STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105521	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Boca Raton, Inc.	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to thoroughly investigate a neglect allegation related to wound care for 1 of 3 residents reviewed for wound care (Resident #3).The findings included:Review of the facility's policy titled, Abuse, Neglect, Exploitation, Mistreatment, Misappropriate of Property and Injury of Unknown Source Prevention (ANEMMI), dated 03/02/19, included the following: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to ensure that the facility is doing all that is within its control to prevent occurrences. Investigation:Investigate different types of incidents; and identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting results to the proper authorities. Reporting/Response:Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: Have evidence that all alleged violations are thoroughly investigated. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Wedge Compression Fracture of Third Lumbar Vertebra, Type 2 Diabetes Mellitus without Complications, Bacteremia, Overactive Bladder and History of Falling. On 07/05/25, Resident #3 was discharged to the hospital from the facility. Review of Section C of the 5-day Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) of 14/15, indicating his cognition was intact. Review of Section H revealed Resident #3 had an indwelling catheter and Section M revealed Resident #3 had an unstageable pressure ulcer/injury. Review of the Physician's Orders showed Resident #3 had orders dated 07/02/25 for Wound consult; change indwelling foley catheter when medically necessary and PRN; and May irrigate indwelling Foley catheter with 60ml of NS q shift PRN for blockage, occlusion or leakage. Further review of the Physician's orders revealed Resident #3 had an order dated 07/05/25 for Piperacillin sod-Tazobactam So Solution Reconstituted 3-0.375 grams (GM), Use intravenously (IV) every 8 hours for wound infection until 07/14/25; and an order dated 07/09/25 for Wound care: Cleanse Sacrum wound with wound cleanser, pat dry, add honey fiber to wound bed, and cover/secure with bordered gauze daily and PRN if soiled or displaced until resolved. On 07/23/25, a review of the facility's investigation folder for Resident #3's neglect allegation related to wound care was conducted. The facility investigation included the following: Resident #3's diagnosis, skin check evaluation, previous hospitalization dated 06/20/25-06/30/25, and interviews with current residents related to neglect. Further review revealed no staff interviews were conducted and no record review of Resident #3's wounds or if care was provided for the wounds. In addition, there was no documentation noted in the investigation of what occurred with Resident #3's wounds (as to explain why there was a neglect allegation) and no procedures in place to prevent further occurrences.An interview was conducted on 07/23/25 at 5:10 PM with the Administrator/Risk Manager, who stated he felt that a thorough investigation was conducted for Resident #3's neglect allegations. When asked if he conducted any staff interviews regarding wound care, he stated yes with Staff C, Registered Nurse (RN) and weekend nurse supervisor, who was the one present when the resident was sent out to the hospital due to profusely bleeding from his penis. Then, the Administrator was asked about the wounds of Resident #3, and did he investigate the relation of the wounds to the neglect allegation, he again stated he interviewed Staff C, RN, who advised the aides to be gentle with Resident #3 since he was bleeding profusely. However, the Administrator was unable to answer the question or provide information regarding Resident #3's wounds.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure treatment measures were implemented for pressure ulcers for 1 of 3 sample residents, Resident #3, reviewed for Pressure Ulcer/Injury, as evidenced by physician orders for wound care and intravenous (IV) antibiotic therapy were not followed, increasing the risk of pressure ulcer worsening for Resident #3.The findings included: Review of the facility's policy titled, Clean Dressing Change, dated 03/02/19, included the following: It is the policy of the facility to ensure change dressings in accordance with State and federal Regulations, and national guidelines. Procedure:1.Verify and review physician's order for procedure. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Wedge Compression Fracture of Third Lumbar Vertebra, Type 2 Diabetes Mellitus without Complications, Bacteremia, Overactive Bladder and History of Falling. On 07/05/25, Resident #3 was discharged to the hospital from the facility. Review of Section C of the 5-day Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) of 14/15, indicating cognition was intact. Review of Section M revealed Resident #3 had an unstageable pressure ulcer/injury. Review of the Physician's Orders showed Resident #3 had orders dated 07/02/25 for Wound consult. Further review of the Physician's orders revealed Resident #3 had an order dated 07/02/25 for Piperacillin sod-Tazobactam So Solution Reconstituted 3-0.375 grams (GM), Use intravenously (IV) every 8 hours for wound infection until 07/14/25; and an order dated 07/09/25 for Wound care: Cleanse Sacrum wound with wound cleanser, pat dry, add honey fiber to wound bed, and cover/secure with bordered gauze daily and PRN if soiled or displaced until resolved (Resident #3 was discharged to the hospital on [DATE]).Review of the admission care Plan revealed for Resident #3's pressure ulcers no interventions were developed.Record review of the July Treatment Administration Record (TAR) for Resident #3 documented no wound care treatment for Resident #3's pressure ulcers from 07/02/25 to 07/05/25. In addition, review of the Medication Administration Record (MAR) indicated Resident #3 was not administered Piperacillin intravenously (IV) every 8 hours for wound infection from 07/02/25 to 07/05/25 (Resident #3 was at the facility from 07/02-07/05/25 without treatment for his wounds).Record review of Resident #3's AHCA 3008-form dated 07/01/25 (part of the hospital discharge paperwork to the facility), the physician wrote under comments: Please see attached IV antibiotics and wound care orders.During an interview conducted on 07/23/25 at 10:58 AM with Staff D, Licensed Practical Nurse (LPN) and wound care nurse, who stated she has been the full-time wound care nurse for 8-9 months and works Monday-Friday. Upon admission of a resident, she stated assessment of wounds is done the next day of admission. She stated she reviews hospital orders and follows the orders upon admission; if need to change the hospital's orders then she will contact the wound care Nurse practitioner (ARNP). She was asked if she assessed Resident #3's wounds upon admission; she stated yes. Further along in the interview, Staff D acknowledged she was scheduled as floor nurse on 07/02/25 instead of the wound care nurse. She further stated on 07/03/25 she was scheduled for documentation for wound care, meaning she would review orders, call family members for updates and future doctor's appointments. Staff D then stated she was off on 07/04/25 and she does not work on the weekends. She stated she saw Resident #3 on 07/02/25 and did a skin assessment because the resident's assigned nurse mentioned to her that the sacrum wound was big. Staff D stated she ordered the wound treatment at that time (Review of the physician's orders for wound treatment was created on 07/09/25, however start date 07/02/25). Then Staff D again added she was assigned as a floor nurse on 07/02/25, assessed Resident #3 briefly and was unable to review the hospital records. A side-by-side review of the July TAR was conducted at this time and Staff D was asked why Resident #3 did not receive wound treatment from 07/02-07/05/25. She stated she was not sure, the floor nurses are responsible for doing the wound treatments when she is not at the facility or when she is assigned as a floor nurse herself. She was also asked why the wound care order was created on 07/09/25 with a 07/02/25 start date, she then stated she was not sure (order was created by Staff D).During an interview conducted on 07/23/25 at 2:03 PM with Staff A, Registered Nurse (RN), who stated she has worked at the facility for 3 months and in July her assignment was on the 2nd floor. She stated she recalls Resident #3 had a wound, however, wound treatment is done by the wound care nurse unless the dressing is soiled and then she would change it, if the wound care nurse is not available, and wound care orders are put in by the wound care nurse.On 07/23/25 at 2:49 PM an interview was conducted with Staff E, ARNP, who stated she has

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to enter orders for indwelling catheter care for a resident admitted with an indwelling catheter for 1 of 1 resident sampled for an indwelling catheter (Resident #3). The findings included: Review of the facility's policy titled, Infection Control-Indwelling Catheter Care, dated 03/02/19, included the following: It is the policy of the facility to ensure that the residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice. Record review for Resident #3 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Wedge Compression Fracture of Third Lumbar Vertebra, Type 2 Diabetes Mellitus without Complications, Bacteremia and Overactive Bladder. On 07/05/25, Resident #3 was discharged to the hospital from the facility. Review of Section C of the 5-day Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) of 14/15, indicating his cognition was intact. Review of Section H revealed Resident #3 had an indwelling catheter. Review of the Physician's Orders showed Resident #3 had orders dated 07/02/25 for change indwelling foley catheter when medically necessary and PRN; and May irrigate indwelling Foley catheter with 60ml of NS q shift PRN for blockage, occlusion or leakage; however, no order for the indwelling Foley catheter care every shift and as needed (PRN) was entered into Resident #3's chart.Review of the Certified Nursing Assistant (CNA) Tasks for Resident #3 dated 07/02/25 - 07/05/25 had no documentation that indwelling Foley catheter care was done.Review of the nursing admission notes dated 07/01/25 documented Resident #3 had a indwelling Foley catheter in place.During an interview conducted on 07/23/25 at 2:03 PM with Staff A, Registered Nurse (RN), who stated she has worked at the facility for 3 months and in July her assignment was on the 2nd floor. She stated she recalls Resident #3 had a urinary foley catheter. Staff A stated she would know if the resident had a foley care order because it will pop-up in the computer system and then she will consult with the Certified Nursing Assistant (CNA) to make sure the care was done.On 07/23/25 at 3:31 PM an interview was conducted with Staff B, RN, who stated she has worked at the facility for 35-36 years and in the last few years she has been assigned to the 2nd floor, her shift is 3PM-11PM. She stated medication and other orders are entered into the computer by the admitting nurse, but sometimes she does ask either the nurse supervisor or another nurse to assist in entering the orders. She stated orders come in with the hospital paperwork packet including diet and medications. Staff B confirmed that she was the admitting nurse for Resident #3 on 07/01/25. She stated Resident #3 was alert and oriented, had a Peripheral Inserted Central Catheter (PICC) line, Foley Catheter and had a few wounds. She stated two other nurses assisted her in entering the orders for Resident #3 since it was toward the end of her shift. She then stated she assessed the foley catheter and did not see any concerns. She acknowledged that the order for foley catheter care should have been entered into the computer.On 07/24/25 at 9:26 AM an interview was conducted with Staff C, RN, who stated she has worked at the facility for 9 months as weekend supervisor. On 07/05/25, she recalls the nurse calling her to the unit because there was a concern with Resident #3, who was bleeding profusely between the thighs. She stated she looked at the catheter bag and saw no blood in the urine and thought he might be bleeding from the rectum. At this time the doctor and 911 were called and Resident #3 was transferred to the hospital.On 07/23/25 at 11:45 AM an interview was conducted with the DON and Administrator, who were informed that Resident #3 never had orders for indwelling Foley catheter care to be done every shift. They acknowledged that Resident #3 was not receiving the proper care for his indwelling Foley catheter.