

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2025
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 C 04/21/2025
NAME OF PROVIDER OR SUPPLIER AVANTE AT BOCA RATON, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET BOCA RATON, FL 33486		
(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
F 000	INITIAL COMMENTS	F 000			
F 684 SS=D	<p>An unannounced complaint survey, complaint # 2025003477 was conducted on _____ at Avante at Boca Raton. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 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 interview and record review, the facility failed to ensure a physician-ordered was scheduled and performed for 1 of 3 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on _____ with diagnoses that included _____ and _____ following _____ affecting Left Non-Dominant Side, and _____</p> <p>A review of the most current Minimum Data Set (MDS) assessment, dated _____, under Section C, revealed a Brief Interview of Mental Status Score of 6 indicating Resident #1 had _____ cognition. Section GG under functional</p>	F 684	<p>F684 Quality of Care</p> <p>A)What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On _____ was _____ scheduled for _____ for _____ at 4pm for Resident #1.</p> <p>B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On _____ Director of Nursing/ designee completed an audit of physician order to ensure any outsource diagnostic testing has been ordered.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/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 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.

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F 684	<p>Continued From page 1</p> <p>limitations in range of motions revealed Resident #1 had _____ on one side. Toileting and hygiene which included the ability to maintain _____ hygiene, revealed that Resident #1 need substantial and maximal assistance.</p> <p>A review of the _____ care progress notes in _____ indicated the resident had fungal rashes to the _____ folds, they were treated with Nystation cream, and which had been resolved. A physician order for a GYN consult for _____ was ordered _____</p> <p>In an interview with Staff K, Nurse Practitioner (NP) on _____ at 12:51 PM, she acknowledged she cared for Resident #1, who can't move on one side and can't speak. When asked if Resident #1 had _____ and rashes, she responded that the resident had a history and was diagnosed with post-_____. She added that she had written notes on Resident #1's electronic medical records regarding the _____</p> <p>A review of the Physician Orders revealed an order dated _____ to schedule a Trans _____</p> <p>In an interview with Staff J, Registered Nurse (RN) at 4:30 PM when asked if she had taken care of Resident #1 before, she responded, that she had cared for her. When asked if she had witnessed any _____ or _____ she responded, she had not. She added she was caring for Resident #1 last week and did not notice any open skin, _____ or irritation in the _____ area. When asked if she was aware there is an order for a _____ for Resident #1, she responded she was not aware</p>	F 684	<p>C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur?</p> <p>a. By _____ the Director of nursing/designee to complete education with the nurses to ensure any outsource diagnostic testing has been submitted to the _____ coordinator.</p> <p>b. On _____ education provided to the _____ coordinator to ensure _____ are scheduled timely for outsource diagnostics and transportation if needed _____</p> <p>D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place?</p> <p>a. Director of nursing/designee will complete audit of residents who have outsource diagnostic testing scheduled in a timely manner and transportation if needed, compliance with federal regulation F684 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved.</p> <p>b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.</p>		

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F 684	<p>Continued From page 2</p> <p>and she had not received an order for an . She also stated she did not see an order for a . . . for Resident #1.</p> <p>In an interview with Resident #1's family member on . . . at 3:50 PM, he stated the facility did not inform him about the . . . and fungal on the . . . area. He was informed during his mother's gynecologist . . . , about a month ago. He added that he is still waiting for the facility to advise him on when the . . . is scheduled. It was ordered during Resident #1's gynecologist visit. He has been waiting for almost a month and still has no schedule yet. He called the facility Administrator again on . . . to ask him when the . . . is scheduled and he still has no updated information from him.</p> <p>In an interview with the Administrator on at 4:08 PM, when asked if he discussed the scheduling of the . . . with Resident #1's son, he responded, "I still have no schedule, but I will inform him". When asked why it is taking long to schedule an . . . , he responded, "It is a special procedure which need more calls to be done".</p>	F 684			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2025
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NAME OF PROVIDER OR SUPPLIER AVANTE AT BOCA RATON, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET BOCA RATON, FL 33486
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey, complaint #2025003477 was conducted on at Avante at Boca Raton. The facility had deficiencies at the time of the survey.</p>	N 000		
N 201 SS=D	<p>400.022(1)(I), FS Right to Adequate and Appropriate Health Care</p> <p>(I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.</p> <p>This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a physician-ordered was scheduled and performed for 1 of 3 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on with diagnoses that included and following affecting Left Non-Dominant Side, and</p> <p>A review of the most current Minimum Data Set (MDS) assessment, dated , under Section C, revealed a Brief Interview of Mental Status Score of 6 indicating Resident #1 had cognition. Section GG under functional limitations in range of motions revealed Resident #1 had on one side. Toileting and</p>	N 201	<p>N201 Right To Adequate and appropriate Health Care</p> <p>A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On was scheduled for for at 4pm for Resident #1.</p> <p>B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Director of Nursing/ designee completed an audit of physician order to ensure any outsource diagnostic testing has been ordered.</p> <p>C) What measures will be put into place or</p>	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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Electronically Signed

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N 201	<p>Continued From page 1</p> <p>hygiene which included the ability to maintain hygiene, revealed that Resident #1 need substantial and maximal assistance.</p> <p>A review of the care progress notes in indicated the resident had fungal rashes to the folds, they were treated with Nystation cream, and which had been resolved. A physician order for a GYN consult for was ordered</p> <p>In an interview with Staff K, Nurse Practitioner (NP) on at 12:51 PM, she acknowledged she cared for Resident #1, who can't move on one side and can't speak. When asked if Resident #1 had and rashes, she responded that the resident had a history and was diagnosed with post-. She added that she had written notes on Resident #1's electronic medical records regarding the</p> <p>A review of the Physician Orders revealed an order dated to schedule a Trans</p> <p>In an interview with Staff J, Registered Nurse (RN) at 4:30 PM when asked if she had taken care of Resident #1 before, she responded, that she had cared for her. When asked if she had witnessed any or she responded, she had not. She added she was caring for Resident #1 last week and did not notice any open skin, or irritation in the area. When asked if she was aware there is an order for a for Resident #1, she responded she was not aware and she had not received an order for an. She also stated she did not see an order for a for Resident</p>	N 201	<p>what systemic changes will you take to ensure that the practice does not reoccur?</p> <p>a. By the Director of nursing/designee to complete education with the nurses to ensure any outsource diagnostic testing has been submitted to the coordinator.</p> <p>b. On education provided to the coordinator are scheduled timely for outsource diagnostics and transportation if needed.</p> <p>D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place?</p> <p>a. Director of nursing/designee will complete audit of residents who have outsource diagnostic testing scheduled in a timely manner and transportation if needed, compliance with federal regulation N201 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved.</p> <p>b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.</p>	
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N	<p>Continued From page 2</p> <p>#1.</p> <p>In an interview with Resident #1's family member on _____ at 3:50 PM, he stated the facility did not inform him about the _____ and fungal _____ on the _____ area. He was informed during his mother's gynecologist _____, about a month ago. He added that he is still waiting for the facility to advise him on when the _____ is scheduled. It was ordered during Resident #1's gynecologist visit. He has been waiting for almost a month and still has no schedule yet. He called the facility Administrator again on _____ to ask him when the _____ is scheduled and he still has no updated information from him.</p> <p>In an interview with the Administrator on _____ at 4:08 PM, when asked if he discussed the scheduling of the _____ with Resident #1's son, he responded, "I still have no schedule, but I will inform him". When asked why it is taking long to schedule an _____, he responded, "It is a special procedure which need more calls to be done".</p> <p>Class III</p>	N 201		