get out of bed. They stated they are helping with activities of daily living (ADL).</p> <p>The resident was observed with a sacral wound dressing while he was walking towards the bathroom with both staff.</p> <p>Staff P, and Staff Q, from Occupational Therapy (OT) were wearing gloves, but no gowns. Staff P, OT was observed touching resident's arms, and the bathroom doorknob. She did not change gloves after she sat the resident on a toilet. After a few minutes Staff P, OT removed her gloves and left the room. She did not perform hand hygiene before leaving.</p> <p>Staff Q, OT remained with the resident in the bathroom, and stated she is new to the facility. She stated she never put on gown when caring for Resident #408.</p> <p>Staff P, OT came back inside the room, but she did not perform hand hygiene before entering. In an interview when she was asked about EBP, she responded, EBP is for a resident with a PEG tube.</p> <p>She stated she did not put on a gown because the resident has no PEG Tube. When asked if she verified with Nurses for which resident in the room the EBP sign is for, she stated she did not. She knows Resident #408's roommate has a PEG tube, but Resident # 408 has no PEG tube and wound.</p> <p>She added that she has been working with the resident for one week but is working in the facility for 8 years. She never put on a gown when assisting the resident in performing ADL.</p> <p>In an interview with Staff B, Licensed Practical Nurse (LPN) on 05/29/25 at 9:45 AM, she stated gowns, and gloves must be worn when providing care for residents with sacral wounds, and PEG tube.</p> <p>In an interview with Resident #408 on 05/29/25 at 1:08 PM, when asked if Staff put on gowns when caring for him, including when he needed to go to the bathroom, he stated, No.</p> <p>2) Resident #73 was admitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia, Dementia, Anxiety, Psychotic, and Mood Disturbance, and Essential Primary Hypertension.</p> <p>A review of quarterly MDS under Section C of Brief Interview of Mental Status revealed a score of 5 indicating Resident #73 had impaired cognitive function.</p> <p>During a medication administration observation on 05/27/25 at 2:03 PM with Staff A, LPN, she stated she will perform a blood sugar test. She opened the drawer of the Dolphin Medication cart and gathered all the supplies she needed without performing hand hygiene. She put on gloves and removed the blue glucometer from a white plastic tray. The glucometer was not contained in a bag.</p> <p>Staff A, LPN placed the glucometer on top of Dolphin medication cart then put the plastic tray at the bottom. She did not perform hand hygiene before and after disinfecting the glucometer using wipes from the purple top container.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff A, LPN stated the glucose strip expires in 05/01/2026. She took one strip, an alcohol wipe, and the glucometer to the resident.</p> <p>Staff A, LPN did not sanitize hands, before putting on gloves. She pricked the residents' finger on the left hand without first cleaning it, obtained the blood sugar reading and wiped the resident's finger with an alcohol wipe.</p> <p>Staff A, LPN approached the medication cart, opened the drawer with the same gloves she used for obtaining the glucose reading (she did not perform hand hygiene nor remove her gloves after obtaining the resident's blood sugar level). Staff A, LPN opened the medication cart and picked up the purple top container, obtained wipes, and disinfected the glucometer, then without waiting for a few minutes, immediately put the glucometer back inside the top drawer of the medication cart. She did not store the glucometer in a bag.</p> <p>With the same set of gloves, Staff A, LPN put the purple top disinfectant container back at the bottom of the medication cart, then removed her gloves.</p> <p>Staff A, LPN did not perform hand hygiene. When asked when she will perform hand hygiene. She stated she did it before opening the medication cart. When asked how long she must wait after disinfecting the glucometer before she can put it back inside the medication cart, she stated as soon as possible or probably in one minute.</p> <p>When asked what she used to disinfect the glucometer, she stated it is a purple top disinfectant.</p> <p>In an interview with Staff A, LPN on 05/27/25 at 2:05 PM, when asked if she disinfected the glucometer properly after using it according to manufacturer's instruction, she stated she just got confused and did not disinfect it the correct way. She acknowledged that she used a disinfectant incorrectly, because she did not wait for the glucometer to dry and immediately put it inside the Dolphin Medication cart, and she did not contain it in a bag.</p> <p>In an interview with Staff S, Registered Nurse (RN), when asked about glucometer disinfection, she stated, she uses a purple top disinfectant with a drying time of 5 minutes. She added that she waits for 5 minutes before putting the glucometer inside a plastic bag on the top drawer of the medication cart.</p> <p>When he was asked for the proper way to disinfect the glucometer, he responded, According to manufacturer's instructions. When asked how to properly store a glucometer in the medication cart, he responded, After disinfection, it is stored in a plastic bag.</p> <p>In an interview and observation during a medication pass with Staff E, RN, on 05/28/25 at 9:04 AM, she was observed disinfecting the wrist band blood pressure device after resident's use. She stated she is using the purple top Micro-Kill 2 with 2-minutes drying time. She added she will contain the wrist blood pressure device in a plastic container for storage after 2 minutes of drying time.</p> <p>During multiple observations, the commonly used disinfectant inside Flamingo Medication Carts were the Micro- Kill bleach germicidal bleach wipes with 3-minute drying time.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3) Resident #97 was admitted on [DATE] with diagnoses including Metabolic Encephalopathy, Dysphagia, and Type 2 Diabetes Mellitus without Complications.</p> <p>A review of MDS revealed a BIMS score of 8 indicating Resident #97 had impaired cognitive function.</p> <p>A review of physician orders dated 04/09/25 revealed EBP for chronic wound and indwelling medical device every shift for MDRO. Another physician order dated 05/16/25 revealed to flush gastrostomy (G)-tube with 50 milliliter (ml) water every shift for PEG.</p> <p>During a medication administration observation on 05/27/25 at 4:32 PM with Staff T, an RN, he stated he will perform blood sugar test for Resident #97. Staff T went to the nearest sanitizing dispenser and performed hand hygiene.</p> <p>He assembled the supplies including a glucometer, lancets and a glucose strip container. He stated he uses a red top disinfectant for the glucometer with a drying time of one minute. When asked if that is the acceptable glucometer disinfectant, he responded, Yes.</p> <p>He went inside Resident #97's room, donned on gown and gloves after performing hand washing. He obtained the blood sugar level and used alcohol wipes before and after obtaining the blood sugar level from the resident's finger.</p> <p>After discarding his PPE and the used lancet, he went back to the medication cart. Staff T, opened the top drawer, disinfected the glucometer using wipes from a red top container (Sani Cloth plus), waited 1 minute, and returned the supplies including one unused lancet, and a glucose strip container he carried inside the room with an EBP signpost.</p> <p>When he was asked why he returned the unused lancet and the glucose strip container back inside the medication cart, he stated, The glucose strip container is almost full, and the lancet was not used.</p> <p>In an interview with the Director of Nursing (DON) on 05/27/25 at 4:45 PM, he stated that unused lancets should not be brought back inside the medication cart. He stated that the glucose strip container must not be brought inside the resident's room.</p>		