

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to store, serve and prepare foods in a sanitary manner in accordance with standards for food safety professionals. The findings included: 1. During the initial kitchen tour, on 09/02/25 at 9:40 AM, accompanied by the Dietary Manager and the Certified Dietary Manager (CDM) from a sister facility, the following were noted: a. There was an accumulation of residue on the handles of the ovens.b. There was an accumulation of dust and debris on pipes over cooking equipment and food preparation table. c. In the walk-in cooler, there was a full sized six-inch-deep pan of raw chicken stored on a shelf directly over a five-pound package of raw ground beef on speed rack. d. There was peeling paint, dust and rust in the vents of the a/c [air-conditioner] handler over a cart that was stored in the area that contained coffee and single service condiments (sugar, creamers).e. There was an accumulation of condensation in the opening from the processing area to the room where the air handler was located and the cart containing coffee and single service condiments (sugar, creamers).f. There was an accumulation of food debris on exterior of the doors of the mechanical ware washing machine. 2. During an observation of the kitchen, on 09/03/25 at 6:55 AM, the following were noted: a. The handles of utensils that were in the three-compartment sink appeared to be damaged in a manner indicative of being melted and determined to no longer be easily cleanable. b. A portion of the wall over the sanitizer basin of the three-compartment sink was cracked and the corner of the window frame was coming apart. 3. During the follow up kitchen tour, on 09/04/25 at 11:23 AM, accompanied by the Dietary Manager and the CDM from a sister facility, the following were noted:a. Staff K, Dietary Aide, was observed with her bare thumb in direct contact with cleaned and sanitized, mouth and food contact surfaces of utensils while portioning for lunch. b. Staff K, Dietary Aide was observed drying cleaned and sanitized utensils with paper napkin prior to wrapping for the lunch meal.c. Staff K, Dietary Aide was noted to be wearing a watch while handling cleaned and sanitized utensils. Staff K was directed to remove the watch and perform hand hygiene before continuing to handle the wares.d. Staff L, Dietary Aide was observed handling dirty wares inserting them into the dirty side of the mechanical ware washing machine. As the cleaned and sanitized wares were coming out of the machine, the machine became backed up and Staff L was unable to put more items in the machine and began handling the cleaned and sanitized wares with same gloved hands as handling the dirty wares. e. Portions of the shelf that supports trays while staff are plating the meal held with duct tape.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment in 18 of 90 resident rooms in the facility affecting rooms 122, 125, 129, 130, 202, 204, 208, 109, 111, 112, 300, 313, 315, 325, 215, 219, 228, and 230, 1 of 3 nursing stations (nursing station for 200 Unit), in 1 of 1 entrance in front of kitchen, and 1 of 1 smoking patio. The findings included: Review of the facility's policy titled, Resident Right- Safe/Clean/Comfortable Homelike Environment, issued and revised date of 03/02/19, included in part the following: It is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights. Observation revealed the following: - On 09/02/25 at 10:50 AM, an observation was made in room [ROOM NUMBER] of an overwhelming odor of urine in the room. - On 09/02/25 at 11:00 AM, an observation was made in room [ROOM NUMBER] of a resident in wheelchair in the doorway of the bathroom with the emergency pull cord wrapped around the grab bar. - On 09/02/25 at 11:05 AM, an observation was made in room [ROOM NUMBER] in bathroom of the emergency pull cord about 12 inches from the floor (short cord). - On 09/02/25 at 9:55 AM an observation was made in room [ROOM NUMBER] in the bathroom of the emergency pull cord wrapped around the grab bar. - On 09/02/25 at 10:36 AM, an observation was made in room [ROOM NUMBER] of air conditioning (A/C) not blowing cold air, just cool air. The A/C temperature was set at 60 degrees Fahrenheit (F), and emergency pull cord in bathroom was wrapped around the grab bar. - On 09/02/25 at 10:40 AM, an observation was made in room [ROOM NUMBER]-1 of the bed which did not go up and down, and a cut cord from the bed was on the floor under the bed. - On 09/02/25 at 10:30 AM, an observation was made in room [ROOM NUMBER]-2 of privacy curtain with reddish brown marks, strong smell of urine and the bathroom emergency pull cord approximately 18 inches from the floor (short cord). - On 09/02/25 at 10:26 AM an observation was made in bathroom of room [ROOM NUMBER] of emergency pull cord approximately 24 inches from the floor (short cord) and missing tile on wall behind toilet. An interview was conducted on 09/03/25 at 2:10 PM with the Director of Maintenance (DOM), who stated he has worked at the facility in maintenance department for 11 years and in the Director role for the past 1.5 years. When asked about issues with maintenance, he stated the staff can report this to the maintenance department in several ways. They can put the issue in TELS system located in the computer or put it in one of the log books located at each of the 2 the nursing stations, or (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Managers can put it in a group chat (text type on phone) that is seen in real time. The DOM stated that most staff put the issues directly into the TELS system. The DOM stated his department checks the log books located at the nursing stations minimally every morning. During a tour of part of the facility conducted on 09/03/25 at 2:25 PM with the DOM, he acknowledged the above findings. 8. On 09/02/25 at 10:55 AM, observation revealed a loose Air Conditioning (AC) console's cover in resident's room [ROOM NUMBER] and visible dust at the AC vents. On 09/03/25 at 1:45 PM, a side-by-side observation of room [ROOM NUMBER] Air Conditioning (AC) console's cover was conducted with the Director of Plant Operations (DOPO) and the Housekeeping Supervisor. The Housekeeping Supervisor confirmed the AC dust and stated it would be cleaned immediately. The DOPO stated when they (staff) cleaned the AC, the removable cover was not put back properly. 9. On 09/02/25 at 10:45 AM, observation revealed a loose AC console's cover and visible dust on the AC vent in resident's room [ROOM NUMBER]. On 09/03/25 at 1:57 PM, a side-by-side observation of room [ROOM NUMBER] AC console's cover was conducted with the DOPO and the Housekeeping supervisor. The Housekeeping supervisor confirmed the AC dust and stated it would be cleaned immediately. The DOPO stated when they clean the AC, the removable cover was not put back properly. 10. On 09/02/25 at 10:45 AM, during an interview, the resident in room [ROOM NUMBER] stated the AC needs to be cleaned, it is all dusty. Observation revealed visible dust in the resident's AC vents. On 09/03/2025 at 1:50 PM, a side-by-side observation of resident room [ROOM NUMBER] AC vents was conducted with the DOPO and the Housekeeping supervisor. The Housekeeping supervisor confirmed the AC vents needed to be cleaned. 11. On 09/02/25 at 2:33 PM, an observation was conducted of room [ROOM NUMBER] of a recliner chair. The chair had a large tattered and torn area located on the front back resting area and on the corner end of both arms. There were multiple brown rust-colored areas located on the middle bottom stand of the resident's overbed table and two (2) reddish colored stains on the tile floor near and to the side of the resident's recliner chair. 12. On 09/02/25 at 2:32 PM, an observation was conducted of room [ROOM NUMBER] and a resting recliner that had tattered and torn back and arms in the resident's room. 13. On 09/03/25 at 10:02 AM, an observation was conducted of room [ROOM NUMBER], and the left side half (1/2) bedrail was observed broken and half hanging off the bed and resting on the floor. 14. On 09/03/25 at 10:30 AM, an observation was conducted of Room# 325, and a resting recliner that had tattered and torn back and arms in the resident's room. 15. Observation In room [ROOM NUMBER] revealed the cover on the arms of the resident's wheelchair were worn to the point that the foam underneath was exposed and there was an accumulation of residue on the handles of the brakes. The surface of the lounge in the room was worn and there was an accumulation of residue on the overbed table. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16. In room [ROOM NUMBER], the waste baskets were overflowing onto the floor. 17. In room [ROOM NUMBER], the seat of the room chair was torn. 18. The wall in the corridor between the 200 and 300 units, where food trolleys are stored at the entrance to the kitchen, was damaged in a manner indicative of repeatedly being hit by the food trolleys. 19. There was an accumulation of dust on the air vent over the nurse's station on the 200 unit. 20. On the outside smoking patio, there were cigarette butts strewn about the patio and in the landscaping as well as some trash.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interviews and record reviews, the facility failed to follow the menu and the approved recipe for lunch served on 09/02/25 and the menu for lunch on 09/04/25. The findings included: 1. The approved menu for the lunch meal on 09/02/25 documented that the residents were to receive 'Ginger-Barbecue chicken'. During an observation of lunch served to the residents in the Dining room on the 200 unit, on 09/02/25 at 12:20 PM, it was noted that the residents were served one (1) bone in chicken leg as the protein for the meal. At the time of the observation, the Surveyor entered the kitchen and asked the Dietary Manager how much of the protein that residents were to receive for the meal. The Dietary Manager stated that the residents should receive three (3) ounces of the protein for the meal. At the request of the Surveyor, the Dietary Manager placed a piece of the bone-in chicken leg on the facility's kitchen scale and the portion weighed 2 ounces - half of which is non-edible bone and cartilage. The Dietary Manager acknowledged that the chicken leg was not enough protein per the facility's menu and stated that the facility was using boneless and skinless chicken thighs until the residents requested the bone in chicken leg, and that the recipe and menu were not updated to reflect the residents' request. 2. The approved recipe for the 'Ginger-Barbecue Chicken' that was on approved menu for the lunch meal served on 09/02/25 documented that the facility was to use boneless and skinless chicken thighs. During an observation of lunch served to the residents in their rooms, on 09/02/25 at 12:20 PM, it was noted that the residents were served one (1) bone in chicken leg. At the time of the observation, the Surveyor entered the kitchen and inquired about the protein being served. The Dietary Manager stated that the residents had requested to have the bone in chicken leg and acknowledged that the recipe had not been updated to reflect the residents' requests. 3. The posted menu that was posted outside of the Dining Room on the second floor for the lunch meal being served on 09/04/25 documented that the residents were to receive 'choice of roll'. During the follow up tour of the kitchen, on 09/04/25 at 11:23 AM, it was noted that, while staff were plating the meal, they were placing two (2) pieces of sliced bread on the plates with the rest of the meal. When the Dietary Manager was asked about not serving the rolls with the meal, the Dietary Manager stated that the rolls did not come in on the delivery that was received on 09/01/25 (the most recent delivery from the food supplier). The Dietary Manager acknowledged that the menu was not changed so that the residents could be notified of the change in the menu.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to bring incontinent supplies with the resident to an outside appointment for 1 of 1 sampled resident reviewed for Activities of Daily Living, Resident #80; and failed to follow up after a Foot and Ankle Surgeon consultation related to a fracture for 1 of 2 sampled residents reviewed for falls, Resident #72. The findings included: 1. Record review revealed Resident #80 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Quarterly MDS, with a reference date of 06/03/25, documented Resident #80 had a Brief Interview for Mental Status (BIMS) score of 06, indicating the resident had severe cognitive impairment. The MDS documented that Resident #80 was dependent upon staff for all Activities of Daily Living (ADLs), except for eating, dependent upon staff for ambulation via manual wheelchair and was 'always incontinent of urine and bowel without the use of a device. Resident #80's diagnoses at the time of the assessment included: Coronary Artery Disease, Hypertension, Hyperlipidemia, Hemiplegia, Muscle weakness, Dysphagia, and Constipation. Review of a progress note, dated 08/26/25 at 10:58 [AM], documented, Resident departed the facility for a scheduled medical appointment at [hospital name]. Resident exited the unit in stable condition via wheelchair, accompanied by a facility [Certified Nursing Assistant] CNA and transportation attendee. Departure occurred following lunch. Resident was appropriately dressed, well groomed, with no signs of incontinence or soiling, and had right arm sling in place. All scheduled morning medications were administered prior to transport. Profile sheet and current medication list were sent with the resident. No complaints voiced. During an interview, on 09/03/25 at 9:13 with Resident #80's son, when asked about Resident #80's appointment on 08/26/25, the son replied, She had an aide with her. I was pulling her out of her wheelchair, and she was went to her knees. We got her out of the wheelchair and got the diaper off of her and the urine smell was so strong that it had to have been there for a while. The facility said that she left around 12:00 PM, and she wasn't like that when she left. Transportation called me at 1:45 PM that she was at the facility to pick up & they keep sending her out in that condition. For her to go home (referring to returning to the facility), the nurse had to tape chucks around her and wear the same clothes back to the facility. I met with the new administrator after the appointment, and she said that she is making changes & the same as the other 5 Administrators have said. During an interview, on 09/05/25 at 9:39 AM, Staff E, Licensed Practical Nurse / Unit Manager (LPN/UM), when asked about the incident, Staff E replied, when she went to [hospital name], she went with a CNA, and her son met them there. She was changed prior to leaving for the appointment. She should have went with an extra brief. She did not go with an extra brief. During an interview, on 09/05/25 at 12:01 PM, Staff J, CNA, when asked about the incident, replied, I changed her prior to leaving. When asked about bringing extra incontinence supplies, Staff J replied, I did not take any, I was in the dining room and they called me and told me that transportation was waiting for us, she went to her room, and her CNA changed her and then we went to the appointment. I was in a hurry and didn't get the supplies to take with us. When she was wet, the doctor's office had a chuck that we used. The nurse at the [hospital name] told me that the hospital did not have any briefs. 2. Review of the facility policy titled, Physician Services, provided by the Administrator revised (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/02/19 documented in the Policy Statement: It is the policy of the facility to provide Physician Services in accordance to State and Federal Regulations. All Physician's orders will be followed, as prescribed, and if not followed, the reason shall be recorded on the resident's medical record during that shift. Record review revealed Resident #72 was admitted to the facility on Tuesday 08/12/25 with diagnoses which included Nondisplaced Fracture of Greater Trochanter of Left Femur, Pain in Left Hip, Periprosthetic Fracture around Prosthetic, Spinal Stenosis, Lumbar Region, Difficulty in Walking, Rhabdomyolysis and Personal History of (healed) Traumatic fracture, Left Foot Drop, Major Depressive Disorder and Insomnia. The record documented a Brief Interview Mental Status (BIMS) score of 13, indicative of intact cognition. Record review of the Resident #72's face sheet form documented that his Medical/Health insurance was listed as a HMO. For most traditional HMO plans, a referral is required from the Primary Care Provider (PCP) to see a specialist for authorization of payment for services. Record review of the Resident #72's Pain Care plan initiated 08/14/25 and revised 09/04/25 indicated Focus: Resident has an alteration in comfort related to left hip fracture, Neuropathy, Lower Back and generalized pain. Interventions: .Medicate as ordered, Observe for non-verbal indications of pain: facial grimaces, restlessness, moaning, mood/behavior changes. Obtain resident rating of the pain scale face/verbal descriptor and document. Remind resident to alert staff if experiencing pain/discomfort. Goal: Resident #72 will have pain/discomfort recognized and controlled by next review date. Record review of the Resident #72's Activities of Daily Living (ADL) Care plan initiated 08/13/25 and revised 09/04/25 indicated Focus: Resident requires assistance with self-care and mobility related to Diagnosis of Fracture Left Femur . Interventions: . Notify Physician if any significant changes. Observe for changes in ADL status . Report to licensed nurse any decrease in ability to complete ADL tasks . The Goal included: Resident #72 will receive the amount of necessary ADL assistance to improve/maintain quality of life. Record review of the Orthopedic Trauma Specialist Progress note from the hospital dated 08/11/25 indicated There is a nondisplaced fracture of the left greater trochanter. Full consult to follow and see as needed. Review of the Neurosurgery consult note from the hospital dated 08/11/25 documented, .suddenly the left leg was having severe pain and gave out . Having difficulty walking around. There is a disc herniation of L5-S1 with extruded fragment going inferiorly towards the left. Therefore, his presentation is with acute pain. Potential referral to Pain Management. Can follow-up with me in a few weeks. Surgery, microdiscectomy, would be an option after a reasonable period of time if he is not improving. Review of Resident #72's After Visit / Hospital Discharge summary dated [DATE] documented for follow-up with both the Orthopedic and Neurosurgeon specialists. On 08/12/25 the Physician's Order documented Percocet 5-325mg tablets 2 tablets every 4-6 hours as needed for pain. For the months of August and September 2025, the Medication Administration Record (MAR) documented Resident#72's pain level range was recorded, at the time of the visit, as: 6-7/10 on Thursday 08/28/25, the 1st time of travel to the Orthopedic office. On Tuesday on 09/02/25, the 2nd (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time of travel to the Neurosurgeon office, the pain level range was recorded, at the time of the visit, as: 5-7/10. An interview was conducted on 09/02/25 at 2:14 PM with Resident #72 who stated he had been experiencing a constant, lower left hip pain, which radiated down his leg to his knee with a pain level range of 8 out of 10. He stated the ordered pain pills did help a little. He verbalized that last month and today, he was taken to 2 separate specialists' offices, an Orthopedic and a Neurosurgeon, for appointments. He stated that on each of these 2 occasions, it turned out to be a waste of both his and the doctor's time, as he had been tired, had been in pain, and that nobody seemed to care about whether or not he had seen the specialist doctor or not. Resident #72 stated that on both times he had been unable to see either specialist due to not having a referral obtained under his Health Maintenance Organization (HMO) insurance. The resident stated he was only provided a copy of what he was told was a referral for the appointment for today 09/02/25 at 1:30 PM. During this interview, the Resident #72 showed the surveyor a copy of what he said was the referral. Upon review of the referral, it was actually a copy of the physician's order authorizing the visit only, but not an actual referral, for purposes of direct insurance payment. Resident #72 expressed his disappointment, and he said that he didn't understand how this could have happened twice. The resident stated that ever since he had been residing in this facility (since 08/12/25) he had been having terrible pain the entire time for which he had still not been seen by any of his specialists. On 08/28/25, the physician's order, the Schedule and the Transportation Form, each documented the Orthopedic follow-up appointment's address of the physician's office was in Fort [NAME], the time of the appointment was at 9:45 AM, the transportation company's number, the pick-up time was at 8AM, and the confirmation number and the expected time of resolution (ETR) was at 10:45 AM. On 09/02/25, the physician's order, the Schedule and the Transportation Form, each documented the Neurosurgeon follow-up appointment's address of the physician's office was in Plantation, the time of the appointment was at 10:45 AM, the transportation company's number, the pick-up time was at 9 AM-9:30 AM, and the confirmation number and the expected time of resolution (ETR) was at 11:45 AM. During an interview conducted on 09/04/25 at 1:56 PM with the Director of Therapy, she stated Resident #72 had received therapy services for Physical Therapy (PT) from 08/13/25 to 09/02/25, five (5) days per week; and Occupational Therapy (OT) from 08/13/25 to 09/02/25, five (5) days per week. The Therapy Director stated Resident #72 had documented generalized hip pain at a level range starting at 8/10 and was decreased to 5/10. On 09/04/25 at 4:21 PM, an interview and side-by-side record review of the Transportation Schedule Form was conducted with the Staffing Coordinator/Scheduler, who stated that she handles and schedules the transportation piece for the residents, and she functions as a back-up, only if the Medical Records Custodian is not available to directly contact the resident's specialist office, for an appointment. She stated, if necessary, she would either go the Unit Manager, ADON or to the DON, to inform them that a referral would be needed from the PCP for the resident to be able to go to a specialist appointment, if needed or applicable. In the case of Resident # 72, the Staffing Coordinator/Scheduler stated that she did not schedule either of his two (2) different specialist appointments: Orthopedic (08/28/25) and Neurosurgery (09/02/25); and that these were both scheduled by the Medical Records / Credentialing Coordinator. The Staffing Coordinator / Scheduler indicated that she only generated the forms which were immediately visible in the facility's Point-Click-Care (PCC) computer system for the nurse staff to be able to see and to be aware of. The Staffing Coordinator / Scheduler revealed she had scheduled the transportation for Resident #72's 2 (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointments, through the resident's HMO insurance and she said that he was picked up and taken to both appointments on the respective days and brought back to the facility. The Staffing Coordinator / Scheduler indicated that she keeps a hard copy of this form in a manilla envelope in her office. She stated she was not aware of whether or not the resident had actually been seen in the office or seen by the specialists on either of those days, as ordered. On 09/04/25 at 5:22 PM, an interview and side-by-side record review was conducted of the Appointment Scheduling documentation with the Medical Records / Credentialing Coordinator, who stated she gets the Physician's orders from the nursing department or sometimes directly from the Nurse Practitioner, in order to schedule any resident's appointments. In the case of Resident #72, she stated that he had a total of 2 appointments scheduled, 1 with the: Orthopedic on 08/28/25 and another with the Neurosurgeon on 09/02/25. She stated she passes this information to the Staffing Coordinator /Scheduler, who, in turn, takes a copy of this form to set up transportation to the specialist appointment for the resident. The Medical Records / Credentialing Coordinator indicated she scheduled these two (2) appointments by contacting the specialist office directly and they would run this through the resident's Humana HMO insurance. She revealed there was no way for her to confirm that the specialist, would accept the insurance, nor whether a referral would be needed. She stated she only calls to speak with someone in the office to schedule the appointment. During the interview, the Medical Records / Credentialing Coordinator revealed she had called the Specialist offices and was not sure of the exact difference between a physician's order and an insurance referral, nor did she verify the requirements for the visit at the time of the calls. She stated she did not contact the 2 specialist offices the day before or the day of, in order to confirm that a referral had been sent or needed to be sent from the PCP to the specialist office. She added that she did not or could not provide a reason why and was not aware of whether or not the resident had actually been seen in the office either of those days and seen by the specialist doctors. On 09/05/25 at 11:43 AM, a telephone interview was conducted with the Office Receptionist for the Orthopedic office, on the day of Thursday 08/28/25, regarding whether or not Resident #72 had shown up and was seen and treated at the specialist's office for an appointment that day. The Office Receptionist stated that this resident did not have an appointment with their office, and she provided a different phone number for the surveyor to call and follow-up with. On 09/05/25 at 10:59 AM, a general voice mail was left for the Neurosurgeon's office in order to ascertain whether or not Resident #72 had shown up and been seen and treated in the office by the specialist on the day of Wednesday 09/02/25, and if a referral had been required; requested a call back and awaiting a response. Ultimately, this office was not available for interview or comment, during the survey. On 09/05/25 at 11:22 AM, an interview was conducted with Staff D, Registered Nurse (RN), who acknowledged that the Medical Records/Credentialing Coordinator had scheduled Resident #72 for his 2 appointments: the Orthopedic Physician on 08/28/25 and the Neurosurgeon on 09/02/25. She stated she had documented in the progress notes that the resident had been picked up and taken to the appointment on that day and brought back to the facility. Staff D, revealed that she had not been aware, nor made aware of whether or not the resident had actually been seen in either of the specialists offices on the respective days, nor was she able to provide a reason why neither of the specialists offices had not been contacted afterwards, in order to confirm whether or not Resident #72 had been at the appointment to see if new orders or physician's progress notes had been obtained. Staff D stated she had not notified her Unit Manager of any of the above. (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/25 at 11:48 AM, a telephone interview was then conducted with the Centralized Scheduling Department's phone number provided by the receptionist for the Orthopedic office, on the day of Thursday 08/28/25, in order to ascertain whether or not Resident #72 had shown up and was seen and treated there in the specialist's office for an appointment that day. The only information that the Centralized Scheduling Department was able to provide, regarding this appointment with the Orthopedic office on that day, was that this appointment, had been cancelled by someone on 08/28/25; with no reason given and no additional information provided. During a telephone interview conducted on 09/05/25 at 2:18 PM, with the RN Weekend Nursing Supervisor, she revealed that in the progress notes that, Patient returned from Orthopedic appointment, states he wasn't seen because he did not have correct referral. Patient states his pain is not managed. Patient reported pain score 5 . On 09/05/25 at 2:42 PM, an interview was conducted with Staff E, Licensed Practical Nurse (LPN/Unit Manager), who stated that he was not made aware that Resident #72 had not been seen by the Orthopedic specialist on 08/28/25. He stated he did not call the specialist physicians' offices to try to follow-up to see if there were any progress notes or any new orders given. Staff E stated he had been informed by Resident #72 that he had not been seen by the Neurosurgeon specialist on 09/02/25, he had not documented this in the resident's record. During an interview conducted on 09/05/25 at 2:50 PM with the RN, Assistant Director of Nursing (ADON), he stated that after the Medical Records / Credentialing Coordinator schedules the appointment, he would receive a copy of the scheduled appointment and would relay this message via an App link to all of the nurses to inform them of an upcoming appointment. The RN/ADON said that he does not obtain any referrals for the resident's appointments. He stated that he does not recall getting a schedule for this resident and was not able to recall any information about the resident with regard to his appointments. He stated that if a resident has a physician's order for a specialist follow-up appointment, that these should be honored and should be followed up to ensure appropriate resident evaluation and treatment. He stated he was not aware of whether or not the resident had actually been seen in the office on either of the 2 days by the specialist doctor. Resident #72 had been provided with only a physician's order, as authorization for treatment and evaluation. There was no evidence to show that a prior referral, authorizing payment for services, had ever been obtained by the facility, and sent over to the specialist office, in order for the resident to be seen, re-assessed and re-evaluated by the Specialist, for appropriate follow-up care and services. The Director of Nursing (DON) acknowledged on 09/05/25 at 3:25 PM that if a resident has a physician's order for follow-up with a specialist for care and treatment, that this should be done. The DON stated the insurance part has nothing to do with her; and she only looks at the clinical piece, and another department deals with the insurance aspect. On 09/05/25 at 4:47 PM, an interview was conducted with the Administrator who stated that the person responsible for scheduling the resident's appointments is the Medical Records personnel. The Administrator said that to her knowledge, Resident #72 was sent over with a referral but as to the exact type of referral, was the question.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to resolve grievances voiced by active members of the Residents and Resident Council, including Residents #97, #101, #104, #115, #142, #15, and #10, in a timely manner. The findings included: Review of the facility's policy, titled, 'Grievances', with a reference date of 11/28/16 and updated 01/2019, documented: I. Policy Statement: It is the policy of the Facility to quickly act on concerns or grievances and arrive at an appropriate resolution. III. Implementation: In implementing this policy, the Facility recognizes each resident's right to: * Prompt efforts to resolve grievances the resident may have, including those with respect to the behavior of other residents. Prompt efforts to resolve include facility actively working toward resolution of that complaint/grievance. IV. Procedures: Any resident, family member of a resident, representative of a resident, person acting on behalf of a resident or employee may initiate a Resident Grievance if they have a concerns or express dissatisfaction regarding the Facility's services. The report may be made verbally or in writing and the reporter has the option of remaining anonymous. Record review for Resident #10 documented on the Quarterly Minimum Data Set (MDS), with a reference date of 07/14/25, a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. An interview was conducted with Resident #10 interview on 09/03/25 at 11:54 AM and Resident #10, when asked about food served in the facility, replied, breakfast and lunch are great - dinner is usually not hot. They don't use the hot plates during dinner. We talk about it at Food Committee. An interview was conducted on 09/02/25 at 12:02 PM with Resident #112, who has a documented BIMS score of 15, according to a Quarterly MDS with a reference date of 06/06/25, and when asked about the food served in the facility, Resident #112 replied, I tell them all the time at Resident Council and they don't do anything about it. Review of the Resident Council Meeting Minutes, on 09/03/25 at 12:08 PM, with the permission of the Resident Council President to review, revealed the following: April 31, 2025, the Resident Council President provided a list of concerns to the DON [Director Of Nursing]: *Use of cell phones and ear buds in front of residents during care and at the desk. *Foreign language constantly heard in halls, at desk and during care *Call bell response is slow, especially during 3-11 shift and on weekends. *CNAs [Certified Nursing Assistants] are often rude and short at times *3-11 shift staff seem to all go on break at once and it is very hard to find people after dinner time. *The residents feel that overall, on the 3-11 shift, and the weekends the level of care changes because of the management staff is not around and the building is not the same. *Food carts come up and it takes a long time for trays to be passed and sometimes trays area cold. CNAs sometimes don't pass trays to rooms not on their assignment, so it gets cold. *Medications sometimes run out because they aren't ordered enough in advance. June 5, 2025: *Use of cell phones and ear buds in front of residents during care and at the desk. *Foreign language constantly heard in halls, at desk and during care if 2 CNAs are working together (little improvement). *Call bell response is slow, especially during 3-11 shift and on weekends. (no improvement). *They feel the CNAs in general have attitudes and are often rude and short at times. *3-11 shift staff seem to all go on break at once and it is very hard to find people after dinner time. (no improvement). *The residents feel that overall 3-11 shift, and the weekends the level of care changes because of the management staff is not around and the building is not the same. *Food carts come up and it takes a long time for trays to be passed and sometimes trays area cold. CNAs sometimes don't pass trays to rooms not on their assignment so it gets cold. (slight improvement). July 30, 2025: *Use of cell phones and ear buds in front of residents during care and at the desk. Continues all shifts, but worse on 3-11 and weekend - stated particularly upsetting because the nurses do it while administering medications. Residents also state that staff sometimes hide in their room or bathroom and use the phone. *Foreign language constantly heard in halls, at desk and during care if two CNAs are working together. continues *Call bell response is slow, especially during 3-11 shift and on weekends. continues *3-11 shift staff seem to all go on break at (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	once and it is very hard to find people after dinner time. continues*The residents feel that overall, 3-11 shift, and the weekends the level of care changes because of the management staff is not around and the building is not the same. continues*Food carts come up and it takes a long time for trays to be passed and sometimes trays area cold. CNAs sometimes don't pass trays to rooms not on their assignment, so it gets cold. continues August 30, 2025*Use of cell phones and ear buds in front of residents during care and at the desk. Continues all shifts, but worse on 3-11 and weekend - stated particularly upsetting because the nurse do it while administering medications.*Foreign language constantly heard in halls, at desk and during care. continues*Call bell response is slow, especially during 3-11 shift and on weekends. continues*3-11 shift staff seem to all go on break at once and it is very hard to find people after dinner time. continues*The residents feel that overall 3-11 shift, and the weekends the level of care changes because of the management staff is not around and the building is not the same. continues*Food carts come up and it takes a long time for trays to be passed and sometimes trays area cold. CNAs sometimes don't pass trays to rooms not on their assignment, so it gets cold. continues* Medications sometimes run out because they aren't ordered enough in advance. An interview was conducted on 09/03/25 at 12:41 PM with the Resident Council President who confirmed the documentation was accurate and the concerns still exist. An interview was conducted with active members of the Resident Council on 09/03/2025 3:35 PM, including Resident #97 with a Brief Interview for Mental Status (BIMS) score of 11 according to an End of PPS Part A Stay Minimum Data Set (MDS) with a reference date of 07/30/25; Resident #101 with a BIMS score of 15 according to an Annual MDS with a reference date of 07/18/25; Resident #104 with a BIMS score of 15 according to a Quarterly MDS with a reference date of 06/17/25; Resident #115 with a BIMS score of 15 according to a Medicare 5-day MDS with a reference date of 08/19/25, and Resident #142 with a BIMS score of 15 according to a Significant Change MDS, with a reference date of 07/17/25, who when asked about the concerns related to staff cell phone use, the attendees agreed that the concern had not been resolved.When asked about the staff speaking foreign languages, all of the attendees agreed that the concern had not been resolved. Resident #97 stated, when I came, I thought that I was in a third world country. Record review revealed the resident was admitted on [DATE].When asked about the staffing concerns on the 3PM-11PM shift and on the weekends, all of the attendees agreed that the concern had not been resolved. Resident #104 stated, I had someone banging on my door for like an hour and a half because there was nobody there to redirect her. Resident #142 stated, - 3-11 is the worst - on Thursday, they do the 'Thursday slide' into the weekend. They (referring to the CNAs) disappear into the break room and just disappear every night all night. All they do is complain about their jobs. When asked about the concerns regarding the food served to the residents by the facility, all of the attendees agreed that the concern had not been resolved. Resident #115 stated, portions are too small and the distance between meals (Resident #115 began using a significant amount of profanity to respond to the concern). I have to sign up for food deliveries. Oatmeal and eggs are always cold.Resident #97 stated, whatever money I have, I spend on food. it is cold, I love oatmeal, but I have to eat it cold.Resident #104 stated, don't like it. It is cold and flavorless. mystery meat.Resident #142 stated, cold breakfast except for breakfast today. tasteless food and you don't know what it is. They don't use the pellet plates for dinner.Resident #101 stated, I like sugar on my oatmeal, and they never have any condiments on the trays. They will serve us a burger without ketchup or mustard and a baked potato with no butter or sour cream. An interview was conducted on 09/05/25 at 10:14 AM with the Activities Director, who when asked about the concerns voiced by the member of the Resident Council and the Food Committee, the Activities Director replied, food on the weekends is not hot a lot of times, it varies by meal and there is less supervision on the weekends. The Administrator and the Director of Nursing (DON) were not able to attend the last meeting because they got held up, so it was rescheduled for them to attend. When asked of what measures had been taken to resolve the concerns, the Activities Director replied, in-servicing, town hall, there is a lot of new staff, and they like a lot of the new staff. An interview was conducted on 09/05/25 at 12:34 PM (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Social Services Assistant and the Regional Social Services Director, who when asked about the grievances by the Resident Council being resolved, the Social Services Assistant stated that she had not been invited to the Resident Council meeting. The Social Services Assistant stated, when the former Social Services Director left, there were mountains of things not done. An interview was conducted on 09/05/25 at 12:54 PM with the Administrator and the DON, who stated that they were not aware of the food concerns. The Administrator stated, I stumbled across some of the education that was done in the past. The DON stated, We are doing Angel Rounds, Management is focusing on these issues when they are doing Angel Rounds. We are setting up break times for the CNAs and the nurse so that they can't go on break at the same time. They brought it up to me a month ago.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to make prompt efforts to resolve the residents' grievances for 2 of 2 residents' sampled for missing property, Residents #37 and #122. The findings included: Review of the facility's policy titled Grievances updated on 01/2019 documented, in part, .the intent of this policy is to support each resident's right to voice their concerns and grievances (for example, . lost clothing.it is the policy of the facility to quickly act on concerns or grievances and arrive at an appropriate resolution.1. Record review documented Resident #37 had an admission on [DATE] with medical diagnoses to include Seizures and Chronic Obstructive Pulmonary Disease (COPD). The resident's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 indicating no cognition impairment. On 09/02/25 at 10:45 AM, an interview was conducted with Resident #37 who stated he was transferred to a local hospital in December 2024 and on his return on 12/27/2024, found out that his room was emptied, everything was gone, including his personal belongings. The resident added that in July 2025, he brought brand new clothes, 10 pair of underwear, socks, sweatpants, T-shirts that were label with his name, the clothing went to the laundry, and they were all lost. The resident stated he filed a complaint and has not heard from anyone, and no replacement was made. The resident stated he bought a new cell phone and showed A15 5G cell phone because the staff poured water over it while it was on his table. He added he reported it, and he has not been reimbursed for it. Resident #37 stated he had called the Social Worker many times and left messages and has not heard back from anyone. Review of the facility's grievances from December 2024 to August 2025 did not document any grievances related to Resident #37's missing clothes or damaged cell phone. On 09/03/25 at 2:57 PM, an interview with the Administrator was conducted who was apprised of Resident #37 voiced complaint to the surveyor. The administrator stated they have not checked the previous Social Worker's phone for messages. The administrator stated the staff do an inventory of the resident's belongings on admission and periodically when something is brought in. The administrator stated she did not see any written grievances from December 2025 and January 2025 for Resident #37. On 09/03/25 at 3:13 PM, a joint interview was conducted with the administrator and the Social Worker Assistant who stated she did not see an inventory sheet for Resident #37. The administrator stated she would do a federal report related to Resident #37 missing property. 2. Record review documented Resident #12 had an admission on [DATE] and a readmission on [DATE] with diagnoses to include Primary Generalized Osteoarthritis and Anxiety Disorder. The resident's MDS quarterly assessment dated [DATE] documented a BIMS score of 15 indicating no cognition impairment. On 09/02/25 at 1:15 PM, an interview was conducted with Resident #122 who stated that about eight (8) months ago she reported to [name] the previous administrator that her pearls (\$3,000) were stolen from her purse. The resident stated she has not heard anything back from anybody. Review of the facility's grievances from December 2024 to August 2025 did not document any grievances related to Resident #122's stolen pearls. On 09/03/25 at 2:25 PM, an interview was conducted with the Administrator who stated working at the facility since 07/30/25. The administrator was apprised of Resident #122 report of her pearls stolen from her purse. The administrator stated the staff do an inventory of the resident's belongings on admission and periodically when something is brought in. The administrator confirmed that there were not written grievances from December 2025 and January 2025 for Resident #122. The administrator was asked to submit Resident #122's inventory sheet. A side-by-side review of the resident's inventory sheet dated 10/16/18 documented Pt refused. The inventory sheet dated 06/20/19 documented No new belongings on readmission. On 09/04/25 at 9:58 AM, an interview was conducted with the administrator who stated she completed a federal report related to Resident #122's missing pearls.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to follow physician's orders for scheduled specialist medical appointment in a timely manner for 2 of 2 sampled residents reviewed for choices, Resident #37 and #142. The findings included: Review of the facility's policy, titled, Quality of Care, revised on 03/02/19, documented .the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices . assist the resident in making appointments. 1. Record review for Resident #37 documented an admission on [DATE] and a readmission on [DATE] with medical diagnoses to include Seizures and Chronic Obstructive Pulmonary Disease (COPD). The resident's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 indicating no cognition impairment. Resident #37's clinical record documented a comprehensive care plan titled Resident #37 has a diagnosis of Seizures disorder with interventions to include give medications as order, monitor labs, notify nurse if seizure occur and post seizure tx (treatment). Review of Resident #37's clinical record documented an active physician order dated 06/19/25 for a Neurology Consult for Seizure disorder and an order dated 01/08/25 for Levetiracetam (a medication for seizures) 500 mg two tablets by mouth two times a day for Seizure. On 09/02/25 at 10:45 AM, an interview was conducted with Resident #37 who stated he was transferred to a local hospital due to a seizure at the facility, broke his back, ribs and had not been seen by an orthopedic doctor, continues to have seizures, had a brain biopsy, taking Keppra for it and had not been seen by a neurologist. The resident stated he had asked for a neurologist consult and was told his insurance does not pay for it, has called the Social Worker (SW) many times and does not get a call back. The resident stated he did not know who the SW was, does not know what insurance coverage he has and would like to sign up for Humana Insurance. On 09/02/25 at 11:00 AM, an interview was conducted with the Social Services Assistant (SSA) who stated the facility has not had a SW for about a month, but the Regional SW helps with anything that she needs help with and was in facility last Wednesday and is coming tomorrow. The SSA was made aware of Resident #37's concerns. On 09/04/25 at 11:19 AM, a joint interview with the Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Nurse Practitioner (NP) was conducted. The ADON stated that he was not aware of any outside doctor consult issues. The NP stated Resident #37 was initially admitted to the facility on [DATE] with a diagnosis of Seizures disorder. The NP stated Resident #37 requested to be seen by a neurologist and an order was written on 06/19/25 for a neurologist consult. The NP stated according to record the resident has not been seen by a neurologist as of today and added she recalled that there were some insurance issues. The NP could not confirm if Resident #37 was seen by a neurologist at a local hospital. The DON stated she would look for the last neurologist consult and added usually the residents are seen annually by a neurologist unless they are having seizures. The DON was reminded that the resident requested to be seen. On 09/04/25 at 12:04 PM, an interview was conducted with the Medical Record / Credentialing (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinator (MRCC) who stated she has been doing residents appointment since July 2025. The MRCC stated when a resident comes from a hospital or an outside consult and with any orders, the clinical team has to give her the doctors' orders to make the appointment. The MRCC was asked regarding the appointment schedule for Resident #37 and provided a copy of the NP order dated 06/19/25 for Neurology consult and stated she wrote on the order can't make appointment, no provider is taking Medicaid. The MRCC was asked what she did once she could not find a provider and stated when she can't find a provider to see a resident, she tells the NP and nursing. On 09/04/25 at 12:55 PM, during an interview, the DON stated that the MRCC mentioned that she was having trouble finding a doctor for Resident #37 last week. On 09/04/25 at 12:35 PM, a joint interview was conducted with the Regional Director of Social Worker (RDSW) and the SSA who were apprised of Resident #37 had not being seen by a neurologist due to insurance issue. The RDSW provided a copy of the hospital consultation notes. Review of Resident #37's local hospital consultation notes dated 09/09/24, almost a year ago, documented .MRI June 22, 2024, the patient was noticed to have a small lesion.suspected to be a cavernoma.Recommend that the patient is re-evaluated for the same concerns. On 09/04/25 at 12:55PM, an interview was conducted with the Administrator who stated she was not aware of insurance issues for Resident #37. She was informed that the resident reported that he had called the SW and had not heard back from the SW. The administrator stated they have not checked the SW phone for messages. 2. Record review revealed Resident #142 had an admission on [DATE] with no readmissions. The resident's diagnoses included Displaced Bimalleolar Fracture of Left Lower Extremity, Injury of Head, Contusion of Unspecified Knee- Unspecified fall 07/04/25; Spondylopathy Lumbar Sacral Region, Chronic Obstructive Pulmonary Disorder (COPD), Pleural Effusion, Persistent Mood disorders, Osteoarthritis left shoulder, Generalized Anxiety Disorder (GAD), Major Depressive Disorder, Implantable Cardiac Defibrillator, Acute Embolism of Deep Vein (LUE) Left Upper Extremity, Insomnia, (CHF) Congestive Heart Failure, Iron deficiency, Hypoglycemia and Hypothyroidism. Review of the facility's 'fall log' documented Resident #142 had a fall with Major Injury on 07/04/25. Review of Resident #142's care plans revealed the following; *Resident #142 has a potential for pain symptoms as evidenced of impaired mobility and osteoarthritis. LLE (left lower extremity) fracture. The care plan was initiated on 05/13/22 and revised 08/10/25 with no new interventions. *Resident #142 is at risk for further falls related to gait balance problems. Psychoactive drug use. LLE fracture. The care plan was initiated on 05/30/22 and revised on 08/10/25; and had interventions to include re-educate in using call when assistance is needed prn; Pt (patient) screen, neuro checks, re-educated on using the call light system to request assistance, created on 09/02/25 by the Regional MDS coordinator. On 09/02/25 at 12:57 PM, an interview conducted with Resident #142 who stated she fell and broke her foot. Observation revealed a beige colored bandage. (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/25 at 10:02 AM, an interview and a side-by-side review of Resident #142's fall with major injury was conducted with the DON. The DON stated on 07/04/25 at 6:15 AM, the resident was found (observed) on the floor, had a BIMS (Brief Interview Mental Status) score of 15 and the resident description of the fall was that she was going to the bathroom and fell, and couldn't put weight on her left leg. The DON stated the resident was alert and oriented, had no signs of concussion, left leg and ankle visible were swollen without laceration or bleeding, and the nurse received orders for fibula and ankle and foot X-rays. X-rays results revealed an Acute fracture of Bilateral Malleolus on left tibia and fibula, and left ankle. The DON stated Resident #142 was transferred to the hospital at 12:10 PM on 07/04/25, was not admitted, and came back to the facility the same day at 2305 (11:05 PM). The DON stated the resident returned with a wrapping like a partial cast on it. The DON stated Resident #142 was seen by Foot and Ankle Surgeon on 07/08/25 who recommended surgery to the ankle, and that a CT scan was done in office. A side-by-side review with the DON of Resident #142's Foot and Ankle Surgeon request for medical clearance for surgery and surgery scheduling form was conducted. The DON was asked why the surgery had not been done and she was unable to provide written documentation of why the surgery was not scheduled nor done as recommended by the Foot and Ankle Surgeon. On 09/04/25 at 11:00 AM, a joint interview was conducted with the ADON and DON. The ADON stated he follows up with the appointments scheduler (MRCC); she schedules the resident's appointments; and once they have everything scheduled, they will inform him of appointment time and date. The ADON was asked if he was aware of Resident #142 needing surgery or refusing surgery and stated he was not aware of that and added that the NP told him last week to call the resident's Foot and Ankle Surgeon to see if they want to see the resident again. He stated he not aware that the resident needed surgery and has not had a chance to call the Foot and Ankle Surgeon's office yet. On 09/04/25 at 11:10 AM, a joint interview was conducted with Resident #142's in-house NP, DON and ADON. The NP stated, honestly, she did not know that surgery was not done, and stated she told the ADON towards the end of last week to call the Foot and Ankle Surgeon's office. The hiccup was that the office did not say the date of surgery. The ADON, DON and the NP were apprised that the Foot and Ankle Surgeon appointment was almost two months ago and no one had followed up on the consult recommendations or discuss the recommendations with Resident #142. On 09/04/25 at 11:40 AM, observation revealed the DON received a call from the Foot and Ankle Surgery office staff, and the DON stated that she was informed that Resident #142 refused to have the surgery at the office, as the resident thought because of surgery she was afraid that the facility will kick her out. On 09/04/25 at 11:53 AM, a joint interview was conducted with Resident #142 and the ADON. The resident stated she did not recall when she went to the Foot and Ankle Surgeon. The resident recalled that the doctor wanted to do surgery, and she did not want it because she was going to be out of the facility and did not want to lose her bed. The resident was asked if she told anybody about it and stated she believes she spoke with the NP. On 09/04/25 at 3:38 PM, an interview was conducted with Resident #142 who stated her foot pain rate is about 5 out of 10 and she can't put her leg straight and has a soft splint on her left leg. Observation revealed left foot turned outward, stated she takes pain medications every day. The resident stated prior to the fall on 07/04/25, she was able to walk slow. The resident was asked if she would like to have her foot surgery done and stated Yes but would like to have X-rays before. (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/25 at 12:08 PM, an interview and a side-by-side review of Resident #142's MDS assessment was conducted with Staff C, MDS Coordinator, who stated the resident had a significant change assessment completed on 07/17/25 due to a decline on three (3) areas; the resident is unable to walk independently after a fall, was sit to stand independently before now needs partial to moderate assistance; and prior to the fall was independently transfer to wheelchair, now needs partial to moderate assistance. The resident's BIMS score was 15 indicating no cognition impairment. Staff C stated Resident #142 was independent with her Activities of Daily Living (ADLs) now she needs partial to moderate assistance after the fall. Resident #142's Annual MDS assessment dated [DATE] documented the resident was independent with her mobility and had no functional limitation in ROM (Range of Motion), no lower extremity impairment. On 09/05/25 at 1:10 PM, an interview was conducted with the facility dedicated Wound Care Nurse (WCN) who stated she was monitoring Resident #142's dressing for signs of infection, or if it needs to be reinforced. The WCN stated the resident had a non-removeable dressing since around July due to a fracture left foot and added she is supposed to go to the Foot and Ankle Surgeon and was not sure when.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure that it followed professional standards for 1 of 3 sampled residents observed for Urinary Foley Catheter and Peri-care, Resident #153. The findings included: Review of the facility policy titled Enhanced Barrier Precautions (EBP) provided by Director of Nursing (DON) issued 04/01/24 documented in the Policy Statement: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: EBP refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employ targeted gown and gloves use during high contact resident care activities 2. Initiation of EBP. b. An order for EBP will be obtained for residents with any of the following. Urinary Catheters 3. Implementation of EBP: a. Make gowns and gloves available immediately near or outside of the resident's room [ROOM NUMBER]. High contact resident care activities include.g. Device care or use. Urinary Catheters. Review of the facility policy titled, Incontinent Care for the Male Resident Steps of the Procedure Skill Competency Form, provided by the DON reviewed 04/2020, documented in the Policy Statement: .4. if the resident has a Foley. 8. Ensure resident's safety at all times and uses Infection Control Procedures appropriately. Record review revealed Resident #153 was admitted to the facility on [DATE] with diagnoses that included Obstructive and Reflux Uropathy, Retention of Urine, Benign Prostatic Hyperplasia and Parkinson's Disease. He had a documented Brief Interview Mental Status (BIMS) score of 13, indicative of intact cognition. Record review Resident #153's Foley Catheter Care plan initiated 08/20/25 and revised 09/03/25 indicated Focus: Resident has an indwelling urinary catheter related to Obstructive Uropathy . Interventions: .Anchor catheter tubing to thigh to decrease risk of trauma. Goal: Resident #153 will be/remain free from catheter-related trauma through the next review date. Resident #153 will have no complications through the next review date. Record review of Resident #153's Enhanced Barrier Precautions Care plan initiated 08/22/25 and revised 08/22/25 indicated Focus: Resident is at risk for multi-drug Organisms (MDRO) related to indwelling medical devices (urinary catheter) requiring Enhanced Barrier Precautions during high contact resident care activities in room, therapy gym or shower room . Interventions: Wear gown gloves during resident high-contact activities in room, therapy, gym, or shower room (i.e. Urinary Catheter.) Goal: Minimize risk of transmission of colonized or infection with MDROs. Observation on 09/04/25 at 11:00 AM revealed no signage or indication at or near the door that Resident #153 was on Enhanced Barrier Precautions (EBP). There was no container or caddy with Personal Protective Equipment (PPE) at or near the door of Resident #153. Observation of Foley catheter and peri care was conducted on 09/04/25 at 11 AM for Resident #153 and performed by Staff A, Certified Nursing Assistant (CNA). At the start of the procedure, Staff A donned a pair of clean gloves only, but she failed to don a protective gown prior to or during performing the procedure. Resident #153 was observed not having his Foley catheter and tubing properly secured and anchored in place to decrease the risk of trauma or pulling on the catheter. On 08/19/25, the physician's order documented, Maintain Indwelling Catheter for Urinary Retention. Foley Catheter care every shift and as needed every shift for monitoring. Change indwelling Foley catheter when medically necessary and as needed every 72 hours as needed for follow-up. May irrigate indwelling Foley catheter with 60 ml of normal saline for blockage, occlusion, leakage, etc. every 42 hours as needed for follow-up. On 09/04/25 at 11:08 AM, an interview was conducted with the CNA, Staff A, immediately following the catheter and peri care, who was asked if the resident was on EBP. Staff A replied she did not know, since there was no sign on the outside door. The CNA was then asked whether or not she should have been wearing a gown prior to, during and throughout the procedure and she stated no, only if there is a sign placed on the door. She added that whenever she does Foley catheter and peri-care for a resident, she does not put (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a gown on. She was asked if the resident had a Foley catheter and an anchor in place and she responded, no, but said that he should have one. On 09/04/25 at 11:24 AM, an interview and side-by-side computerized record review was conducted with the nurse, Staff D, who acknowledged this resident should have been on and should have had a physician's order for EBP. She stated Resident #153 did not currently have orders for EBP related to his Foley Catheter due to high contact activity. She further acknowledged that a gown should have been worn by staff when completing Foley catheter care for this resident, and that a Foley catheter anchor with strap should have been in place. On 09/04/25 at 11:34 AM, an interview was conducted with Staff E who stated that this resident should have been on EBP for his Foley Catheter and had a physician. He acknowledged that the staff members should have been wearing a gown prior to the start, during and throughout the Foley catheter care and the resident should've had a Foley catheter strap with anchor in place. On 09/04/25 at 09/04/25 at 1:30 PM, the Director Of Nursing (DON) stated an order for EBP should have been obtained with appropriate signage placed on the resident's door. The DON acknowledged that appropriate PPE should always be worn during care and the resident's Foley catheter should have been properly anchored and secured in place.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to follow physicians' orders for 1 of 3 sampled resident reviewed for tube feeding, Resident #20. The findings included: Review of the facility's policy titled, Physician's Services, with an issued and revised date of 03/02/19, included in part the following: All physician orders will be followed as prescribed and if no followed, the reason shall be recorded on the resident's medical record during that shift. Review of the facility's policy titled, Residents admitted to the Facility with Tube Feedings Already in Place, documented, in part, A resident who is fed by gastrostomy tube shall receive appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and to restore, if possible, normal eating skills. Record review for Resident #20 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Other Seizures, Encounter for Attention to Gastrostomy, and Aphasia. The MDS dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) could not be completed due to the resident is rarely/never understood. Review of the physician's orders for Resident #20 revealed an order dated 07/17/25 for two times a day Isosource 1.5 or Jevity 1.5 (formulary type) at 80 milliliter (ml) for 20 hour (hr.) via J-tube. On 2:00PM off 10:00 AM (Total 1600ml/24 hr. Review of the Care Plan for Resident #20 dated 01/02/25 with a focus on the resident requires tube feeding related to dysphagia. The goals were for the resident to remain free of side effects or complications related to tube feeding and will be free of aspiration through next review date. The interventions included in part the following: Provide tube feeding and water flushes. See MD orders for current feeding orders. On 09/02/25 at 9:55 AM, an observation was made of Resident #20 receiving tube feeding of Isosource 1.5 (formulary type) at 75ml/hr. via pump. On 09/02/25 at 5:00 PM, an observation was made of Resident #20 receiving tube feeding of Isosource 1.5 at 75ml/hr. via pump. The tube feeding bag was labeled with a date of 09/02/25 with no time and rate of 85ml/hr. An interview was conducted on 09/03/25 at 12:10 PM with Staff B, Registered Nurse (RN), who stated she has worked at the facility for about 8 years. When asked if she cared for Resident #20 yesterday, she said yes. When asked about tube feeding for Resident #20, that it was running at the wrong rate yesterday in the morning and in the late afternoon, she said she stopped the tube feeding at 10:00 AM and restarted it at 2:00 PM per the physician's orders. When asked if she verifies the rate, the RN stated she does not really look at the rate. The RN stated she only verifies the rate when the tube feeding runs out and she puts up a new bag because in the morning the tube feeding does not run too much on her shift, and she trusted the nurses before her to do the right thing.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to attempt to use appropriate alternatives and obtain informed consent prior to installing bedside rails, and failed to provide regular inspection and maintenance to identify areas of possible entrapment for 1 of 1 sampled resident, reviewed for bedrails, Resident #90. The findings included: Review of the facility's policy titled, Bed Rails with an issued and revised date of 03/02/19, included in part, the following: The facility shall provide adequate management of bedrails to ensure that residents attain or maintain the highest practical physical, mental and psychosocial well-being. Procedure: 2. If a bed or side rail is used, the facility will ensure correct installation, use, and maintenance of bedrails, including but not limited to the following elements: a) Assess the resident for risk of entrapment from bed rails prior to installation. b) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. c) Ensure that the bed's dimensions are appropriate for the resident's size and weight. D) Follow the manufacturers' recommendations and specifications for installing and maintaining bedrails. 5. When bed/side rails are deemed to be appropriate for the resident, upon completion of the Side Rail Evaluation, the admitting nurse will review risks and benefits and obtain informed consent. Record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Budd-Chiari Syndrome (a narrowing or a blockage {obstruction} in one or more of the veins that drain your liver {hepatic veins}), Obesity, and Weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating an intact cognitive response. Review of the physician's orders for Resident #90 revealed an order dated 12/03/22 for bilateral enablers/side rails for use as mobility aid for positioning. Record review for Resident #90 revealed the resident had a height of 61 inches and a weight of 206.2 pounds on 08/05/25. Review of the Side Rail Evaluation for Resident #90 dated 12/03/22 documented in part the following: Resident request. Recommended type of side rail(s): left upper and right upper. Recommended use of side rail(s): anytime. There were no additional Side Rail Evaluations for Resident #90. Review of the Side Rail Informed Consent and Release with a date that the month was unclear, but the day was the 15 and the year was 2022 did not have the resident's name on it, but only the date of birth. The consent was signed by a nurse assessor but not signed by the resident or the family representative. Review of the Care Plan for Resident #90 revealed no care plan for side rails/enablers. There were care plans that included side rails/enablers as an intervention. On 09/02/25 at 11:27 AM, an observation was made of Resident #90's bed. The observation revealed loose side rails on each side of the bed, the one on the right side of the bed was very loose and at an approximate 30-degree angle. An interview was conducted on 09/02/25 at 1:47 PM with Resident #90 who was asked how long the side rails have been on his bed, and he stated 'since day 1 when he got here.' When asked if he uses the side rails to get in and out of bed, he said yes. When asked if he thinks the side rails are loose, he said they are not too loose, I don't think they would come off. On 09/03/25 at 10:00 AM, an additional observation was made of Resident #90's bed with loose side rails on each side of the bed, the one on the right side of the bed was very loose and at an approximate 30-degree angle. An interview was conducted on 09/03/25 at 12:10 PM with Staff B, Registered Nurse (RN), who stated she has worked at the facility for about 8 years. When asked about side rails or enablers, the RN stated the resident is assessed / evaluated on admission and if the resident wants or needs them, they will get permission (consent) from the family or the patient if the patient is able to give permission. When asked who puts the side rails/enablers on the bed, she said she thinks the beds come with them. When asked who inspects the bed rails, she said maintenance. When asked (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about reassessing or re-evaluating for the bed rails, she said that it is just ongoing, and they document it as ongoing safety measures in place. An interview was conducted on 09/03/25 at 2:10 PM with the Director of Maintenance (DOM) who stated he has worked at the facility in maintenance department for 11 years and in the Director role for the past 1.5 years. When asked about issues with maintenance, he stated the staff can report this to the maintenance department in several ways, they can put the issue in TELS system located in the computer or put it in one of the log books located at each of the 2 the nursing station or Managers can put it in a group chat (text type on phone) that is seen in real time. The DOM stated that most staff put the issues directly into the TELS system. The DOM stated his department checks the log books located at the nursing stations minimally every morning. They also have guardian angel rounds conducted by management team that goes into each resident's room daily and checks to see if there are any issues that need to be addressed. When asked about how many types of beds they have, he stated they only have 2 types of bed brands Invacare and [NAME]. The DOM stated new beds come in with the side rails separate (unattached to the bed) and he will attach the side rails to the bed before he delivers the bed to the residents' rooms. The only time he does not attach the side rails is if the resident refuses the side rails. The DOM stated everybody has bed rails or if there are no bed rails then the resident had refused the bed rails, but most everyone has bed rails. When asked if he knows how many beds have side rails attached and how many have no side rails attached, he said he does not know that information. When asked who does the inspection of bed rails, the DOM said it is done by himself, or his 1 assistant and they are checked every month. When asked if he keeps a log of what beds have had the side rails inspected by the Maintenance Department, he said they do not keep a log, they just inspect them for cleanliness or being loose. If they are dirty he informs housekeeping, if they are loose, they are tightened immediately. When asked if the side rails are compatible with the bed per manufacturer's guidelines, he said all of the beds have the original side rails. When asked if the mattress is changed, such as putting on an air mattress, do they inspect the bed and rails to ensure the bed is safe and no entrapment can occur, he said when the mattress is changed, they use the same size mattress. During a tour of part of the facility conducted on 09/03/25 at 2:25 PM with the Director of Maintenance acknowledged the above findings. A random room (Room # 118-1) was randomly selected, and the DOM was asked what type of bed was in use, he had to look under the bed and stated it was a Basic American Metal Product bed not the Invacare and [NAME]. The DOM then stated only the new beds coming into the facility were the Invacare and [NAME] beds and there may be additional beds in the facility. In observation of Resident #90's bed with the DOM, he acknowledged both side rails were loose. An interview was conducted on 09/05/25 at 1:05 PM with the Wound Care Nurse who stated she has been working at the facility for about 2 years. She stated she is part of the guardian angel program, and she has an assignment that includes Resident #90. When asked what does the guardian angel program include, she checks the room every morning Monday through Friday to see if the call light works, the remote for the bed, the position of the resident, any clutter in the room, side rails and if the resident has any concerns. If there are any issues, she will report them to the appropriate person.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on review of policy and procedure, observation and interview, the facility failed to ensure that it maintained a currently dated posting for the Nurse Staffing Information, which had documented dates of two (2) incorrect days, for 1 of 4 days observed, at the start of this survey, for day of 09/02/25. The findings included: Record review of the facility policy and procedure, titled, Staffing, provided by the Administrator effective and revised 04/16/25 documented in the Policy Statement: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing document will be posted on a daily basis and will contain the following information:.b. The current date.2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. 3. The information posted will be:.b. In a prominent place readily accessible to residents, staff, and visitors.An observation on entrance tour to the facility, located at front desk, conducted on Tuesday 09/02/25 at 8:30 AM revealed that the posted Nurse Staffing Information was not dated correctly. The posting had an inaccurate date of Saturday 08/30/25, which was representative of 2 calendar days earlier than the start of the survey on Tuesday 09/02/25.An interview was conducted with the Staffing Coordinator / Scheduler, on 09/03/25 at 12:30 PM, regarding the Nurse Staff Postings, who stated she posts the daily Nurse Staffing Information everyday Monday through Friday at 8:30 AM. On the weekends, she said that she would prepare the document to include the census on Fridays for the Weekend Day Supervisor / Manager on Duty (MOD) or the receptionist who sits at the front desk for the weekend in order for them to post this on Saturday or Sunday. Staff stated that the receptionist forgot to change this over the holiday weekend. The Staffing Coordinator / Scheduler acknowledged that Nurse Staff Posting Form dated as Saturday 08/30/25 was the incorrect one and the correct, current form should have been posted. On 09/04/25 at 10 AM, the Administrator and the Director of Nursing (DON) both acknowledged the Nurse Staffing Information Form must be posted daily with the current 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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the attending physician documented in the residents' medical records that the identified irregularity by the consulting pharmacist had been reviewed and what, if any, action has been taken to address it, as evidenced by lack of documentation by the attending physician, if no change in the medication, of his or her rationale in the residents' medical records for 2 of 5 sampled residents reviewed for unnecessary medications, Residents #14 and #142. The findings included: Review of the facility's policy titled, Medication Regimen Review with a revised date of 06/01/24, included in part the following: The consultant pharmacist will provide the resident's MRRs (Medical Record Review) to the facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. The attending physician/prescriber should address the consultant's pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident per facility policy, or applicable state and federal regulations. 1. Record review revealed Resident #14 was originally admitted on [DATE] with most recent readmission on [DATE], with diagnoses that included in part the following: Chronic Obstructive Pulmonary Disease, Polyneuropathy, Major Depressive Disorder, Generalized Anxiety Disorder, Primary Insomnia, Drug induced Subacute Dyskinesia, and Fibromyalgia. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognitive response. Review of the Physician's Orders for Resident #14 included in part the following: An order dated for 05/07/25 for phenazopyridine HCL (Pyridium) 100mg tab by mouth every hour hours for bladder spasm was discontinued on 05/15/25, An order dated 07/25/25 for zolpidem tartrate tab 10mg by mouth daily for insomnia An order dated 07/25/25 for Amiodarone HCL tab 200mg by mouth once a day for Antiarrhythmics. Review of the Pharmacy Consultant Report with a Recommendation date of 04/12/25 for Resident #14 included in part the following: Resident receives amiodarone, which is only intended for use for life-threatening arrhythmias and has a Boxed Warning about substantial toxicities. Amiodarone should be closely and continually assessed both clinically and through appropriate lab monitoring. Recommendation: The following monitoring plan is recommended: thyroid function tests, followed by a TSH (Thyroid Stimulating Hormone) concentration every 6 months. Hepatic function at baseline and every 6 months thereafter. Pulmonary function test at baseline and periodically based on symptoms especially in individuals with underlying lung disease. Chest x-ray at baseline and periodically thereafter. ECG (Electrocardiogram) at baseline and at least annually. Ophthalmological evaluation baseline and annually. Blood Pressure and apical pulse at least weekly. Monitor gastrointestinal side effects especially during initiation and titration. There was no response from the physician or ARPN. Review of the Pharmacy Consultant Report with a Recommendation date of 05/08/25 for Resident #14 included in part the following: Resident has received phenazopyridine for symptomatic relief of (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dysuria for greater than 2 days. Prolonged use may mask the symptoms of unresolved cystitis and increase the risk of complications. Recommendation: Please discontinue phenazopyridine. There was no response from the physician or ARPN. An interview was conducted on 09/05/25 at 9:00 AM with the Director of Nursing (DON) who was asked about the pharmacy review and recommendations. The DON stated she identified there were no responses from the physician or ARNP (Advanced Registered Nurse Practitioner) in regard to the pharmacist recommendations. This was identified after the facility did an audit of the pharmacy recommendations during the recertification survey after surveyors requested pharmacy reviews / recommendations. The facility put a PIP (Performance Improvement Plan) in place on 09/03/25. 2. Review of Resident #142's clinical record documents an admission on [DATE] with no readmissions. The residents diagnoses included Displaced Bimalleolar Fracture of Left Lower Extremity, Injury of Head, Contusion of Unspecified Knee- Unspecified fall 07/04/25, Spondylopathy Lumbar Sacral Region, Chronic Obstructive Pulmonary Disorder (COPD), Pleural Effusion, Persistent Mood disorders, Generalized Anxiety Disorder (GAD), Major Depressive Disorder, Implantable Cardiac Defibrillator, Acute Embolism of Deep Vein (LUE) Left Upper Extremity, Insomnia, (CHF) Congestive Heart Failure, Hypoglycemia and Hypothyroidism. Review of Resident #142's active physician orders included: *Amiodarone 200 mg one time a day for abnormal heart rhythm *Eliquis 5 mg every 12 hours for DVT (Deep Vein Thrombosis) * Zolpidem (Ambien) 10 mg at HS for Insomnia Review of the Consultant Pharmacist Medication Regimen Review (MRR) documents the following: *March 1, 2025, through August 31, 2025 - Comment: Resident #142 has received Ambien 10 mg at bedtime for insomnia; Recommendation: For initial attempt at gradual dose reduction (GDR). The report revealed no written response form the physician. *June 1, 2025, through June 30, 2025 - Comment: Resident #142 receives Amiodarone which is only intended for use for life-threatening arrhythmias and has a boxed warning about substantial toxicities (i.e., pulmonary, hepatic and cardiac toxicity); Recommendations: Hepatic function at baseline and every 6 months thereafter, pulmonary function tests at baseline and periodically based on symptoms especially with underlying lung disease, Ophthalmological evaluation using funduscopy examination at baseline and annually. The physician response documented, I accept the recommendations, please implement as written. *June 1, 2025, through June 30, 2025- Comment: Resident #142 receives an oral anticoagulant, Eliquis, Recommendations: LFT (Liver Function Test) at least annually. The physician response documented, I accept the recommendations, please implement as written. On 09/05/25 at 3:45 PM, during an interview, Staff C, MDS Coordinator was asked to check with the DON regarding copies of the supportive documents for the Consultant pharmacist recommendations carried out for Resident #142. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/25 at 5:27 PM, during an interview, the Regional Clinical Services/RN stated the following recommendations had not been done for Resident #142: *GDR for Ambien recommended in March 2025. *Hepatic function at baseline and every 6 months thereafter, pulmonary function tests at baseline and periodically based on symptoms especially with underlying lung disease, Ophthalmological evaluation using funduscopic examination at baseline and annually recommended and accepted by the physician in June 2025. *LFT recommended and accepted by the physician in June 2025.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of policy and procedure, the facility failed to ensure that only authorized staff had access to the first-floor medication cart #1's keys as evidenced by the Registered Nurse (RN) handed the medication cart keys to a Certified Nursing Aide (CNA) to open the smoking room; failed to ensure that residents medications were properly supervised / stored as evidenced by medications being left unattended on the resident's bedside table during a Medication Administration Observation for 1 of 9 sampled residents (Resident #79); failed to ensure that expired wound care dressings were removed from 2 of 2 treatment carts located in the medical preparation room in the first floor and the second floor units; failed to ensure that 2 of 2 Medical Preparation / medication storage room reviewed had readily accessible soap and/or alcohol-based hand rub (ABHR) to perform hand hygiene; and failed to ensure the medication storage room was free of resident's personal belongings as evidenced by a plastic bag with personal belongings observed in 2 of 2 medication storage rooms reviewed (First and Second Floor units). The findings included: Review of the facility's policy titled General Dose Preparation and Medication Administration revised on [DATE] documented, .facility staff should not leave medications or chemical unattended.1. On [DATE] at 4:16 PM, observation revealed Staff F, Registered Nurse (RN), handed her medication cart keys to Staff G, Certified Nursing Assistant (CNA). Consequently, an interview was conducted with Staff G who stated she was assigned to open the smoking room, and the nurse had the key. Observation revealed Staff G walked 20-35 feet away from Staff F and opened the smoking room. At 4:20 PM, observation revealed Staff F received the medication cart keys from Staff G. On [DATE] at 9:05 AM, observation revealed the facility's Director of Plant Operations (DPO) was asking Staff H, Licensed Practical Nurse (LPN), for the smoking-room keys, as he needed to open the room for the life safety surveyor. On [DATE] at 9:11 AM, observation revealed Staff H handed her medication cart keys to the Director of Nursing (DON). The DON stated she can have the keys and added I'm a nurse. The DON was asked if only nurses can have the key and stated Yes, only nurses can have the medication cart keys.On [DATE] at 4:36 PM, an interview was conducted with Staff F, RN, who was asked about her handing the medication cart keys to Staff G, CNA, on [DATE]. Staff F stated she was busy and was giving the keys to the CNA but was told by another nurse not to give the key to a CNA. 2. On [DATE] at 5:01 PM, observation of medication administration for Resident #79 performed by Staff I, LPN, was conducted. Staff I poured the following medications: Lactulose oral solution 10 millimeters (ml) for constipation, Carbidopa-Levodopa oral tablet 25-100 milligrams (mg) for Parkinson's and Entacapone oral tablet 200 mg for Parkinson's. Staff I entered the resident's room with the poured medications in a cup on a foam tray, placed the foam tray on top of the resident's bedside table and walked away to the bathroom to perform handwashing. Staff I was unable to supervise and keep an eyesight on the medication. Observation revealed Resident #79 was out of bed sitting in a wheelchair and moving back and forth in the wheelchair. The resident was mumbling and not responding to questions asked. On [DATE] at 4:42 PM, an interview was conducted with Staff I who stated he should not have left Resident #79's medications on the table out of his sight. Staff I stated he was to have the medications on his sight at all times until he administers them and added he should've washed his hands first. 3. On [DATE] at 1:05 PM, a side-by-side review of the facility's 1st floor unit's Medical Preparation room (medication storage room) was conducted with Staff H, LPN. The review revealed an unlocked treatment cart in the room with the following:*One opened bottle of Hydro Peroxide with an expiration date on 05/24.*One opened bottle of Dermal Wound cleanser undated; Staff H was not able to read the bottle expiration date.*One unopened bottle of Geri-Lanta (antacid medication). Staff H stated it should not be in the treatment cart.*One Xeroform Medicated Petrolatum dressing with an (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expiration date on 05/2025.*One opened and undated Super Absorbent dressing. Staff H stated it should not be in the cart. *29 Calcium Alginate Dressings with an expiration date on [DATE].*One opened 0.25% Acetic acid with not an opening or expiration date noted.Staff H, LPN confirmed all listed items expiration dates and stated the floor nurses, and the wound care nurse uses dressing supplies from the treatment cart. On [DATE] at 1:10 PM, during the side-by-side review of the facility's 1st floor unit's Medical Preparation room (medication storage room) with Staff H, LPN, the surveyor's hand got sticky and there was no soap or hand sanitizer in the room to perform hand hygiene. Staff H confirmed there was no soap in the room. Staff H pulled a hand sanitizer bottle from her pocket. Staff H stated she did not know why there was no soap in the room and added she would tell someone. Further observation revealed an accumulation of ice in the refrigerator freezer located in the medical preparation room on the first floor (Photographic Evidence Obtained). Staff H did not know who was responsible to clean it. The refrigerator was filled with residents' medications. The review revealed an unidentified plastic bag with a pair of dirty boots (Photographic Evidence Obtained). On [DATE] at 4:27 PM, during an interview, Staff E, Unit Manager, was apprised of the first-floor medication storage refrigerator with accumulation of ice, photographic evidence was shown, expired items found and what looks like residents' belongings, on the first floor. He stated he would let the Assistant Director of Nursing (ADON) know. 4. On [DATE] at 4:08 PM, a side-by-side review of the facility's second floor Medical Preparation room (medication storage room) was conducted with Staff E, Unit Manager. The review revealed the following:*A labeled plastic bag for Resident #150 with personal belongings such as a cell phone, a phone charger and a wallet, in a drawer. Staff E stated residents' personal belongings should not be in the medication storage room. Review of Resident #150's clinical record documented a discharge to a local hospital on [DATE]. *An unlocked treatment cart with 29- Xeroform Petrolatum Dressing with an expiration date on 05/2025. During an interview, Staff E stated the treatment cart should be locked and added there was only one key for both carts, but they were getting another one. During the review, the surveyor attempted to do handwashing and there was no soap in the medication storage room. Staff E stated there should be soap in the room for the staff to do handwashing. On [DATE] at 1:10 PM, an interview was conducted with the facility's dedicated Wound Care Nurse (WCN) who stated she works Monday through Friday, and the floor nurses do the residents wound care on the weekends. The WCN stated each nurse's station has a treatment cart and that she uses supplies from those unit's cart, and every Friday she checks all treatment carts supply for expiration dates and added the floor nurses needs to check for expiration dates also. On [DATE] at 2:13 PM, a side-by-side review of the Medical Preparation room was conducted with the Regional Clinical Services and the Director of Nursing (DON). They were apprised of the two-rooms lacking soap.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide food in correct form (mechanical soft), as ordered by the physician for Resident #56. The census at the time of survey was 135. The findings included: Record review revealed Resident #56 was admitted to the facility on [DATE]. Review of the most recent complete assessment, an admission MDS, with a reference date of 07/23/25, revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident was cognitively intact. Resident #56's diagnoses at the time of the assessment included: Cancer, Hypertension, Hyperlipidemia, Thyroid disorder, Malnutrition, and Chronic Lung Disease. Review of Resident #56's physician diet orders included: Regular Diet, Mechanical Soft texture, dated 08/27/25. During an observation of the lunch meal served to the residents in the Dining room on the 200 unit, on 09/02/25 at 12:20 PM, Resident #56 was observed with a piece of bone-in chicken with skin on it. The resident was attempting to eat the chicken with a fork. It was noted that the resident ate very little of the chicken (approximately one quarter of the served chicken). During an interview, on 09/03/25 at 9:42 AM, with the Speech Language Pathologist (SLP), when asked about the resident being served the bone-in chicken leg with the skin on, the SLP stated, it is not appropriate for her because she has left-sided weakness and left-sided droop and can't masticate food properly and that is why she needs mechanical soft.		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 38 residents on Enhanced Barrier Precautions (Residents #20, #77, #14); failed to disinfect reusable equipment between residents' use (Resident #128 and #79); and failed to perform hand hygiene during medication administration observation for 2 of 9 residents (Resident #95 and #127). The findings included: Review of the facility's policy titled, Enhanced Barrier Precautions with an issued date of 04/01/24 included in part the following: Policy: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDRO). Definitions: EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. Policy Explanation and Compliance: 1. Prompt recognition of need: a) All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions. b) All staff receive training on high-risk activities and common organisms that require EBP. C) The facility will have the discretion of how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of EBP: b)An order for EBP will be obtained for residents with any of the following: Wounds, and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of EBP: a) Make gown and gloves available immediately near or outside of the resident's room. 4. High-contact resident care activities include: d)Providing hygiene, g)Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy /ventilator tubes. 1. Record review for Resident #20 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Other Seizures, Encounter for Attention to Gastrostomy, and Aphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented in Section C that a Brief Interview of Mental Status (BIMS) could not be completed due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #20 revealed in part the following: An order dated 07/17/25 for 'two times a day Isosource 1.5 or Jevity 1.5 at 80 ml/20hr via J-tube. On 2:00PM off 10:00 AM (Total 1600ml/24 hr.).' An order dated 04/30/24 for 'Enhanced Barrier Precautions every shift.' Review of the Care Plan for Resident #20 dated 07/07/25 documented a focus for Enhanced Barrier Precautions (EBP) for the resident is at risk for multidrug resistant organisms (MDRO) related to feeding tube requiring EBP during high contact resident care activities. The goal was to minimize risk of transmission of colonized or infection with MDROs. The interventions included in part the following: Wear gown and gloves during resident high contact activities in room, therapy gym or shower room (i.e. dressing bathing/showering, transferring, providing hygiene, changing line, toileting/changing briefs, device care or use. (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/02/25 at 9:55 AM, an observation was made of Resident #20 receiving tube feeding of Isosource 1.5 (formulary type) at 75ml/hr. via pump. There was no EBP sign inside or outside of the resident's room or evidence the resident was on EBP, and there were no disposable gowns or masks in the room or in close proximity to the room. On 09/02/25 at 5:00 PM, an observation was made of Resident #20 receiving tube feeding of Isosource 1.5 at 75ml/hr. via pump. The tube feeding bag was labeled with a date of 09/02/25 with no time and rate of 85ml/hr. There continued to be no EBP signage outside or inside the room and no gowns in the room or in close proximity to the room. On 09/03/25 at 9:30 AM, an observation was made of Resident #20 receiving tube feeding of Isosource 1.5 at 80ml/hr. via pump. The tube feeding bag was labeled with a date of 09/03/25 and rate of 80ml/hr. There still was no EBP signage outside or inside the room and no gowns in the room or in close proximity to the room. An interview was conducted on 09/04/25 at 12:45 PM with the Assistant Director of Nursing / Infection Preventionist (ADON/IP) who acknowledged Resident #20 had an EBP care plan since 07/07/25 and should have had EBP in place long before that. 2. Record review for Resident #77 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Other Osteomyelitis Lower Leg and Obstructive and Reflux Uropathy. The MDS assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating an intact cognitive response. Review of the Physician's Orders for Resident #77 revealed in part the following: An order dated 03/07.25 for Enhanced Barrier Precautions - Chronic Wound and Suprapubic Catheter medical device. An order dated 07/24/25 to monitor suprapubic catheter for signs and symptoms of infection and leakage. An order dated 07/24/25 to cleanse suprapubic catheter with normal saline, pat dry and apply dressing every shift and as needed. Review of the Care Plan for Resident #77 dated 03/31/25 documented a focus on 'the resident has a Suprapubic catheter related to Urethral Stricture'. The goals were for the resident to be/remain free from catheter related trauma and to show no signs/symptoms of urinary tract infection through the next review date. The interventions included in part the following: Change catheter as ordered. Change drainage bag per policy. May irrigate suprapubic catheter with 60mls of normal saline every shift as needed for blockage, occlusion, leakage etc. Review of the Care Plan for Resident #77 dated 03/31/25 documented a focus on Enhanced Barrier Precautions (EBP): resident is at risk for multidrug resistant organisms (MDRO) related to chronic wounds and suprapubic catheter requiring EBP during high contact resident care activities in room, therapy gym or shower room, urinary catheter. The goal was to minimize risk of transmission of colonized or infection with MDROs. The interventions included in part the following: Wear gown and gloves during resident high contact activities in room, therapy gym, or shower room (i.e. dressing, bathing/showering, transferring, providing hygiene, changing line, toileting/changing briefs, device (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care or use, urinary catheter). On 09/02/25 at 10:30 AM, an observation was made of Resident #77 lying in bed with the urinary drainage bag on side of bed covered with privacy cover. There was no EBP sign outside or inside of room, no evidence the resident was on EBP, and no gowns in the room or in close proximity to the room. 3. Record review for Resident #14 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Urinary Tract Infection, Parkinson's Disease, and Obstructive and Reflux Uropathy. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #14 revealed in part the following: An order dated 07/25/25 for Foley Catheter care every shift and as needed. An order dated 07/25/25 for Enhanced Barrier Precautions every shift. Review of the Care Plan for Resident #14 dated 04/29/24 documented a focus on Enhanced Barrier Precautions (EBP) resident is at risk for multidrug resistant organism (MDRO) related to indwelling medical devices requiring EBP during high contact resident care activities in room, therapy gym or shower room. The goal was to minimize risk of transmission of colonized or infection with MDROs. The interventions included in part the following: Wear gown and gloves during resident high-contact activities in room, therapy gym or shower room (i.e. dressing, bathing/showering, transferring, providing hygiene, changing line, toileting/changing briefs, device care or use). Review of the Care Plan for Resident #14 dated 05/27/21 documented a focus on resident has a suprapubic catheter and bilateral nephrostomy tubes related to Neurogenic bladder. He also has indwelling catheter post urethral surgery. The goals were resident will show no signs/symptoms of urinary infection and will be/remain free from catheter related trauma through review date. The interventions included in part the following: Maintain indwelling catheter for obstructive uropathy size 18 French 10 cc balloon. On 09/02/25 at 11:05 AM, an observation was made of Resident #14 in the wheelchair returning to his room followed by Staff B, Registered Nurse (RN), to the resident's side of bed. The RN pulled the curtain and applied gloves, did not put on a gown, and proceeded to touch the catheter tubing and drainage bag. There was no EBP sign on the door or inside the resident's room, no evidence the resident was on EBP, and there were no gowns in the room or in close proximity to the room. An interview was conducted on 09/02/25 at 11:18 AM with Staff B who was asked what she did with the catheter for Resident #14. She stated it was dragging on the floor and so she had him come back to his room so she could adjust it. When asked about not wearing a gown, she replied, she just wore gloves. An interview was conducted on 09/02/25 at 1:44 PM with Staff A, Certified Nursing Assistant (CNA), who stated she has worked at the facility for about 9 years. When asked about Enhanced Barrier Precautions (EBP), she said you needed to wash your hands, and if there is a sign on the door for EBP, you need to put on a gown to do care, take the gown and gloves off in the room, bag it up and (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	throw it away properly. When asked where the personal protective equipment (PPE) including gown, gloves and masks are kept, she said they are usually on the door either inside or outside of the room. An interview was conducted on 09/03/25 at 12:10 PM with Staff B, RN, who stated she has worked at the facility for about 8 years. When asked about who would require Enhanced Barrier Precautions (EBP), she said any resident with an invasive device like a catheter, foley, intravenous access, dialysis or wound. When asked if they need an order for EBP, she said they should have an order, the physician gives the order. When asked about a care plan for EBP, she said they should, but she does not put it in the care plans. When asked if a sign needs to be posted for EBP, she said yes it should be on the outside of the door. When asked if there are 2 residents in the room and a sign on the door, how do they know which resident the EBP sign is for, she said she works here so she just knows. When asked about gowns, she said usually they are in a caddy on the resident's door or in a caddy in the hallway. She acknowledged there was no EBP signage on the door for Resident #20 or Resident #14, and only Resident #14 had a caddy on the door with gowns. When asked about no gowns yesterday in the hallway near Residents #20 and #14 rooms, she said sometimes they run out of the gowns. During a side-by-side observation conducted on 09/03/25 at 4:25 PM with the DON and the Assistant Director of Nursing / Infection Preventionist (ADON/IP) who acknowledged there was no EBP sign on the door for Resident #20 nor was there any isolation gowns in the room or readily available. During a telephone interview conducted on 09/03/25 at 4:35 PM with the Central Supply Clerk (CSC), who stated he has worked at the facility for 7 years and with the ADON/IP present for the interview. The CSC was asked about the supply of gowns, he said they had no supply, all stock was placed on the floor earlier today and they are expecting a shipment tomorrow. When the ADON/IP was asked if he was aware that the facility did not have any ample supply of gowns, he said we only have what the facility will provide. When asked if he has discussed this with the Director of Nursing (DON) or the Administrator, he said no. During an interview conducted on 09/03/25 at 5:00 PM with the ADON/Infection Preventionist who stated he has worked at the facility for 4 months. When asked about what the criteria is that would require a resident the need to be on EBP, the ADON/IP stated the residents who should be on EBP were residents with (urinary) foley, wound, IV (intravenous access), PEG (Percutaneous Endoscopic Gastrostomy) a type of feeding tube and trach. When asked if they need an EBP sign on the door of the room, the ADON/IP said yes and they need gowns and gloves as well, most will have a caddy for the personal protective equipment (PPE) (i.e. gowns and gloves) on the resident's room door, or it will be located in a caddy in the hallway. When asked if they had any issues with not having enough supplies of PPE specifically the gowns, he said he was unsure. When asked if they follow the CDC (Center for Disease Control) guidelines, he said yes. 4. Review of the facility's policy titled General Dose Preparation and Medication Administration revised on 01/01/22 documented .prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy (e.g., handwashing) .after medication administration, facility staff should take all measures required by facility policy.including.clean any reusable equipment or supplies. Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Equipment revised on 01/01/25 documented .reusable multiple-resident items are items [NAME] may be used multiple items for multiple residents. Examples include.blood pressure cuffs.multiple-resident use equipment shall be cleaned and disinfected after each use. (continued on next page)		

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 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avante at Boca Raton, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15th Street Boca Raton, FL 33486	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Infection Control-Hand Hygiene revised on 03/02/19 documented .hand hygiene should be performed.upon and after coming in contact with a resident (e.g.lifting a resident.after removing gloves. On 09/02/25 at 4:38 PM, medication observation for Resident #128 performed by Staff I, Licensed Practical Nurse (LPN) was conducted. Staff I entered the resident's room, performed handwashing and donned gloves, then placed the blood pressure machine with the cuff and the pulse oximeter (device to check the blood oxygen saturation) on top of the resident's bed linen. Staff I placed the blood pressure cuff on the resident's left arm and the pulse oximeter on the resident's left-hand finger, upon completion of vital signs check, Staff I removed the blood pressure cuff and machine and the pulse oximeter from the resident and placed the equipment on top of the chair in the room. Further observation revealed Staff I returned to the medication cart with the reusable equipment and placed the equipment (blood pressure and the pulse oximeter) on top of the medication cart without disinfecting the equipment. 5. On 09/02/25 at 5:01 PM, medication observation for Resident #79, performed by Staff I, Licensed Practical Nurse (LPN), was conducted. Staff I entered the resident's room and without disinfecting the reusable equipment, placed the reusable blood pressure machine with the cuff and the pulse oximeter on top of Resident #79's over the bed table. Staff I proceeded to do hand hygiene, placed the blood pressure cuff on the resident's right arm, and the pulse oximeter on the right-hand finger. On 09/02/25 at 5:16 PM, an interview with Staff I was conducted who stated he cleans the reusable equipment after every patient (resident) and confirmed he did not clean/disinfect the equipment in between Resident #128 and Resident #79 during medication administration observation. Staff I stated he was under a little pressure. 6. On 09/03/25 at 9:30 AM, medication administration for Resident #95, performed by Staff H, LPN was conducted. Observation revealed Resident #95 was self-transferring from the wheelchair to the bed with great difficulty and landed on top of a box of tissues. Staff H assisted the resident by lifting her to remove the box of tissue from underneath the resident, the resident refused to take her medications. Further observation revealed Staff H exited the room without performing handwashing, dropped the resident's oral medication into the drug buster bottle, then walked to the nurse's station, without performing hand hygiene, logged in to the desktop computer and dialed on the telephone pad. Staff H then proceeded to the medication cart and started to pour medications for Resident #127 without performing hand hygiene. Consequently, an interview was conducted with Staff H who stated the facility's handwashing policy was to wash her hands after care, after medications administration and added it is very important to do hand washing. Staff H was apprised of the observation findings and replied she did use hand sanitizer. Staff H was apprised that she was not observed doing hand hygiene.		