STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105372	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LAKE WORTH, INC.	2501 N A ST , LAKE WORTH, Florida, 33460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced recertification revisit survey was conducted in conjunction with a complaint survey, complaint number 2025010030, from to at Avante at Lake Worth, Inc. The facility was not in compliance with the CFR 42, Part 483, Requirements for Long Term Care Facilities.	F0000		/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, 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 residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review the facility failed to ensure physician's orders were followed for monitoring and administration for 1 of 3 sampled (Resident #90). The findings included: Record review for Resident #90 revealed the resident was originally admitted to the facility on with most recent readmission on with diagnoses that included in part the following: , Dependence on , Hidradentis Suppurative (HS), and Type 2 Without Complications. The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status score of 13 which indicated the resident was .	F0684	F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by this practice? On medication review completed with NP. How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? On , Director of Nursing/designee completed an audit of all resident residents receiving to ensure supplemental orders are in place. On , Director of Nursing/designee completed an audit of all resident receiving , to ensure a medication review has been completed. What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? By the Director of Nursing/ designee completed education with the licensed nursing staff regarding supplemental for monitoring, what to do if a medication is scheduled while a resident is at . How will the corrective actions be monitored to ensure	/2025

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105372	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

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AVANTE AT LAKE WORTH, INC.	2501 N A ST , LAKE WORTH, Florida, 33460

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F0684 SS = D	Continued from page 1 Review of Physician's Orders for Resident #90 revealed the following orders: An order dated Aspart Injection Solution 100 UNIT/ML (Aspart) Inject 5 unit , one time a day (scheduled for 11:30 AM) for that also had supplemental orders added to monitor . An order dated Semglee Solution Pen-injector 100 UNIT/ML Inject 50 unit , at bedtime for (with no supplemental orders for monitoring). Review of Medication Administration Record (MAR) from to for Resident #90 documented Aspart ordered daily at 11:30 AM was not given 5 out of 14 opportunities when the resident was at , nor was the monitored those days. During an interview conducted on at 12:45 PM with the Director of Nursing (DON) who was asked about Resident #90 who is and receiving long acting at bedtime and once a day at 11:30 AM. The DON stated Resident #90 goes to by 10:00 AM and returns approximately 3:00 PM three times a week. When asked when are his checked, the DON stated prior to administration of 11:30 AM dose of . The DON confirmed the supplemental order on the 11:30 AM dose to check prior to dose given. Resident #90 goes to Monday, Wednesday and Friday. The DON is unaware if the physician is aware of the resident not receiving his 11:30 AM on days (three times a week). The DON stated he will need to clarify the order for the 11:30 AM with the prescribing physician to address the resident who is out of the facility three times a week routinely for . The DON acknowledged the nurse documented the 11:30 AM was not administered 5 times during month of , while the resident was out at . During an interview conducted on at 3:47 PM with Resident #90's Primary Physician (PP) who was asked about Resident #90, he said he is aware of the resident receiving out of the facility three times a week and that he is and has orders for long acting and short acting . The PP stated that when a resident is on typically they check the daily and it is usually associated	F0684	Continued from page 1 the practice will not recur; what quality measures will be put into place? Director of Nursing/designee to complete random audit to ensure resident receiving have supplemental orders. weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. Director of Nursing/designee to complete random audit to ensure a medication review has been conducted for resident receiving weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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F0684 SS = D	Continued from page 2 with a ⌄ for . The PP stated it is not typical to check ⌄ only once a day, they usually check it more. The resident was recently readmitted and maybe there was an order carried over from the hospital and that is why the resident did not have more frequent ⌄ checks. The PP stated his Nurse Practitioner does see the patient more often than him with his supervision. When asked if he was aware that the resident did not receive his short acting or ⌄ checks (scheduled for 11:30 AM daily) on the three days the resident goes to , he said he was under the impression the resident would get the ⌄ checked and receive his upon return from . When asked if he was aware the resident has a chair time for at 10:00 AM and usually returns to the facility around 3:00 PM, he said in his medical opinion he would like to see the ⌄ be more frequently with a ⌄ more than once a day. The PP stated he believes it was an oversight that the ⌄ were not ordered and checked three times a day. The PP acknowledged the facility could have reached out to him to clarify the order for and ⌄ checks. During an interview conducted on at 1:00 PM with Staff A Licensed Practical Nurse (LPN) who was asked if a resident has and ⌄ ordered and they go out to , when the ⌄ / is ordered what would she do, the LPN said she would consider it a missed dose and check the ⌄ when they return from . When asked about clarifying the order with the physician, the LPN said that would probably be the best thing to do.	F0684		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10250961	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LAKE WORTH, INC.	2501 N A ST , LAKE WORTH, Florida, 33460

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N0000	INITIAL COMMENTS An unannounced relicensure revisit survey was conducted with a complaint survey, complaint number 2025010030 from to at Avante at Lake Worth, Inc. Federal deficiencies were not found to be corrected at the time of the survey.	N0000		/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE