

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142</p> <p>Based on interview, record review, and observation, the facility failed to provide a clean, homelike environment for the residents in the facility.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1) The shower room on the second floor had brown colored matter on the floor of the shower stall on the left side of the room from the entrance. The wall above the grab bar on the left facing into the stall had a rust colored stain. There were rust colored stains on the surfaces of the grab bars. The walls of the shower were noticeably marked with black stains. The paint on the floor had peeled in several locations. 2) The shower room on the first floor had gaps between the floor and walls on both shower stalls. The floors and walls had black markings. 3) The floor tiles on the south wing of the second floor had noticeable cracks in several tiles. 4) room [ROOM NUMBER], the bed rail had peeling paint with rust colored staining. 5) Privacy Curtains in room [ROOM NUMBER] and 222 had black stains. 6) room [ROOM NUMBER] blanket had holes. <p>Photographic Evidence Obtained.</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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