

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  05/02/2024
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 - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948</b></p> <p>Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary maintain a sanitary, orderly, and comfortable interior for 12 of 27 resident rooms located on the facility's first floor, 11 of 31 rooms located on the facility's second floor, and the second floor dining room.</p> <p>The findings included;</p> <p>During the surveyors screening of the residents and resident rooms on 04/29-30/24 and the environment tour conducted on 05/02/24 accompanied with the facility's Corporate Maintenance Director, the following were noted;</p> <p>First Floor:</p> <p>room [ROOM NUMBER]: A/C filter dust laden, bathroom toilet requires recaulking to the floor, and room call light cord too short.</p> <p>room [ROOM NUMBER]: Bathroom toilet base was loose, and room electrical cover missing.</p> <p>room [ROOM NUMBER]: A/C filter dust lade, and loose wall cable cover.</p> <p>room [ROOM NUMBER]: Room window sill in disrepair.</p> <p>room [ROOM NUMBER]: A/C filter dust laden, Room walls (4) damaged and numerous large areas of black scuff marks, and loose room base boards.</p> <p>room [ROOM NUMBER]: Bathroom ceiling tiles (3) damaged.</p> <p>room [ROOM NUMBER]: No over-bed light cord (Bed-1), room window sill damaged.</p> <p>room [ROOM NUMBER]: A/C filters dust laden .</p> <p>room [ROOM NUMBER]: A/C filters were dust laden, room ceiling tiles (5) damaged.</p> <p>room [ROOM NUMBER]: A/C filters dust laden.</p> <p>(continued on next page)</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
---	-------	-----------

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  05/02/2024
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 - Some</p>	<p>room [ROOM NUMBER]: Room window sill damaged and Room walls (4) damaged and numerous large areas of black scuff marks.</p> <p>room [ROOM NUMBER]: A/C filters dust laden, room ceiling tiles (3) in disrepair.</p> <p>room [ROOM NUMBER]: Bathroom emergency call cord missing , bathroom ceiling tiles (2) large black mold type matter build-up.</p> <p>Second Floor:</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and areas of large black scuff marks, television cable cord (5 feet) taped to room wall, and privacy curtain too short (B-2).</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks, and bed rails rusted (B-2).</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks, internal toilet bowl surface was rust laden, room air-conditioning filter dust laden, and wheel chair arms (B-1) torn.</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks, exterior of over-bed table rusted (Bed-1), bathroom floor heavily stained, bathroom call bell too short for proper use, bathroom lights out (2) , and exterior of bathroom entry/exit door damaged.</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks.</p> <p>room [ROOM NUMBER]: Bed rail loose (Bed-), over-bed table does not fit under bed (Bed-1), Room walls (4) damaged and numerous large areas of black scuff marks.</p> <p>room [ROOM NUMBER]: Cable cord (8 feet) taped to wall.</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks, and bathroom ceiling tiles (3) damaged.</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks.</p> <p>room [ROOM NUMBER]: Room walls (4) damaged and numerous large areas of black scuff marks, window sills damaged, wall outlet has a burnt face.</p> <p>room [ROOM NUMBER]: Toilet will not flush, room walls (4) damaged and numerous large areas of black scuff marks, and hole in wall near air-conditioning unit.</p> <p>Community Shower Room: Peeling floor paint over the entire floor surface, and ceiling tile damage.</p> <p>Second Floor Main Dining Room:</p> <p>* Walls (4) - large areas of black scuff marks and in disrepair</p> <p>(continued on next page)</p>		

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  05/02/2024
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 - Some</p>	<ul style="list-style-type: none"> <li>* Oxygen Concentrator being stored in the dining room - filter hanging and was dust laden used by Resident #11.</li> <li>* Wall air-conditioning vent _ heavily soiled and build-up of black mold type substance</li> <li>* Room floor heavily soiled black and build-up of dried food matter - residents complaining of floor condition</li> <li>* Serving table noted to be heavily soil, stained, and worn</li> <li>* Live bugs noted in the dining room on 05/02/24.</li> </ul> <p>Following the 05/02/24 tour the findings were confirmed with the Corporate Maintenance Director (CMD) and the Administrator. The CMD stated that employees have access to the facility's computerized TELS system to report maintenance and housekeeping issues. Further stated that staff are not utilizing the system to report issues with resident rooms and common area.</p>		

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  05/02/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36057</p> <p>Based on observation, interviews and record review, the facility failed to provide fingernails grooming for 2 of 3 sampled residents, Residents #26 and #43, observed for nail grooming/care.</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Activities of Daily Living (ADLS) Maintain Abilities revised on 03/02/19 documented .a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good .grooming and personal hygiene .</p> <p>Review of the facility's Job Description for Certified Nursing Assistants (CNAs) documented under essential job functions: personal care functions- assist residents with bathing, dressing, grooming .</p> <p>1) Review of Resident #26's clinical record documented an admission on 01/24/22 and a readmission on 06/02/22. The resident diagnoses included: Seizures, Muscle Weakness, Unspecified Protein-Calorie Malnutrition, Cognitive Communication Deficit, Expressive Language Disorder, Psychosis, Generalized Anxiety Disorder, Major Depressive Disorder, Dementia, and Mood Disturbance.</p> <p>Review of Resident #26's care plan titled, (Resident's name) has an ADL (Activities of Daily living) Self Care Performance Deficit (requires assistance with functional abilities) related to disease process (Seizure), and Impaired Mobility initiated on 01/28/22 and revised on 02/19/24. The care plan included an intervention that read .DRESSING/GROOMING: resident requires setup assistance to dress/groom .</p> <p>Further review of Resident #26's clinical record revealed no active care plan related to refusal of care or fingernails grooming.</p> <p>Review of Resident #26's Minimum Data Set (MDS) annual assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 6 indicating that the resident had severe cognition impairment. The assessment documented under Functional Abilities and Goals that the resident needed partial to substantial assistance with personal hygiene.</p> <p>Review of Resident #26's Certified Nursing Assistant (CNA) tasks record documented that the resident required substantial to maximal assistance with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) 25 of 30 days and 5 days required total assistance from staff with personal hygiene.</p> <p>Review of Resident #26's skilled nursing notes from 01/26/22 to 04/29/24 and general nursing progress notes from 01/24/22 to 04/23/24 revealed a lack of written documentation of the resident's refusal of fingernails grooming.</p> <p>On 04/29/24 at 11:25 AM, observation revealed Resident #26 wheeling himself in a wheelchair down the hallway. An interview was conducted with the resident who stated he was waiting to go to smoke.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/24 at 10:15 AM, during an interview with Resident #26, observation revealed the resident fingernails were elongated and most of the them had a black matter underneath the nails. The resident stated he had not ask the staff to get them clean and he likes them long. The resident stated he did not refuse for them to clean them, but that no one had offered to get them clean.</p> <p>On 05/01/24 at 8:25 AM, an interview was conducted with Staff D, CNA who stated the CNAs were responsible to do the resident's fingernail care (grooming).</p> <p>On 05/01/24 at 8:27 AM, an interview was conducted with Staff E, CNA who stated the CNAs were responsible to do the resident's fingernail care and added they had to ask for a clipper kit. Subsequently, a side by side observation of Resident #26's fingernails was conducted with Staff E who stated his fingernails needed to be done and will do today. Staff E was asked why it had not been done and stated, he fights. Staff E was asked if she notified the nurse and stated she had.</p> <p>On 05/01/24 at 8:31 AM, an interview was conducted with Staff F, Registered Nurse (RN) who stated the Director of Nursing (DON) makes a schedule for a CNA to do the resident's fingernails. Staff F stated she had not been informed that Resident #26 fights to gets his fingernail care.</p> <p>On 05/01/24 at 9:05 AM, an interview was conducted with Staff G, CNA who stated a CNA was scheduled to do the resident's fingernails.</p> <p>On 05/01/24 at 11:46 AM, an interview was conducted with the DON who stated that it was all CNAs responsibility to do the residents fingernail care/grooming. The DON was apprised that the nursing staff reported that a CNA was assigned weekly to do the resident's fingernails. The DON replied that was not accurate and added that once a month she does a round and if she sees that multiple residents needs fingernail care, she will schedule a CNA to get that done.</p> <p>During the interview, the DON stated that Resident #26 told her that he wanted his fingernails long because he likes to get the nails in between his teeth. The DON was apprised of Resident #26's black matter underneath his fingernails. The DON stated that was not good. The DON stated she was not aware of any resident refusing fingernail care and was apprised that there was no documentation on Resident #26 of refusing fingernail grooming.</p> <p>On 05/01/24, observation from 12:08 to 12:15 PM revealed Resident #26 sitting in wheelchair down the hallway close to the DON's office. The resident had his head down and had his left hand index and middle fingers inside his mouth and moving the fingers back and forth repeatedly. Further observation revealed multiple staff members passed by the resident and did not attempt to address the resident's behavior.</p> <p>2) Review of Resident #43's clinical record documented an admission on 06/10/21 with a readmission on 08/14/23. The resident diagnoses included Essential Hypertension, Anxiety Disorder, Psychosis, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Seizures and Mood Disorders.</p> <p>Review of Resident #43's MDS quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 15 indicating that the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident needed substantial to maximum assistance from the staff to complete the activities of daily living including personal hygiene.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #43's care plan titled (Resident's name) has an ADL Self Care Performance Deficit (requires assistance with functional abilities) related to disease process Cerebral Vascular Accident (CVA), left sided Hemiplegia, Musculoskeletal impairment (contracture to upper/lower extremities) initiated on 06/11/21 and revised on 02/19/24. The care plan documented an intervention that read . DRESSING/GROOMING: Resident with left sided weakness and contractures requires assistance for upper/lower dressing and grooming, assist as needed initiated on 06/11/21 .BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse initiated on 06/11/21.</p> <p>Further review of Resident #43's clinical record revealed no active care plan related to refusal of care or fingernail grooming.</p> <p>Review of Resident #43's general nursing progress notes from 01/10/24 to 04/16/24 revealed no written documentation of the resident's refusal of fingernail grooming.</p> <p>Review of Resident #43's CNA's tasks record documented that the resident is dependent on the staff for his personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).</p> <p>On 04/29/24 at 10:26 AM, an interview was conducted with Resident #43 who stated that he had asked for his fingernails to be done and only one person does it. The resident added he had a stroke that left his left side paralyzed and gets spasms. The resident stated that when he get his left hand's spasms, he could not control it and the hand gets into his soiled brief.</p> <p>Observation revealed Resident #43's right hand fingernails elongated and right thumb nail jagged. The resident stated that he scratches his genitals and bleeds. During the interview, the resident removed a quilted cloth mitt (oven kitchen glove) from his left hand. Observation revealed left hand with a contracture and elongated discolored and ragged fingernails.</p> <p>On 05/01/24 at 9:05 AM, an interview was conducted with Staff G, CNA who stated a CNA was scheduled to do the resident's fingernails.</p> <p>On 05/01/24 at 9:13 AM, an interview was conducted with Staff H, CNA who stated that she was hired 2 months ago and attended a full orientation for CNAs. Staff H was asked who was responsible to do the resident's fingernail care and stated they have someone that comes to do toenails. Staff H was unable to state who was responsible to do the resident's fingernail care.</p> <p>On 05/01/24 at 11:24 AM, an interview was conducted with Staff I, Licensed Practical Nurse (LPN) who stated that the nurses and CNAs were responsible to do the resident's fingernails care. Staff I stated she had not been informed of Resident #43 refusing of fingernail care. Consequently, a side by side observation of Resident # 43's left and right hand fingernails was conducted with Staff I. Staff I asked the resident if he wants his fingernails cut and file; the resident stated, what do you think?. Staff I stated she will discuss with the DON Resident #43's fingernails care and added he may need a Dermatologist consult.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/01/24 at 11:46 AM, an interview was conducted with the DON who stated that it was all CNAs responsibility to do the residents fingernail care/grooming. The DON was not aware of any resident refusing fingernail care and was apprised that there was no documentation on Resident #43 of refusing fingernail grooming.</p>		

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  05/02/2024
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36734</p> <p>Based on observation, interview, and record review, the facility failed to address a significant weight loss in a timely manner for 1 of 10 residents sampled for nutrition (Resident #48).</p> <p>The findings included:</p> <p>Resident #48 was admitted to the facility on [DATE] with diagnoses including malnutrition. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and had weight loss.</p> <p>Resident #48 was care planned for nutritional problem or potential nutritional problem related to anorexia on 04/12/24. An intervention included to administer medications as ordered.</p> <p>Record review revealed Resident #48 was sent to the hospital for lethargy on 03/23/24, and returned to the facility on [DATE] with a diagnosis of Urinary Tract Infection. Resident #48's last recorded weight at the facility prior to hospitalization was 182.8 pounds (lbs). Resident #48's weight was 162.6 lbs on readmission to the facility on [DATE].</p> <p>A review of Resident #48's Nutrition Comprehensive Evaluation/Risk Screen dated 04/05/24 documented:</p> <p>Resident #48 was admitted with Urinary Tract Infection and PMH (primary medical history): Hep B, Pro-Calorie Malnutrition, Depression, Hyperlipidemia, Vit D deficiency, HTN (Hypertension), GERD (Gastric Reflux). CBW (current body weight) 162.8# (pounds). Wt Hx (weight history): 162.6# (4/1), 182.8# (3/11), 182# (3/8), 182.4# (3/6). Wt change: 10.4% x30, 19.7% x180. Resident was in hospital 3/25 to 3/31. BMI: 26.3 (&gt;23; normal for age). Current diet: Regular diet, pureed texture, thin consistency. Intake reported to be 26-100%. Resident required total assist for meals. Visited resident at bedside in am and pm. Resident was not alert and not responding to questions. Spoke with nurse, no swallowing difficulties reported at this time. No N/V/C/D (nausea, vomiting, constipation, diarrhea) mentioned. Nutritional needs not being completely met at this time. No pressure injuries noted. Medications: atorvastatin, ondansteron, gabapentin, amoxicillin, vit D3. Labs not avail at this time. Recommendation: continue providing feeding assistance, diet as ordered. medpass 2.0 twice per day (kcal 120, PRO 5g-each) between breakfast and lunch for nutrition support. Monitor: intake, wt, skin, labs as avail. RD/ DTR (Registered Dietitian/Dietary) available as needed.</p> <p>A review of Resident #48's orders revealed the following:</p> <p>03/20/24 Health Shake two times a day for nutrition support lunch/dinner *may substitute frozen nutritional treat if house shake unavailable*</p> <p>04/22/24 Regular diet, Pureed texture, Nectar consistency Diet</p> <p>04/22/24 Additional 240ml of water PO (by mouth) every 6 hours for hydration</p> <p>(continued on next page)</p>

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  05/02/2024
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>04/25/24 Mirtazapine Oral Tablet 7.5 MG Give 7.5 mg by mouth at bedtime for weight loss R/T (related to Depression)</p> <p>04/25/24 Please insert IV MID line for hydration therapy</p> <p>04/25/24 Wound consult</p> <p>04/30/24 Calorically Dense Oral Supplement three times a day for nutrition support 120ml Medpass 2.0 Supplement</p> <p>04/30/24 Weekly Weight one time a day every Tues for 4 Weeks</p> <p>Resident #48's lunch tray was observed on 04/29/24 at 12:30 PM on the resident's bedside table. There was no Health Shake or frozen nutritional treat observed.</p> <p>An interview was conducted with the Diet Tech (DT) on 05/01/24. The DT stated she assessed Resident #48 on 04/05/24 and acknowledged the resident's significant weight loss. The DT stated she recommended Medpass (Protein Supplement) 2 times a day. The DT further acknowledged there was no order for the Medpass 2 times a day. The DT stated she puts her own orders in, and could not explain the reason the order was not placed for Resident #48 to receive the Med Pass 2 times a day. The DT acknowledged Resident #48 developed a Pressure Ulcer to the sacrum. The DT stated she ordered calorically dense oral supplement (Medpass) 3 times a day for further nutritional support and to monitor weight x4 weeks.</p>		

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  05/02/2024
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 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>01948</p> <p>Based on interview and record review , it was determined the facility failed ensure that dialysis communication forms completely and accurately document the condition and monitoring for complications before and after dialysis treatments for 1 (Resident #23) of 1 resident sampled for dialysis.</p> <p>The findings included:</p> <p>During the review of the clinical record of Resident #23 on 04/30/24 and 05/01/24, the following were noted:</p> <p>Date of Admission: 03/15/17 (original, 12/26/23 (re-admission)</p> <p>Diagnoses: End Stage Renal Disease</p> <p>Current Physician's Orders: Resident to receive Dialysis on T-Th-Sat at Dialysis Center-1 PM Pick-up time for End Stage Renal Disease.</p> <p>During the review of the facility's Dialysis Communication Forms from 02/06/24 through 04/30/24 noted that 24 of the 25 communication documents failed to be properly documented. A review of the facility's form noted that the form has 3 sections which included the following:</p> <p>(1) Facility to Complete Prior to Dialysis: medications administered prior to dialysis, vital signs, examine Shunt Site, Pain, Bruit/Thrill, Signs of Infection, Changes, Physician Orders, New Labs, and Nurse Signature, and Time Left for Dialysis.</p> <p>(2) Dialysis Center to complete for Facility: Vital Signs, Pre-Post Weight, Dialysis Times, New Orders, Monitor of Shunt Site, Dressing Dry &amp; Intact, Ports, Lab Values, Pertinent Occurrences During Treatment, Medications Administered, Recommendations, Signature, and Title.</p> <p>(3) Facility to Complete Upon Return from Dialysis: Vital Signs Pain, Access Site, Bruit Present, Bleeding, Nurse Signature, and Date</p> <p>A review of the dated forms noted 24 of 25 communication forms were not documented in their respective sections by the Dialysis Center and/or Facility as evidenced by the following:</p> <p>Section #1- 04/30/24, 04/27/24, 04/25/24, 04/16/24, 04/13/24, 04/12/24, 04/11/24, 04/04/24, 03/28/24, 03/21/24, 03/19/24, 03/05/24, 02/20/24, 02/17/24, 02/15/24, 02/10/24, 02/06/24.</p> <p>Section #2 - 04/23/24, 04/13/24, 04/12/24, 03/26/24, 03/12/24, 02/20/24, 02/17/24, and 02/15/24.</p> <p>Section#3 - 04/27/24, 04/23/24, 04/12/24, 04/09/24, 04/02/24, 03/26/24, 03/12/24, 02/20/24, 02/17/24.</p> <p>(continued on next page)</p>

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  05/02/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Following the review of the Dialysis Communication Forms of Resident #23, the findings were reviewed and confirmed with the Director of Nursing on 05/02/24. Noted to state that numerous required sections of the forms are not being documented by facility nursing staff and the Dialysis Center staff.</p>		

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  05/02/2024
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 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>01948</p> <p>Based on interview and record review, it was determined that the the facility failed to provide 2 (Resident's #60 and #23) of 2 sampled residents with a nourishing, palatable, well balanced bagged meal or snack to take to dialysis appointments.</p> <p>The findings included:</p> <p>1) During an interview conducted with the alert and interviewable Resident #60 on 04/29/24 and 04/30/24, he stated he has resided in the facility for the past 3 years and leaves the facility for dialysis appointments three times per week (Tuesday/Thursday/Saturday) at 5-5:30 AM. Resident #60 went on to state that a breakfast meal or snack is not provided to him prior to leaving for the dialysis appointments. The resident further stated that a bagged snack or lunch is not being provided on a regular basis to take with him to the dialysis appointments. Stated that when a bagged snack is sent it contains only a package of crackers and a 4 ounce House Shake. The resident also stated he is hungry prior to leaving for dialysis and is also hungry during dialysis treatments. Stated he has requested a bagged meal or snack form nursing staff on many occasions, however there has been no resolution.</p> <p>On 04/30/24 at 10 AM, a follow up interview was conducted with Resident #60 following his return from a dialysis session. He stated a breakfast meal was not provided prior to leaving for the appointment and the bagged snack contained a package of crackers that had been already opened and a House Shake that was warm and not drinkable.</p> <p>During a review of the clinical record of Resident #60, the following were noted:</p> <p>Date of Admission: 07/31/20</p> <p>Re-Admission: 02/11/23</p> <p>Diagnoses: Chronic Kidney Disease, Dependence on Dialysis</p> <p>Current Physician orders:</p> <p>*11/2/22 - Dialysis - Tuesday/Thursday/Saturday - pick-up time 05:15 -0545 AM</p> <p>MDS: 2/7/24 - Quarterly</p> <p>Section C: BIMs Score =12</p> <p>Section D: No Mood issues</p> <p>Section GG: Eating= Set-up/Clean Up Assist</p> <p>Section K: NO Swallow Disorder - Height =68 Weight =152#,</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Mechanical Altered Diet and Therapeutic Diet</p> <p>Weight History:</p> <p>3/6/24 = 152 pounds</p> <p>2/5/24 = 152 pounds</p> <p>Ht = 68</p> <p>BMI=23.1</p> <p>Ideal Body Weight Range; 145-191 pounds</p> <p>Care Plan Review: 02/25/24</p> <p>* Risk For Malnutrition - interventions did not document breakfast meal prior to dialysis appointments or bagged lunch to take to dialysis appointments.</p> <p>On 05/02/24 the facility's Registered Dietetic Technician and Corporate Food Service Director were interviewed concerning the resident's statements of not being provided a breakfast meal prior to leaving for dialysis appointments or bagged snack/meal to take to dialysis appointments. The interview revealed that staff were not able to confirm if a meal was being provided prior to leaving the facility for dialysis appointments nor could not confirm if a bagged snack/meal was being provided to take to dialysis appointments.</p> <p>2) During interviews conducted with the alert and oriented Resident #23 on 04/30/24 and 05/01/24, the resident stated that he leaves the facility for dialysis appointments at 10:30 AM three times per week on Tuesday, Thursday, and Saturday. Resident #23 stated he returns from the dialysis appointments at approximately 3-4 PM. Further stated that for the past year the facility has not provided him with a nourishing bagged lunch to take to the dialysis appointment, nor is he provided with a nourishing bagged snack to take to dialysis appointments. Further stated he has requested a bagged lunch meal or snack on numerous occasions but there has been many changes in the facility's administration and his request has not been resolved.</p> <p>During the review of the clinical record of Resident #23, the following were noted:</p> <p>Date of Admission: 03/15/17</p> <p>Re-Admission: 12/26/23</p> <p>Diagnoses: End Stage Renal Disease,</p> <p>Review of Current Physician Orders noted:</p> <p>12/26/23 - Resident to receive dialysis on Tuesday/Thursday, Saturday. Pick up time is 11 AM.</p> <p>Review of current MDS (01/2/24)</p> <p>(continued on next page)</p>

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  05/02/2024
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 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Section C: BIMS Score = 15 (no cognitive impairment)</p> <p>Sec D: No Mood Issues</p> <p>Section GG: Eats Independently</p> <p>On 05/02/24 the facility's Registered Dietetic Technician and Corporate Food Service Director were interviewed concerning the resident's statements of not being provided a nourishing bagged lunch meal or snack to take with to dialysis appointments. The interview revealed that staff were not able to confirm if a bagged lunch meal or bagged snack was being provided prior to leaving the facility for dialysis appointments.</p>

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  05/02/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined that the facility's approved menu was not followed that potentially effected 111 of the facility residents.</p> <p>The findings included</p> <p>1) Review of the facility's approved menu the week of 04/28/24 noted that 2% Milk is documented to be served to Regular Diet, No Added Salt Diet, Pureed Diet, Mechanical Soft Diet, Renal Diet, and Skim Milk to be served to Low Fat/Cholesterol Diet. Orange Juice to Regular Diet, Mechanical Soft Diet, Pureed diet, Therapeutic Diet.</p> <p>Observation of the facility's food supply on hand conducted on 04/29/24 at 9 AM noted that only Whole Milk was available for residents and no supply of 2% milk and skim milk. Interview with the Certified Dietary Manager at the time of the observation noted that the facility's residents were without milk for the last 2 days and an emergency whole milk order was obtained and delivered on 04/28/24. It was also noted that there was no supply of Orange Juice on hand. She also stated that there has been no supply of Orange Juice for the last 7 days.</p> <p>2) Review of the facility's approved menu for the Lunch meal of 04/29/24 noted the following to be served:</p> <ul style="list-style-type: none"> <li>* Roll:Regular/Mechanical Soft, and Therapeutic, and Renal Diet</li> <li>* Pureed Roll: Pureed Diet</li> <li>* Pureed Parsley Noodles: 4 ounces to Pureed Diet</li> <li>* Blueberry Shortbread: Regular/Mechanical Soft, Therapeutic Diet, and Renal Diet</li> <li>* Pureed Blueberry Shortbread: Pureed Diet</li> </ul> <p>During the observation of the lunch meal tray line in the main kitchen and interview conducted with the Breakfast/Lunch Cook (Staff A) on 04/29/24 at 11 AM, the following were noted:</p> <ul style="list-style-type: none"> <li>* No rolls and pureed roll available for the last 7 days. Staff A states the rolls were noted to be ordered.</li> <li>* Pureed Parsley Noodles, Staff A stated she was unaware the pureed Parsley Noodles were documented to be served to pureed diet.</li> <li>* Blueberry Shortbread and pureed Blueberry Short Bread not served. Blueberry Pie substituted. Staff A stated ingredients for short cake were not ordered.</li> </ul> <p>(continued on next page)</p>

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  05/02/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) During the review of the approved menu for the Dinner meal of 04/29/24 noted the following to be served:</p> <ul style="list-style-type: none"> <li>* Potato Salad: Regular Diet, Mechanical Soft Diet, Therapeutic Diet</li> <li>* Pureed Potato Salad: Pureed Diet</li> <li>* Cinnamon Applesauce; Regular, Mechanical Soft Diet, Pureed Diet, Therapeutic Diet, and Renal Diet</li> <li>* Baked Potato: Low Fat/Cholesterol Diet</li> <li>* Noodles: Renal Diet</li> </ul> <p>During the interview with the Dinner Cook (Staff B) on 04/29/24 at 3 PM, he stated the following:</p> <ul style="list-style-type: none"> <li>* Only canned diced potatoes and mayonnaise available. All ingredients not purchased.</li> <li>* Marinated Cucumbers and pureed Marinated Cucumbers not purchased. No substitution for the Cucumbers planned and prepared.</li> <li>* NO canned Applesauce purchased. Staff B stated he will attempt to pureed canned Apple Slices.</li> <li>* NO Baked Potatoes purchased. NO substitute planned or prepared.</li> <li>* Unaware that Noodles were served for the lunch meal.</li> </ul> <p>4) Interview conducted with the Certified Dietary Manager (CDM), during the lunch meal service of 04/29/24, she stated she was informed by the administration she was over the food budget and many foods could not be ordered at this time without emergency permission from the Administrator. Interview with the administrator on 04/29/24 noted that the food purchasing is under budget restraints and all the CDM needed to do was to contact her for an emergency food order. The Administrator stated CDM had not notified her over the last 7 days of the need to place an emergency food order.</p> <p>5) During individual interviews conducted with facility residents on 04/29/24 and 04/30/24, it was noted that 15 sampled resident had food issues that included failure to follow the approved menu, failure to provide an alternate menu, and failure to provide between meal snacks. The sample residents included the following:</p> <p>Resident #2</p> <p>Resident #8</p> <p>Resident #11</p> <p>Resident #14</p> <p>Resident #15</p> <p>(continued on next page)</p>		

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  05/02/2024
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)
F 0803  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Resident #23  Resident #60  Resident #64  Resident #68  Resident #69  Resident #80  Resident #85  Resident #89  Resident #92  Resident #100

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  05/02/2024
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance that potentially affected 111 of the facility residents.</p> <p>The findings included:</p> <p>During the initial kitchen/food service observation tour conducted on 04/29/24 at 9 AM, it was noted that there were approximately 11 pans of foods covered with aluminum foil located on the stove top. Further observation noted that there was no heat being applied to the covered food pans.</p> <p>An interview with the breakfast/lunch Cook (Staff A) at the time of the observation noted that all of the pans located on the stove top were for the lunch meal of 04/29/29. Also stated that all foods in the pans were totally cooked and would be put in to the steam table.</p> <p>Further interview noted that the food pans contained lunch foods which were identified as the following:</p> <ul style="list-style-type: none"> <li>* Maple Glazed Fish (3 pans)</li> <li>* Ground Maple Glazed Fish (1 pan)</li> <li>* Pureed Maple Glazed Fish (1 pan)</li> <li>* Parsley Noodles (2 pans)</li> <li>* Pureed Parsley Noodles (1pan)</li> <li>* Carrots (2 pans)</li> <li>* Pureed Carrots (1 pan)</li> </ul> <p>Further interview conducted with the breakfast/lunch cook noted that the lunch tray would not begin until approximately 12 PM. Further stated that the pans of prepared lunch foods would remain on the stove top or in the steam table for the next 3 hours until the start of the lunch tray line. Further interview revealed that Staff A was not aware that prolonged cooking and holding of foods will result in compromised and destroyed nutritive value of the foods. Also negatively affected the taste, flavor and appearance of foods.</p> <p>Interview with the Certified Dietary Manager (CDM) also conducted during the 04/29/24 observation stated she was unaware that foods were being completely cooked and held hours prior to the meal service. She stated that foods are required to be prepared as close to the meal time as possible, and that the early cooking was for convenience.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>It was further discussed with the CDM that 111 residents (Regular Diet, Mechanically Altered Diet, Therapeutic Diet) were potentially affected.</p>		

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  05/02/2024
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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide liquids in a Nectar Thick form for 1 (Resident #60) of 2 resident's with physician ordered thickened liquids.</p> <p>The findings included:</p> <p>During the review of the clinical record of Resident #60, the following were noted:</p> <p>Date Of Admission: 7/31/20</p> <p>Re-Admission: 2/11/23</p> <p>Diagnoses: Chronic Kidney Disease Stage 4, Acute Kidney Failure, Type 2 Diabetes, Protein-Calorie Malnutrition, Dyspahgia, Dependence on Dialysis</p> <p>Current Physician Orders:</p> <p>2/27/24 - Renal Diet, Mechanical Soft Meat, Nectar Consistency,</p> <p>9/26/23- ProHeal Critical Care</p> <p>3/1/23 - 1500 ml Fluid Restriction - 900 ml Dietary/600 ml Nursing (7-3 = 240/3-11=300 ml/11-7 = 60 ml</p> <p>11/2/22 - Dialysis - Tuesday/Thursday/Saturday - pick-up time 05:15 -0545.</p> <p>MDS: 2/7/24 - Quarterly</p> <p>Section C: BIMS =12 (Mild Cognitive Impairment</p> <p>Section D: No Mood issues</p> <p>Section GG: Set-up/Clean Up Assist</p> <p>Section K: NO Swallow Dis - 68 152#,</p> <p>Mechanical Altered Diet, Therapeutic Diet</p> <p>Weight History:</p> <p>3/6/24 = 152 #</p> <p>2/5/24 = 152 #</p> <p>(continued on next page)</p>

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  05/02/2024
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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ht = 68</p> <p>BMI=23.1</p> <p>IBWR: 145-191#</p> <p>Observation of the Breakfast meal on 05/01/24 noted the meal tray served to the room of Resident #60. A review of the resident's meal tray ticket for the meal documented a Mechanical Soft, Renal Large Portions Nectar Thick Liquids, and Fluid Restriction. Further review of the ticket documented only 6 ounces of thickened coffee to be served with the breakfast. Observation of the meal tray noted that the resident was served 6 ounces (180 ml) of non-thickened coffee, 8 ounces (240 ml) of non-thickened cranberry juice, and 8 ounces (240 ml) of Milk. The total amount of non-thickened fluids served on the breakfast tray was 660 ml.</p> <p>Following the breakfast meal of 05/01/24 the surveyor discussed the fluid restriction and nectar thickened liquids with the facility's Registered Diet Technician (DTR). It was noted the DTR to state that the physician ordered fluid restriction was not followed for the breakfast meal and that tray liquids that included coffee, cranberry juice , and milk were not thickened to the physician orders for Nectar Thick Liquids. It was further discussed that the resident was served an additional 480 ml of fluids over the breakfast allotment of 180 ml of fluids.</p>

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  05/02/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined the facility failed to provide food preferences and food options of similar nutritive value to potentially 111 residents who may choose not to eat food that is initially served or who request a different meal choice.</p> <p>Findings included:</p> <p>1) During the observation of the lunch meal in the main kitchen on 04/29/24 at 11:30 AM, it was noted that approved menu items of maple Glazed Fish, Parsley Noodles, and Carrots were being served to regular, mechanically altered diet and therapeutic diets. Further observation of the meal service noted that there was not an alternate hot entree, hot starch food, or hot vegetable prepared and available as an alternate for the facility residents. Interview with breakfast/lunch Cook (Staff A) at the time of observation noted to state a baked chicken breast or leg is supposed to be always available for the lunch and dinner meals but the facility has not had chicken available for meals for over 7 days. Staff A stated she was not informed why chicken was not available for meal preparation and serving. The interview and review of the approved menu noted that an alternate hot entree, starch, vegetable was not documented.</p> <p>2) Interview with the Certified Dietary Manager (CDM), during the meals service of 04/29/24 noted to state she was informed by the administration she was over the food budget and many foods could not be ordered at this time without emergency permission from the Administrator. Interview with the Administrator on 04/29/24 noted that the food purchasing is under budget restraints and all the CDM needed to do was to contact her for an emergency food order. The Administrator stated the CDM had not notified her over the last 7 days of the need to place an emergency food order.</p> <p>3) During the interview conducted with the CDM on 04/29/24 it was noted that the facility has a Alternate Menu Ticket that included foods to always be available for lunch and diner meals. The surveyor requested a copy of the alternate menu and noted the following foods to be always available for meals:</p> <p>Entree:</p> <ul style="list-style-type: none"> <li>* Baked Boneless Chicken</li> <li>* Grilled Cheese Sandwich</li> <li>* Turkey &amp; Cheese Sandwich</li> <li>* Tuna Salad Sandwich</li> <li>* Fruit Platter</li> <li>* Chefs Salad</li> </ul> <p>(continued on next page)</p>		

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  05/02/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Sides:</p> <ul style="list-style-type: none"> <li>* Potato Chips</li> <li>* Chefs Vegetables</li> <li>* Steamed Rice</li> </ul> <p>Interview with the CDM concerning the Alternate Menu Ticket on 04/29/24 noted the following:</p> <p>Entree:</p> <ul style="list-style-type: none"> <li>* Baked Boneless Chicken - not available for past 7 days.</li> <li>* Grilled Cheese Sandwich: On 04/29/24 at 10 AM it was noted staff just purchased American Cheese at a local grocery store. Interview with the CDM noted that sliced American Cheese has not been available for the past 2-3 days.</li> <li>* Turkey &amp; Cheese Sandwich - Available but the approved dinner menu entree was a turkey sandwich.</li> <li>* Tuna Salad Sandwich - no tuna available for the past 7 days.</li> <li>* Chicken Salad Sandwich - no chicken available for the past 7 days.</li> <li>* Fruit Platter - no fresh fruit available for the last 10-14 days.</li> </ul> <p>Side:</p> <ul style="list-style-type: none"> <li>*Potato Chips - not available for the last 7-19 days.</li> <li>* Chef Vegetables - a hot vegetable alternative has stopped being prepared for some time.</li> <li>* Steamed Rice - rice available however not being prepared as an alternate fro lunch and dinner meals.</li> </ul> <p>3) During individual interviews conducted with facility residents on 04/29/24 and 04/30/24, it was noted that 15 sampled resident had food issues that included failure to follow the approved menu, and failure to provide an alternate menu, and failure to provide between meal snacks. The sample residents included the following:</p> <p>Resident #2</p> <p>Resident #8</p> <p>Resident #11</p> <p>Resident #14</p> <p>(continued on next page)</p>

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  05/02/2024
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)
F 0806  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Resident #15  Resident #23  Resident #60  Resident #64  Resident #68  Resident #69  Resident #80  Resident #85  Resident #89  Resident #92  Resident #100

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  05/02/2024
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide physician ordered therapeutic diet (Fluid Restriction) of 1 (Resident #60) of 2 residents sampled for Dialysis.</p> <p>The findings included:</p> <p>During the review of the clinical record of Resident #60, the following were noted:</p> <p>Date Of Admission: 7/31/20</p> <p>Re-Admission: 2/11/23</p> <p>Diagnoses: Chronic Kidney Disease Stage 4, Acute Kidney Failure, Type 2 Diabetes, Protein-Calorie Malnutrition, Dyspahgia, Dependence on Dialysis</p> <p>Current Physician Orders:</p> <p>2/27/24 - Renal Diet, Mechanical Soft Meat, Nectar Consistency,</p> <p>9/26/23- ProHeal Critical Care</p> <p>3/1/23 - 1500 ml Fluid Restriction - 900 ml Dietary/600 ml Nursing (7-3 = 240/3-11=300 ml/11-7 = 60 ml.</p> <p>11/2/22 - Dialysis - Tuesday/Thursday/Saturday - pick-up time 05:15 -0545.</p> <p>MDS: 2/7/24 - Quarterly</p> <p>Section C: BIMS =12 (Mild Cognitive Impairment</p> <p>Section D: No Mood issues</p> <p>Section GG: Set-up/Clean Up Assist</p> <p>Section K: NO Swallow Dis - 68 152#,</p> <p>Mechanical Altered Diet, Therapeutic Diet,</p> <p>Weight History:</p> <p>3/6/24 = 152 #</p> <p>2/5/24 = 152 #</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ht = 68</p> <p>BMI=23.1</p> <p>IBWR: 145-191#</p> <p>Observation of the Breakfast meal on 05/01/24 noted the meal tray served to the room of Resident #60. A review of the resident's meal tray ticket for the meal documented a Mechanical Soft, Renal Large Portions Nectar Thick Liquids, and Fluid Restriction.</p> <p>Further review of the ticket documented only 6 ounces of thickened coffee to be served with the breakfast. Observation of the meal tray noted that the resident was served 6 ounces (180 ml) of non-thickened coffee, 8 ounces (240 ml) of non-thickened cranberry juice, and 8 ounces (240 ml) of Milk. The total amount of non-thickened fluids served on the breakfast tray was 660 ml.</p> <p>Following the breakfast meal of 05/01/24 the surveyor discussed with the fluid restriction and nectar thickened liquids with the facility's Registered Diet Technician (DTR). It was noted the DTR to state that the physician ordered fluid restriction was not followed for the breakfast meal and that tray liquids that included coffee, cranberry juice , and milk were not thickened to the physician orders for Nectar Thick Liquids. It was further discussed that the resident was served an additional 480 ml of fluids over the breakfast allotment of 180 ml of fluids.</p>

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  05/02/2024
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>01948</p> <p>Based on interview, observation, and record review, it was determined that the facility failed to provide suitable, nourishing snacks to potentially 111 facility residents who want to eat at non-scheduled times or outside of scheduled meal service times.</p> <p>The findings included:</p> <p>1) During the initial food service tour conducted on 04/29/24 at 9 AM with the facility's Certified Dietary Manager, it was noted low levels of food supplies of frozen, canned, dairy, and daily pantry foods. The surveyor requested a copy of the Snack Menu and list of residents who received scheduled between meal snacks.</p> <p>A review of the facility's Resident Snack Menu noted the following foods to be always available:Puddings</p> <p>Gelatins</p> <p>Cookies</p> <p>Crackers</p> <p>Sandwiches for diabetics</p> <p>Turkey (alternate days)</p> <p>Cheese (alternate days)</p> <p>Peanut Butter &amp; Jelly</p> <p>A review of scheduled Nourishment/Snacks to be prepared daily as part of the residents nutritional care plan (diabetes, underweight, dialysis) noted only 8 listed residents which included Sampled Residents #23, #37, #45, #64, #75, and #98.</p> <p>Further review of the list noted no documentation of the times (10 AM/2 PM/8 PM) the residents were scheduled to receive the scheduled snack. A review of the type of snacks to be provided to these residents included:</p> <p>Fresh Fruit</p> <p>Half Sandwich</p> <p>Health Shakes</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Fruit Cup</p> <p>Turkey &amp; Cheese Sandwich</p> <p>Graham Crackers</p> <p>2) During the interview with the CDM on 04/29/24 at 2 PM concerning the Resident Snack Menu, the following were noted:</p> <p>Puddings: (canned or individual portions) not available for at least the last 7 days .</p> <p>Gelatins: not available for at least the last seven days.</p> <p>Cookies: not available for unknown time.</p> <p>Crackers: no Graham Crackers available for at least the last 7 days.</p> <p>Turkey Sandwich: Turkey Breast in supply but frozen and was being utilized for the dinner meal of 04/29/24.</p> <p>Cheese: No sliced American Cheese available for the last 3 days. Facility went out to local grocery store on 04/29/24 and purchased 2 pounds of sliced American Cheese to be utilized for the lunch meal of 04/29/24.</p> <p>Peanut Butter: No commercial containers of Peanut Butter in supply. Unknown how long not available.</p> <p>During the interview the CDM indicated to the surveyor that the next scheduled food delivery would be on 05/02/24.</p> <p>3) During an interview conducted with the Registered Dietetic Technician and Corporate Food Service Director on 05/02/24 at 10:30 AM, it was revealed that they could not verify if the scheduled snacks were being prepared and served to the residents with nutritional care plan issues. The list included 6 sampled residents, Residents #23, #37, #45, #64, #75, and #98.</p> <p>4) During individual interviews conducted with facility residents on 04/29/24 and 04/30/24, it was noted that 15 sampled residents had food issues that included failure to follow the approved menu, failure to provide an alternate menu, failure to provide food substitutions and failure to provided between meal snacks. The sample residents interviewed included the following:</p> <p>Resident #2</p> <p>Resident #8</p> <p>Resident #11</p> <p>Resident #14</p> <p>(continued on next page)</p>

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  05/02/2024
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)
F 0809  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Resident #15  Resident #23  Resident #60  Resident #64  Resident #68  Resident #69  Resident #80  Resident #85  Resident #89  Resident #92  Resident #100

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  05/02/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>The findings included:</p> <p>1) During the initial kitchen/food service sanitation tour conducted on [DATE] at 9 AM and accompanied with the facility's Certified Dietary Manager (CDM), the following were noted:</p> <p>(a) The exterior of the exhaust hood system that is located directly over the major cooking equipment was noted to be soiled and covered with rust. It was discussed with the CDM at the time that the rust could fall into foods being prepared and result in food contamination. The CDM stated that she has put in numerous request to maintenance over the past 3 months for the issue to be resolved, however no one has assessed the hood issue.</p> <p>(b) Observation of the ceiling mounted commercial light fixtures (7) noted that exteriors were heavily soiled. Two of the light fixtures were noted to be potentially falling from the ceiling over food preparation and serving areas. The CDM stated that she has put in numerous request to maintenance over the past 3 months for the issue to be resolved, however no one has assessed the light fixture issue.</p> <p>(c) Numerous floor tiles in the food serving area were noted to be broken and missing.</p> <p>(d) Observation of walk-in refrigerator noted that the exterior of the internal fan cover was covered with dust and black mold type substance. The CDM stated that the fan is required to be cleaned by the maintenance department, but is not on their cleaning schedule.</p> <p>(e) Observation of the walk-in freezer noted that the door exterior was rust laden and the opening fixture was falling off leaving the door ajar. The CDM stated that she has put in numerous request to maintenance over the past 3 months for the issue to be resolved, however no one has assessed the freezer issue.</p> <p>(f) Observation of the walk-in refrigerator noted that there were 4 - 32 ounce containers of Yogurt with a manufacturers stamped expiration date of [DATE]. The CDM stated she was unaware of the expired Yogurt. The surveyor requested that the Yogurt be discarded from possible use immediately.</p> <p>(g) Observation of the Trauleson reach-in refrigerator #1 noted that 6 of 6 internal food storing shelves were soiled and rusted and in need of replacement.</p> <p>(h) At the request of the surveyor the chemical level of the 3 compartment sink was tested . The test revealed that there was no level of sanitizing chemical and did not meet the regulatory requirement. The surveyor requested that the 3-compartment sink not be utilized unit the chemical level meets the regulatory requirement.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(i) At the request of the surveyor the chemical level of 3 cleaning rag red buckets were tested . The test revealed that there was no level of sanitizing chemical and did not meet the regulatory requirement. The surveyor requested that the buckets not be utilized unit the chemical level meets the regulatory requirement .</p> <p>(j) Observation of the dish machine hood system noted that the interior was rust laden. It was also noted that the internal hood vent was heavily soiled and build-up of a black mold type substance. The CDM stated that she has put in numerous request to maintenance over the past 3 months for the issue to be resolved, however no one has assessed the dish machine hood issue.</p> <p>* Photographic evidence obtained from the [DATE] tour.</p> <p>2) During a follow-up kitchen/food service sanitation tour conducted of the main kitchen on [DATE] at 11:30 AM, and accompanied with the Corporate Food Service Director, the following were noted:</p> <p>k) Trash container located in the food preparation/serving area noted to be full and overflowing onto kitchen floor.</p> <p>l) The oven back splash was noted to be heavily soiled and large build-up of black carbon matter.</p> <p>m) Coffee cart located in the chemical room.</p> <p>n) Wall mounted Fire Sprinkler noted to be rusted and draining on dish room wall.</p> <p>o) The soiled cleaning rags noted to be left unattended on clean preparation and serving surfaces.</p> <p>p) Floor of the Pantry Room noted to have large areas of peeling paint.</p> <p>Photographic evidence obtained from the [DATE] tour.</p>		

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  05/02/2024
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to be administered in a manner to ensure an adequate food supply necessary to provide the nutritional needs of 111 of the 120 residents in the facility.</p> <p>The findings included:</p> <p>During the initial kitchen/food service tour conducted on [DATE] at 9 AM, with the facility's Certified Dietary Manger (CDM), it was noted there was limited food supplies on hand to ensure that the nutritional needs of the facility's 111 residents who eat by mouth. It was noted that the facility currently had 9 residents who receive their nutrition by a gastrostomy tube feedings. During the initial tour, it was noted a shortage of on-hand food supplies that included: frozen foods (meats, entrees, vegetables, etc.), dairy products (milk, cottage cheese, sliced cheeses, yogurt, etc.), canned foods (fruits, vegetables, puddings, etc.), fresh fruits and vegetables, juices ( individual portion control orange juice, apple juice, cranberry juice, etc.), and daily pantry food supplies (crackers, peanut butter, pastas, puddings, gelatins, assorted breads, and snacks).</p> <p>During the [DATE] tour the CDM stated that she is under monthly food budget/spending restrictions, specifically if over the monthly food budget no food purchases may be made without contacting the Administrator about resident food supply shortage and requesting an emergency food purchasing order. The CDM further stated that the Administrator is new to the facility and numerous requests for emergency food service orders were not approved nor was there communication concerning the food supply with the Administrator.</p> <p>During the observation, the CDM asked the surveyor to observe the current supply of dairy products. It was noted that there was only a limited supply of whole milk (no 2 % or skim), cottage cheese, or yogurt. The CDM stated that there was no supply of milk on Friday and Saturday and a request for an emergency order/delivery was granted for only whole milk. The whole milk was delivered on Sunday ([DATE]). The CDM also showed no supply of orange juice that would be available for the residents and stated they were out for the last ,d+[DATE] days. The CDM stated that the next scheduled food delivery would be Thursday ([DATE]), and until then the residents would be only served foods on hand. The surveyor requested a current inventory of all foods on hand to be separated by frozen foods, fresh foods, grocery foods, canned foods, dairy, and staple foods to be completed by [DATE].</p> <p>On [DATE] the CDM submitted only a list of frozen foods on hand, but failed to submit the other inventory requests. The lists could not be obtained by the surveyor due to the CDM being suspended for failure to perform duties on [DATE]. A review of the Frozen food inventory noted a list of approximately 23 food items, however there were sufficient amounts of these food to meet the approved menu.</p> <p>(continued on next page)</p>		

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  05/02/2024
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 1 PM, an interview was conducted with the Administrator concerning the food supply issues. The Administrator stated she has been employed at the facility for approximately 1 month and during this time had numerous issues with food shortages. She stated Dietary has an operating food budget, however even if the budget is exceeded the CDM may request a food delivery with no exceptions. She stated she was not informed of the food supply shortages in order to place an emergency food order. The CDM has been counseled and written up on occasions concerning this issue. The interview went on to noted that she was informed on Friday ([DATE]) that the facility was out of milk and an immediate action plan was put into place to purchase milk. She stated the milk was delivered the following day. The CDM was counseled to be held responsible for ordering food and supplies within the department. The Corporate Food Service Director (CFSD) was contacted to educate staff on ensuring that foods are served according to the approved menu. The cook staff will notify the CFSD /designee when food supplies becomes low and/or unable to prepare foods according to the approved menu. The facility food supply was audited for quality compliance and the CDM was found to be in poor management of her position. The CDM has been educated multiple times on her job performance and the immediate action was to suspend pending outcome of the investigation. The CFSD will now be responsible for oversight of the kitchen until a replacement is found. The CFSD will to ensure that food procurement, preparation and service is done according to the approved menu and diets.</p> <p>On [DATE] the CFSD spoke with the surveyor and it was noted that the were numeorus low levels of foods to ensure the appoved menu is followed and an emergecny delivery order was placed for a delivery date of [DATE].</p> <p>On [DATE] the surveyor invesitgated the current supply of foods within the dietary department. It was observed on [DATE] at 11 AM the dietary staff were bringing in foods just purchased at a local grocery store. The staff has plastic bags of Juices (Orange &amp; Apple) and sliced American Cheese to able to be serve for the lunch and dinner meals of [DATE].</p> <p>On [DATE] a large delivery from the contract food vendor was completed, however numeorus items were still not in supply. Of special note, there was no fresh fruit and vegetables in supply until [DATE] and oranges were not available for the entire survey.</p> <p>On [DATE] at 11 AM, the surveyor conducted an interview with the CFSD and observation of the lunch tray line assembly and observed the current food supply. The observation noted the following:</p> <p>Lunch meal Observation - main kitchen -[DATE] at 11:15 AM</p> <ul style="list-style-type: none"> <li>* NO tartar sauce for fish entree - residents complaints.</li> <li>* No rolls available - weeks.</li> <li>* Substitutes - only turkey or grilled cheese sandwiches.</li> <li>* Staff bought sliced cheese from store on [DATE] - cheese not available to ,d+[DATE] days.</li> <li>* Substitution list for residents not followed/ foods not available.</li> <li>* Menu no alternative for hot meal.</li> </ul> <p>(continued on next page)</p>		

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  05/02/2024
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>* No lunch alternative- chicken not available -Staff A stated chicken has not been available for 1 week.</li> <li>* Ran out frozen carrots - using canned.</li> <li>* No alternate vegetable - only carrots - residents complaints.</li> <li>* Pureed Parsley Pasta - not prepared - instant mashed served.</li> <li>* Blueberry Shortbread - not prepared.</li> <li>* NO pureed blueberry shortbread prepared.</li> <li>* NO Portion Control juices available - for 3 days.</li> <li>* NO sliced cheese available for 1 week.</li> <li>* NO cottage cheese available - 1 week.</li> <li>* NO yogurt available - 3 days - 18 pounds expired in walk-in.</li> <li>* NO resident snacks available - 3 days -1 week.</li> <li>* NO Fresh Fruit /Vegetables available- ,d+[DATE] weeks.</li> <li>* NO Chicken available -1 week.</li> <li>* NO Canned Applesauce available.</li> <li>* NO Health Shakes - 1 week.</li> <li>* NO milk 2 day - emergency delivery Sunday - only regular milk - no 2% or skim - menu based on 2% milk.</li> <li>* NO parsley /oranges available for garnish - for 2 weeks.</li> </ul> <p>Dinner Menu [DATE]:</p> <ul style="list-style-type: none"> <li>* Deli Sandwiches - Roast beef not available on [DATE].</li> <li>* Marinated Cucumbers (not available on [DATE]) - 3 PM no determination of the substitute.</li> <li>* Cinnamon Applesauce (not available on [DATE]).</li> <li>* Baked Potato (not available for renal diet on [DATE]).</li> </ul> <p>(continued on next page)</p>

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  05/02/2024
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During the survey conducted on [DATE] through [DATE], it was noted that Resident #23 and #60 were not being provided a meal prior to leaving for dialysis nor given a nutritious snack to take with them to their dialysis appointment 3 times per week. Numerous request by these residents was done without resolution. The residents stated they were hungry and without food while at their respective dialysis appointments.</p> <p>During the survey of [DATE] through [DATE], it was noted that the Alternate Menu List that documented 7 alternative entrees and 3 side foods to be available daily were not in supply. There were numerous resident complaints.</p> <p>Refer to Tag F 806.</p> <p>During the survey conducted on [DATE] through [DATE], it was noted through resident interviews and administrative staff interview that the between meal snack list and scheduled snack list were not available. The interviews noted the the snack foods had not been available for days.</p> <p>Refer to Tag F 809.</p> <p>During the survey conducted on [DATE] through [DATE], it was noted that physician ordered thickened liquids were not available for a least 1 sample Resident #60. Portioned controlled thickened liquids that included milk, juices, water, had not been available for ,d+[DATE] days. It was also noted that physican orderd Health Shakes (dietary protein/calorie supplements were not available for the last ,d+[DATE] days.</p> <p>During individual interviews conducted with residents concerning food issues on [DATE] - [DATE], it was noted they had issues with the following:</p> <ol style="list-style-type: none"> <li>1) Approved menu not followed on a regular basis. Further stated to voice to administration without resolution.</li> <li>2) Running out of foods on a regular basis. Further stated to voice to administration without resolution.</li> <li>3) No meal substitutions (entree, starch, vegetable, dessert, etc.) available on a regular basis. Foods not available on the posted Daily Foods Available. Further stated to voice to administration without resolution.</li> <li>3) Poor food quality, appearance, taste, temperature. Further stated to voice to administration without resolution.</li> <li>4) Between meal snacks and evening snacks not available. Items listed on the Daily Snack List not available. Further stated to voice to administration without resolution.</li> </ol> <p>The residents interviewed included the following:</p> <p>Resident #2</p> <p>Resident #8</p> <p>(continued on next page)</p>		

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  05/02/2024
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)
F 0835  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	Resident #11  Resident #14  Resident #15  Resident #23  Resident #60  Resident #64  Resident #68  Resident #69  Resident #80  Resident #85  Resident #89  Resident #92  Resident #100