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	12/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 interview and record review the facility failed to provide care and services to meet the needs for 2 of 3 residents investigated for Quality of Care, Resident #1 and Resident #2.The findings include:(1) Resident #1 did not receive necessary doses of an expensive multidrug antibiotic and subsequently returned to the hospital to continue treatment. On 12/08/25 at 2:26 PM, an interview was conducted with the Admissions Director (AD). The AD explained that the admission process can start a week prior to admission, which was the case for Resident #1. The AD stated that he would receive the admissions information from the hospital to determine if the facility was appropriate for the admission. According to the AD, he enters the medication list into the pharmacy's computer system to check for availability for all medications required. The AD stated that when he entered the information for the IV Antibiotic Recarbio, he entered the wrong dosage amount by entering milligrams instead of grams. This error caused the pharmacy's computer system to not flag the medication as expensive. The AD explained that when Resident #1 physically arrived at the facility the AD saw the actual dosage and when he re-entered the dosage it flagged as an expensive medication. This caused the medication to be rejected. The AD further explained that since the error occurred, he was not certain if the facility put in any measures to try to prevent this error from occurring again. On 12/09/25 at 2:30 PM, The Regional Nurse Consultant (RNC) was interviewed regarding the antibiotic issue for Resident #1. The RNC stated she had investigated the problem with the IV antibiotic. The RNC stated that the medication had to be compounded at the pharmacy's [NAME] facility and then shipped to the Long-Term Care facility. The RNC stated she was informed by the pharmacy that it would take 24 to 48 hours before the product would arrive. The RNC stated that when the family was informed, they requested Resident #1 be sent back to the hospital to continue treatment. This request was granted. On 12/09/25 at 9:11 AM, the Medication Administration Record (MAR) was reviewed for Resident #1. Resident #1 missed 5 antibiotic doses spanning between admission and his transfer back to the hospital. (2) On 12/08/25 at approximately 11:00 AM, during a record review for Resident #2, a nurse's progress note documented Resident #2 had been experiencing a nosebleed (Epistaxis). The nurse documented that he instructed Resident #2 to sit forward and pinch her nose. The note documented that the nurse called the Director of Nursing (DON) and the doctor. The note was dated 11/27/25 at 22:36 (10:36 PM). A second note dated 11/28/25 at 6:50 AM indicated that Resident #2 had a change in condition and was sent to the hospital with a low blood pressure of 78/50. Resident #2 was described as lethargic. Doctor's Orders revealed Resident #2 had been ordered Ticagrelor 90 mg tablets twice a day and Aspirin 81 mg once a day. Ticagrelor is an antiplatelet medication. Aspirin also has antiplatelet properties. On 12/08/25 at 2:13 PM, an interview was conducted with Staff A who was the primary nurse for Resident #2. Staff A had worked the 3:00 PM to 11:00 PM shift on 11/27/25 and continued working from 11:00 PM on 11/27/25 to 7:00 AM 11/28/25. During the interview Staff A explained that when he was rounding at 22:36 (10:36 PM) he noted Resident #2 was having a nosebleed. Staff A stated he had Resident #2 pinch her nose and to lean forward to stop the bleeding. Staff A stated Resident #2 felt uncomfortable leaning forward and she leaned back instead. Staff A stated he called the doctor and the DON, but it seemed like the bleeding stopped not too long after. When Staff A was asked if he monitored Resident #2 throughout the night, he stated he had. When asked why there was no documentation of observations throughout the night, Staff A answered he must have forgotten but that didn't mean he wasn't monitoring Resident #2. On 12/09/25 at 11:01 AM, a telephone interview was conducted with Staff B, who was the Certified Nursing Assistant (CNA) assigned to Resident #2 from 3:00 PM to 11:00 PM on 11/27/25. Staff B stated that around 10:30 PM she checked on Resident #2 and saw the resident had a nosebleed. Staff B then reported the nosebleed to the nurse. Staff B stated she did not check Resident #2 after that because it was the end of her shift and she was going home. When asked to describe Resident #2's nosebleed she stated it was a little bit, like a trickle. On 12/09/25 at 11:16 AM, a telephone interview was conducted with Staff C, who was the CNA assigned to Resident #2 from 11:00 PM 11/27/25 to 7:00 AM 11/28/2025. Staff C stated that when she came on Resident #2 was bleeding a lot. Staff C stated she had to clean the floor, and the bed from all the blood. Staff C stated that she had to change Resident #2's clothing also. Staff C stated that she provided a towel to Resident #2 so she could wipe the blood from her face. Staff C stated that she replaced the towel 3 times. Staff C stated that at some time during her shift Resident #2 asked to be put in a diaper because she felt too tired to get up and go to the bathroom. Staff C stated she