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

PRINTED: 09/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105521	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	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 An unannounced Recertification survey was conducted on - at Avante At Boca Raton, Inc. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal regulation	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private .... each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	**F164** 1) **Corrective actions for Residents affected:** Residents #32 and #172 experienced no negative outcome and were provided privacy upon discovery of need. 2) **Identify other Residents potentially affected:** Audit was conducted of current Residents to ensure Residents were provided privacy. Appropriate interventions were implemented if needed.	

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

TITLE Administrator (X6) DATE 9-16-16

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.

RECEIVED
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F 164 Continued From page 1 — F 164

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to ensure the privacy of 2 of 4 residents reviewed for as evidenced by the care nurse failed to provide privacy to 2 residents during care treatment (Resident #172 and Resident #32).

The findings included:

1) During observation of care on beginning at 12:00 PM for resident #172 whose windows provide direct visual of the first floor shared outdoor courtyard and other first floor surrounding the courtyard. Further observation the care nurse and aide repositioned Resident #172 with her thigh; leg and heel uncovered and in view of the courtyard. The care nurse pulled over Resident #172's gown; undid the adult brief and the skin on her hip was revealed. After surveyor intervention the care nurse was asked to close the blinds on the windows to prevent further visual of Resident #172 from the courtyard during care.

During an interview on 8/24/16 at 3:00 PM the care nurse acknowledged the findings.

2) On at 9:00 AM Observation of care performed by the Care Nurse (WCN) for Resident #32 was conducted. The WCN was assisted by Staff N, C.N.A. At 9:40 AM WCN was observed leaving the resident's . Upon her return at 9:45 AM the WCN stated that she was waiting for housekeeping to bring napkins and remove the trash. Observation of the resident can overflow was made.

3) Measures Implemented:

Nursing staff reeducation will be completed by / by the DON or Designee re: providing Residents Privacy.

4) Monitoring:

DON or Designee will conduct random weekly audits of Residents during the routine provision of care and services for 3 months to ensure that Residents are afforded privacy. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

5) Date of Correction:

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F 164	Continued From page 2 On at 9:54 AM the housekeeper knocked on the closed door, entered Resident #32 . The housekeeper had a full visual view of the resident who was lying in bed without the privacy curtains pulled and uncovered. After the housekeeper entered the resident's , Staff N and WCN were observed covering the resident's body with a white sheet. Additional observation revealed housekeeper came out of Resident #32's proceeded to empty the overflow trash can next to the resident's cabinet located against the wall facing the resident. Further observations revealed while the housekeeper was in the to emptying the trash can, the WCN and Staff N were observed removing the resident's white sheet, pulled resident up in the bed and turned the resident over the left side without the privacy curtains pulled.	F 164		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was noted that the facility failed to maintain a clean and home-like environment to best accommodate the needs of the residents residing in 3 out 3 of units (First floor, Second Floor and the Court Yard). The findings included:	F 253	**F253** **1) Corrective actions for Residents affected:** **a.** The privacy curtain in -2 the privacy curtain was replaced and the rail was cleaned immediately. **b.** The wall around the sink between the faucets in was cleaned immediately. **c.** The doors of 221 and 227 were repainted. **d.** The side of the vanity in was repaired.	

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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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F 253 Continued From page 3

During observations conducted by the survey team on , during the initial tour of the facility, revealed the following:

In , the privacy curtain next to bed 2 had stains on it; the resident's bed side rails were noted to be heavily stained, there were gray and black marks observed on both.
In the wall around the sink between the faucets was dirty.
In the baseboard on the wall next to the not sealed and exposed the wall's interior and frame.
In and 227 there was peeling paint observed on the and walls. And there were Black scratch marks on the
In the right side of the 's vanity was with water and the base was split-opened. The toilet paper holder was loose and the was partially dirty.
Underneath the call bell plug, the outlet plate cover was broken and exposed the wiring and the interior of the wall.
In , the caulking around the was cracked and peeling off and there was scraped paint observed on the and frame.

During the Environmental Tour on at 9:00 AM with the Maintenance Directors, and the Housekeeping Director, they acknowledged the findings and stated they were new at the facility and that everything would be taken care of.
Additionally, the base boards and walls next to 216, 218, 221, 223, 224, and 230 were observed either in disrepair, broken, or peeling off the wall.

F 253

e. The sink in was re-caulked and area repainted.
f. The base boards and walls next to 216, 218, 223, 224, and 230 were repaired.
g. The patched area in was repainted.
h. The holes in the wall in were patched and the area repainted.

2) Identify other Residents potentially affected:

An audit was conducted of the facility to identify other areas or items. Areas or items identified were repaired or replaced as needed.

3) Measures Implemented:
Reeducation of staff to report any broken or equipment and damaged areas in the TELS preventative maintenance system for resolution and tracking by / / .

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F 253	Continued From page 4 In room 303 there was a wide white plastered area on the wall adjacent to the resident bed's headboard that was not painted over to match the color of the other painted areas in the . In , the wall by the bed's headboard was cracked and the plastered area was not repainted. During an interview with the Interim Administrator on duty on at 12:00 PM, he acknowledged the findings and said that on the next visit, there will be total transformation at the facility.	F 253	Environmental issues discovered during Guardian Angel rounds will be discussed at daily Stand-Up Meeting. **4) Monitoring:** Plant Operations Director and Housekeeping Manager or Designee will conduct random weekly audits for 3 months and monthly going forward. Audit results will be reviewed with QAA committee for corrective action as needed. **5) Date of Correction:** , , 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F279** **1) Corrective actions for Residents affected:** Resident #130 experienced no negative outcome and an incontinence plan of care was completed.	

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F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop a comprehensive care plan for incontinence that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, for 1 of 21 sampled residents (Resident #130). The findings included: On , a review of Resident #130's clinical record, the Minimum Data Set (MDS) reveals that the resident suffers from the following diagnosis: accident prevention ( ), failure, Acacia, and . She uses a Geri Chair (3-position recliner). She is totally dependent on staff to provide extensive assistance for her personal care, such as bathing, , dressing and toileting. She requires only limited assistance with eating. She has a Brief Interview of Mental Score (BIMS) of , which indicates the resident is unable to make decisions regarding her care, treatment and services. On at 01:42 PM, an observation was conducted of Resident # 130 in the restorative dining the second floor. The resident had completed her lunch and was awaiting to be transferred back to her the Staff. The resident was observed appropriately dressed, neat and clean. She was free of any foul odors of or feces. She was in a pleasant mood. On at 01:45 PM, as the Surveyor walked	F 279	**2) Identify other Residents potentially affected:** A Plan of Care audit of current Residents was conducted to ensure comprehensive care planning completed. Appropriate interventions were implemented if needed. **3) Measures Implemented:** Reeducation of MDS Nurses was completed / by Clinical Reimbursement/MDS or Designee re: completion of comprehensive care planning with special emphasis on incontinence.	

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F 279	Continued From page 6	F 279		

down the hall toward the resident's follow-up with her. The Surveyor noticed a strong foul odor 3 doors away from the resident's , and upon entering the , noticed that the smell emitted from the resident herself. An observation was conducted with the resident in her . At the time, she was sitting in her Geri Chair. She was the only person in her the time of the visit. She talked to the Surveyor without concern.

On at 02:30 PM, an observation of the resident was conducted. She was noted to be in the same position in her Geri Chair. The Surveyor detected the same foul odor emitting from the resident.
There were several staff members moving back and forth through the hallway during the time the resident was being observed by the Surveyor.

On at 03:21 PM, an observation was conducted with the resident in her . The foul odor was still present in the hallway and on the resident. The surveyor contacted the second floor Unit Manager and she came into the confirmed that the resident needed to have her briefs changed.
She went to get the two CNA's to change the resident. She was made aware of the length of time the resident had been left in this same condition and agreed that this practice was unacceptable. She was unable to locate the CNA assigned to Resident #130.

On at 12:15 PM, an interview was conducted with Staff P, Certified Nursing Assistant (CNA), assigned to Resident #130 for that day. She says she was trained to check the residents after every meal. She says Resident

4) Monitoring:
MDS Nurse or Designee will conduct random weekly audits of Care Plans for 3 months to ensure Care Plans are Comprehensive with special emphasis placed upon incontinence care. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

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F 279	Continued From page 7 #130 is unable to tell if she is wet. On at 1:46 PM, a review of the care plan does not include care planning for incontinence. for bowel and .. On at 9:05:18 AM, a review of the care plan dated related to , development in process. immobility, total incontinence of bowel and .Percanteous Endoscopic)) Tube, Red upon admission. (,). No feeding tubes. 9:36 AM, an interview was conducted with the Director of Nursing (DON) to advise her that the Care Plan for Resident #130 did not include a section for Care. The Care plan only speaks to the resident being at risk for She confirmed. On at 02:58 PM, an interview was conducted with CNA Staff A, B and C, who stated that a resident should never be left unchanged for as long as an hour. They agreed that the resident should be tolleted after every meal. They indicated that each resident should have a check and change every two hours. On at 03:04 PM, an interview was conducted with Staff N, who stated she was called by the Unit Manager to change the resident and the smell was very strong. She stated the resident's assigned CNA had left early on Monday and today . She stated that CNA was off on . On at 03:28 PM, an interview was conducted with the DON. She was advised of the	F 279		

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F 279	Continued From page 8 findings of the investigation.	F 279	F280	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged , or otherwise found to be under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure Resident comprehensive care plan for and skin integrity was revised for 1 out of 21 sampled residents (32) who developed new The findings included: Resident #32 was originally admitted to the facility	F 280	**1) Corrective actions for Residents affected:** Resident #32 experienced no negative outcome and plans of care for and skin integrity were revised. **2) Identify other Residents potentially affected:** A Plan of Care audit of current Residents with and skin integrity was conducted to ensure care plans were revised. Appropriate interventions were implemented if needed. **3) Measures Implemented:** Reeducation of Interdisciplinary Care Plan Team was completed by Clinical Reimbursement/MDS or Designee re: completing revision of care plans.	

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F 280 Continued From page 9 F 280

on and a readmission on with the following diagnoses: Tube, of lumbar-sacral spine and pelvis, Right one - left side, Acute post-procedural failure.

On at 9:00 AM an observation of care performed by the Care Nurse (WCN) for Resident #32 was conducted. Observation made revealed Resident #32 had a dressing on the right bunion and on the right medial first toe dated . Additional observation revealed the WCN proceeded to remove the dressing in place and performed care as ordered. After resident was turned, observation revealed Resident #32 had two (2) open on the right mid lateral foot and right lateral foot. Further observation at 10:35 AM revealed when the WCN cleaned the right mid lateral foot, Resident #32 pulled away the right foot. The WCN stated that she had to stop care because resident is pulling away and had facial grimacing.

On at 11:30 AM an interview was conducted with one of the facility Minimum Data Set (MDS) coordinator, Staff J. She stated Resident #32 has been in the facility since . Staff J stated that Resident is at risk for and a "Potential for skin integrity" care plan was developed. Staff J added that the resident came into the facility with no . Side by side review of Resident #32's care plan "Potential for skin integrity" was conducted with Staff J. Review of above mentioned care plan revealed that the care plan was created on with a revision date

4) Monitoring:
MDS Nurse or Designee will conduct random weekly audits of Care Plans for 3 months to ensure Care Plan revisions are completed. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

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F 280	Continued From page 10 of . Further review of "Potential for skin integrity" care plan revealed that Resident #32's right foot , were not addressed. Staff J confirmed and agreed that Resident #32's "Potential for , skin integrity" care plan did not address any . Side by side review of "Resident has a to left " care plan for Resident #32 was conducted with Staff J. Staff J stated that the care plan was created on due to the development of a left . Further review of left care plan revealed a revision date of and did not address that Resident #32's left was healed on . Side by side review of Resident #32 quarterly MDS completed on with Staff J was conducted. Review of the quarterly assessment revealed that "Resident has a or greater " and "resident has one or more unhealed , (s) at or higher." The assessment did not list the numbers of , or the stages. Side by side review of Resident #32 weekly care progress report dated was conducted with Staff J. Review of the above mentioned report revealed a left medial and right lateral mid foot , acquired in house. Staff J stated Resident went out of the facility due to Hyponatremia (low) on and returned on and went out again due to Hyponatremia on and returned on . Side by side review of Resident #32 nursing admission/readmission data collection form dated with Staff J was conducted. Review of the above mentioned form revealed under skin conditions- right inner and outer ankle region multiple wounds noted, and left foot outer bunion.	F 280		

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F 280	Continued From page 11	F 280		

Staff J stated that MDS coordinators are responsible for creating and revising resident care plans. Staff J stated the WCN provides them with a weekly written report for them to update the resident's , care plan. Staff J stated that they have up to 72 hours to update the care plan once the care assessment is completed. Staff J acknowledged that Resident #32 active/current , care plan was not revised.

On at 3:33 PM an interview was conducted with the facility WCN. The WCN stated that she started to see Resident #32 for a left medial , on acquired in house. The WCN stated that the care physician saw the resident on and , and Resident 32's left medial , healed/resolved on .

The WCN stated that Resident #32 acquired in house a right lateral foot and a right lateral mid foot , , which were identified on . The WCN stated that treatment was started, then resident went to the hospital on / and returned on . The WCN stated that the in house acquired got worse while in the hospital. The WCN added that Resident #32 went out again on to the hospital and returned on with the following wounds right lateral mid foot with measurement as 3 cm x 2 cm x 0.5 cm with and black (eschar), right lateral foot with maroon, purple and black discoloration, right bunion beefy red 1 cm x 1.5 cm, right medial toe 1 cm x 1 cm x 0.5 cm beefy red, and left bunion 1 cm x 1 cm intact maroon,

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F 280	Continued From page 12 purple in color. The WCN stated that the MDS coordinator, Dietary, Assistant Director of Nursing (ADON), and the Director of Nursing (DON) receive a weekly QA & A log every Wednesday or Thursday in addition to resident skin graph report and the physician report. The WCN stated that resident care plan is done by the MDS coordinator even when is identified over the weekend. The WCN acknowledged that Resident #32 care plan was not revised and is not updated. On at 4:38 PM an interview with the facility Registered Dietitian (RD) was conducted. The RD stated that she receives and reviews a copy of the care report weekly. Review of Resident #32 clinical record revealed the following physician orders for care: Cleanse right , lateral foot with normal or cleanser. Dab dry. Skin prep twice daily until resolved. Cleanse right lateral mid foot with normal or cleanser. Dab dry. Skin prep edges twice daily until resolved. Cleanse Left bunion with cleanser or normal . Dab dry. skin prep edges until resolved. Cleanse Right medial toe with cleanser or normal . Dab dry. Skin prep edges. Apply silver cover with dry dressing daily until resolved. Cleanse Right bunion with cleanse or normal . Dab dry. Skin prep edges. Apply silver cover with dry dressings daily until resolved.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

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F 311 Continued From page 13

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure the continuity of restorative program for 1 of 1 resident (Resident #40) who had a referral for restorative program since

On at 10:20 AM Observed Resident #40 sitting in a wheelchair outside the facility towards the left side of the main entrance. Approached Resident who agreed to be interviewed and privacy was provided. During the interview Resident stated " I want to use my and walk ". Resident stated that he had his leg amputee 4 years ago and was having physical and was told that the insurance ran out. Resident was asked when was the last time he used his and replied back in , 2016.

On at 1:30 PM observed Resident #40 outside by the main entrance area with no in place.

Review of Resident #40 clinical record revealed that resident was admitted on with an original admission on . Resident diagnosis included type II, Pain, Abnormal gait, History of falling,

Review of Physical evaluation and plan

F 311 **F311**

1) Corrective actions for Residents affected:
Resident #40 experienced no negative outcome, was screened by and has been picked up by Restorative Nursing.

2) Identify other Residents potentially affected:
An audit was conducted of current Residents receiving Restorative Nursing to ensure continuity of Restorative Nursing programming is maintained. Appropriate interventions were implemented if needed.

3) Measures Implemented:
Reeducation of Restorative Nursing Team will be completed by / / by DON or Designee re: provision of Restorative Nursing Programming.

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F 311	Continued From page 14 treatment dated revealed resident long term goals as patient will safely ambulate on level surface 90 feet using rolling walker (RW) with caregiver assistance (CGA) and 10 % verbal cues for strides length symmetry and adequately floor clearance on right swing through. Physical assessment summary revealed resident with right above the knee amputation (R AKA) with newly acquired presents with in ability to donn/doff , right hip flexibility, lower limb strength, safe functional mobility and proper and safe gait mechanics with . Focus of plan of treatment = Restoration. Review of physical discharge summary completed on revealed discharge recommendations are Restorative Nursing Program (RNP) for transfers and ambulation with RW, AK and gait belt in hallways up to 75 feet with caregiver assistance. Review of to nursing referral for restorative nursing program dated revealed- Issue: Resident is at risk for Decline in Functional Mobility; Goals of Intervention: Maintain and/or Improve transfers and Ambulation; Caregiver Training/Skills practice of activities to be performed with Resident as follow: Donn/Doff liner and , transfer bed to wheelchair with and gait belt with caregiver assistance, Ambulate with with RW; Frequency and duration: three (3) times a week. On at 1:00 PM Observed resident #40 outside on his wheelchair playing word puzzle. On at 2:38 PM an interview with Staff O-C.N.A was conducted. Staff O stated that resident	F 311	**4) Monitoring:** MDS or Designee will conduct random weekly audits for 3 months of Residents receiving Restorative Nursing Programming to ensure continuity of the Restorative Nursing Programming is maintained. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** , 2016	

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F 311	Continued From page 15 does not walk. When asked about Resident #40 , Staff O replied that she did not know where it was located. Staff O looked for resident's in his closet and did not find it. Staff O stated that she had to go get Resident #40 and bring him back to the unit for him to be changed. On at 9:15 AM observed resident outside sitting in a wheelchair no in place. On at 9:17 AM an interview with the Rehabilitation Program Manager (RPM) was conducted in her office. The RPM stated that she has been working at the facility since 2016. RPM stated that Resident #40 was discharge from physical on with Restorative Nursing Program for transfer and ambulation with assistance. The RPM stated that physical goals were for Resident #40 to transfer, and transfer with the use of the and ambulation. The RPM added that Resident #40 is to have assistance putting on the . The RPM stated that the resident should be able to use his and walk. The RPM added that the facility Restorative program is a nursing program run by the MDS department. The RPM stated that they try to do quarterly assessment before they do the quarterly MDS. The RPM stated that Resident #40 last physical and occupational screen were done on . On at 9:39 AM an interview with Staff F-second floor Unit Supervisor was conducted. Staff F was asked to provide a list of residents on restorative program. Staff F replied that she needed to call the Minimum Data Set Coordinator (MDS) for the list. Staff F proceeded with the call,	F 311		

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F 311	Continued From page 16 hanged up and stated that she was not given clear information. Staff F stated that the MDS department does not have a current list of residents on the restorative program. Staff F stated that she did not know who was overseeing the restorative program and stated that she will speak with her Nursing supervisor for clarification. Staff F returned and stated that they identified an issue with the restorative program on 2016 when the new DON started. Staff F stated that at the time we did not have the appropriate/trained staff, that the program was not consistently been follow up for re-evaluation. Staff F stated that we recognized that we did not have the staff to meet the resident needs for the program. Staff F added that they do not have documented Restorative Service Delivery Record for Resident #40 given during the month of and 2016. Staff F added that the most recent documented services they have for Resident #40 is 2016. Staff F stated that a nurse was hired this week (week of). When asked to speak with the new restorative program nurse, Staff F replied that she was not working that day. Staff F stated that the Restorative program is been revamped and the residents on restorative are not getting the program. Staff F was asked about Resident #40 not in the resident's replied that resident's is kept at the physical department where they do the restorative program. On at 10:15 AM Staff F provided a copy of the Restorative Service Delivery Record for the month of 2016. Staff F was asked again for a copy of Restorative Service Delivery Record for the month of and 2016 and again replied they did not have documented restorative	F 311		

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F 311	Continued From page 17 services for those two months.	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used drugs are not given these drugs unless drug is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 6 residents (Resident #97) was free from unnecessary medications, as evidenced by the facility provided to Resident #97 six times a day instead of 3 times a day for 8 days.	F 329	**F329** 1) **Corrective actions for Residents affected:** Resident #97 experienced no negative outcome and the medication order was clarified. 2) **Identify other Residents potentially affected:** Audit was conducted of current Residents medical records to ensure Residents are free of unnecessary medications. Appropriate interventions were implemented if needed. 3) **Measures Implemented:** Reeducation of Nurses will be completed by / / by the DON or Designee re: ensuring Residents are free from unnecessary medications.	

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F 329 Continued From page 18

F 329

The findings included:

During a medication pass observation of Resident #97 on at 10:21 AM this surveyor asked Nurse M are you giving medication twice, and Nurse M stated, yes. It is ordered at 9:00 AM and 10:00 AM. After surveyor intervention Nurse M was asked to clarify the physician's order regarding the duplicate dosage of prior to administration to Resident #97.

During an interview on at 10:25 AM a side by side review of Resident #97's record was conducted with the 1st floor Unit Manager in the presence of Nurse M.

Review of the physician order dated documented 5 mg (milligrams) via tube (three times a day).

Review of the 2016 MAR documented the Nurses have signed the 5 mg as administered six times daily from thru , 2016. Further review of the record lacked evidence of documentation of modification of the physician's order prior to surveyor intervention.

During the interview on at 10:25 AM with the 1st floor Unit Manager confirmed the findings. Additionally, the 1st floor Unit Manager stated, the Nurse who entered the physician order into the electronic MAR (Medication Administration Record) entered 5 mg at 9:00, 1300 and 1700 and again entered 5 mg at 10:00, 1400 and 1800. Furthermore, the 1st floor Unit Manager confirmed the procedure for the 24-hour chart check was not done.

4) Monitoring:
DON or designee will conduct random weekly audits of medical records for 3 months to ensure Residents are free from unnecessary medications. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

5) Date of Correction:
, 2016

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure potentially hazardous food was stored below 40 degrees, food contact surfaces were allowed to air dry, and beverages were protected from contamination during transport. This has the potential to affect the residents who eat orally, 59 of 78 residents. The findings included: On during the initial tour of the main kitchen at 7:40 AM, accompanied by the Certified Dietary Manager, (CDM) the following concerns were identified: 1) A double door reach in Traulsen Refrigerator displayed a temperature on the outside of the door 37 degrees, but the inside thermometer read 60 degrees, the items inside included salad dressings, thickened juices, mayonnaise, sauces, and bread. On at 9:37 AM, the reach in Traulsen was checked once more; Again it displayed 37 degrees on the outside, but the inside thermometer was at 60 degrees according	F 371	**F371** 1) **Corrective actions for Residents affected:** **a.** All Potentially Hazardous Foods were immediately discarded from the Traulsen refrigerator. It was emptied and thoroughly cleaned. An OUT OF ORDER sign was placed on it. Repair service called immediately. **b.** The cutting boards were immediately taken down, re-washed and sanitized. They were then air dried and stored correctly. **c.** Dietary provided container to house lids for cups on subsequent meal deliveries. 2) **Identify other Residents potentially affected:** **a.** During the repair of the Traulsen refrigerator a preventative maintenance check was done on all other refrigerators. **b.** All cutting boards were re-washed and sanitized.	

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F 371	Continued From page 20 to the separate thermometer placed on the inside. The CDM checked the temperature of BBQ sauce stored within and discovered the temperature was 57 degrees. The CDM acted to dispose of the potentially hazardous ingredients including gallon containers of mayonnaise, salad dressing, and thickened juices. 2) On the clean pot storage area, three plastic cutting boards, green, red, and yellow were placed on the shelf horizontally and not allowed to air dry. When separated, there was moisture between the cutting boards that would foster growth of . 3) During the tray pass in the Courtyard hallway on at 12:20 PM, the aide poured the coffee and placed it on the tray. She then traveled to the far end of the hall to deliver the tray to with the coffee uncovered. She continued to serve the trays with the uncovered coffee cup to additional that were more than 10 feet away. On at 12:09 AM, the aide poured coffee and added it to the food tray. She carried the food tray with the uncovered coffee down the hallway approximately 40 feet to In an interview on , the direct care nurse, Staff E, confirmed that there are no covers for the coffee cups and they are carried from the cart to the routinely.	F 371	c. All units were provided a container to house lids for cups. **3) Measures Implemented:** Dietary staff were educated on / on the importance of using external and internal thermometers and the potential hazards and on the proper equipment cleaning, sanitizing and storage of the cutting boards. Nursing staff were educated on the proper placing of lids on the cups for meal delivery. **4) Monitoring:** CDM, Diet Tech, Unit Managers or designee will conduct random weekly observations of the external and internal reach in refrigerator thermometers, meal delivery and positioning of contact surfaces following washing to ensure air-drying for 3 months.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 21 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to secure 2 of 3 medication and 1 treatment cart as evidenced by the facility failed to have a permanently affixed compartment for the storage of a controlled drug in the second floor unit medication ; the facility failed to	F 431	**F371 (cont.)** Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** , 2016 **F431** **1) Corrective actions for Residents affected:** A permanently affixed compartment in the medication refrigerator for storage of a controlled drug in the second floor unit medication be installed by / / .	

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F 431 Continued From page 22
lock the first floor treatment cart and the facility failed to lock the refrigerator in the first floor medication storage

The findings included:

1) During observation on at 2:30 PM of the 2nd floor medication the presence of the day shift 2nd floor Unit Manager there was a clear box with a lock on it laying on the shelf in the medication refrigerator. Further observation showed the Unit Manager was able to lift and show the clear box containing 3 vials to this surveyor. During an interview on at 2:50 PM the Unit Manager confirmed the box was not permanently affixed.

2) On at 7:48 AM Initial tour was conducted on the facility first floor unit and an unattended and unlocked treatment cart was observed parked in the hallway next to

On at 8 AM further observations revealed that the treatment cart continues to be unlocked and unattended. On at 8:05 AM an interview was conducted with first floor Staff H-RN. Staff H confirmed the treatment cart was unlocked and unattended. Staff H stated the treatment cart must be locked at all times. Side by side review of medications in the treatment cart was conducted with Staff H. The medications in the treatment cart were as follow: one tube of Acetonide cream, one tube of Silvakollagen gel, two tube of 5 % cream, one tube of ointment locate in the first drawer; a jar of OP sulfur-Vaseline, one tube of Triamicinolone, one box of D packets, two opened Derma gauze-

F 431

2) Identify other Residents potentially affected:
An audit was conducted of the two remaining refrigerators, one on first floor and one in the Courtyard unit. Appropriate interventions will be implemented by / .

3) Measures Implemented:
Reeducation of Nurses will be completed by / / by DON or Designee re: drug storage with special emphasis placed upon locking treatment/medication carts, medication refrigerators, and containers of controlled substances mounted in medication refrigerators.

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F 431	Continued From page 23 impregnated gauze dressing (note on packaging read sterile unless opened or damaged) package located in the third drawer; two opened bottles of Normal one dated the other one was not dated, were observed in the fourth drawer, two opened dressing gauze package one dated , the other one was not dated, but opened were also located in the fourth drawer. 3) On at 2:42 PM, medication storage review on the first floor was conducted with the day shift LPN. Observed locked refrigerator. Temperature at 48 degrees. Review of the refrigerator log posted revealed temperature logged at 46 degrees for 6 out of 25 days. She acknowledged the temperature on the log. On at 4:21 PM the first floor medication observed again, with Staff G, LPN. Observed medication refrigerator unlocked. Observed label on top of refrigerator states "lock refrigerator." LPN confirmed and locked the refrigerator after temperature was rechecked. Refrigerator temperature revealed 44 F degrees.	F 431	**4) Monitoring:** DON or Designee will conduct random weekly audits for 3 months of medication refrigerators, treatment and medication carts, and containers of controlled substances mounted in medication refrigerators to ensure medications are secured. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** , 2016	
F 441 SS=D	483.65 CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of and . (a) Control Program The facility must establish an Control	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105521	A. BUILDING ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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F 441 Continued From page 24

Program under which it -
(1) Investigates, controls, and prevents
in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to

(b) Preventing Spread of
(1) When the Control Program determines that a resident needs isolation to prevent the spread of , the facility must the resident.
(2) The facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the .
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain an Control Program designed to provide a safe, sanitary and comfortable environment free of potential . This was evidenced by: a food tray served to bedside next to half full urinal, use of soiled medication crusher and staff failure to perform hand hygiene during tray pass.

F 441

F441

1) **Corrective actions for Residents affected:**
Residents experienced no negative outcome. Urinal was removed from Resident's bedside and nurse aide was reeducated, medication crusher was replaced, and staff reeducation re: hand hygiene was initiated upon discovery of need.

2) **Identify other Residents potentially affected:**
An audit was conducted of current Residents and facility practices to ensure appropriate control practices were followed. Appropriate interventions were implemented if needed.

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F 441 Continued From page 25

The findings included:

1) On at 11:47 AM an observation of the -2 revealed an urinal, half full of , sitting on the bedside table. At 11:52 AM the direct care Staff D delivered the food tray and placed it on the bedside table next to the half full urinal. In an interview immediately thereafter, the unit manager Staff F confirmed that the aide should not have placed the food tray next to the urinal and stated she would educate the aide.

2) During medication pass observation on at 3:00 PM, the device used to crush residents' medication on the first floor had debris on it.

3) On at 8:23 AM Dining observations was conducted on the facility second floor. Staff L, C.N.A. delivered a tray to a resident in , asked the resident if she needed help, and resident stated no. Staff L came out of proceeded to the tray cart and obtained another tray without doing hand hygiene. Observed staff L proceeded to deliver the food tray to the resident in -2. Additional observations revealed staff L touched the over the bed table, removed the main entrée cover, and exited the resident's performing hand washing or hand sanitation. Observed staff L proceed to the tray cart and obtained another tray from the cart. Observed staff L delivered the tray to resident in -1. After placing the resident ' s tray on the over the bed table, staff L was observed touching the resident's back area. Further observation revealed staff L proceeded to the resident's and performed hand washing by lathering with soap for 6 seconds,

F 441

3) Measures Implemented:
Reeducation of Nursing staff will be completed by / by DON or Designee re: Control with special emphasis placed upon hand hygiene, universal precautions, and use of hand sanitizer.

4) Monitoring:
DON or Designee will conduct random weekly audits of staff during the provision of routine care and services for 3 months to ensure appropriate control practices are followed. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required.

5) Date of Correction:
, 2016

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F 441	Continued From page 26 then assisted the resident by removing the lids from liquid containers.	F 441	F463	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - /TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident ; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an operable communication system between the resident : the nursing station for 5 of 40 sampled residents (Resident #18, #23, #97 and in & #230). The findings include: 1) On at 2:37 PM, during an observation of call bell function, the call bell in was not functioning. In an interview, the alert and oriented resident, #18, stated that he has had problems with the call bell for several weeks. He said he reported it to more than one person. He was provided a tinkle bell in place of the call bell for about two weeks, but it disappeared. He said when he needs help he either shouts out or bangs the phone on the bedside table to get attention. Sometimes no one hears him and he just gives up. In an interview, the direct care aide Staff C, stated she was unaware that the call bell was not working and verified with the surveyor that the call bell was not working. In an interview, the unit manager, Staff B, stated that she recalled	F 463	1) **Corrective actions for Residents affected:** The call bells in 204, 218, 230 and 311 the call buttons were repaired by the maintenance staff. 2) **Identify other Residents potentially affected:** An audit was conducted of all in the facility to ensure that all call bells are functioning. Appropriate repairs were made if needed. 3) **Measures Implemented:** Call bell functionality is on the monthly TELS preventative maintenance program. Reeducation of staff to immediately report any call bell that does not function properly will be completed by / /	

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F 463	Continued From page 27 the call bell not working in , but maintenance repaired it. It should be working today she said. The Unit Manager said staff provides a hand bell, and she thought Resident #18 had a hand bell in his . At 2:50 PM, the surveyors and the Unit Manager observed together and verified the call bell was not working and that there was not a hand bell in the the resident to summon help. On at 9:26 AM, in an interview the two maintenance helpers stated they find out about call bells not working from the nursing staff and from the computerized work orders. The computer system also alerts them when call bell audits are due, however no record of call bell audits was provided. 2) During observation on at 1:20 PM of Resident #23 in showed the call bell was not functioning. During an interview on at 1:20 PM the C.N.A. (Certified Nursing Assistant) confirmed the findings. During an observation on beginning at 1:40 PM, in the presence of the evening shift 1st floor Unit Manager, showed Resident #97 lacked a call bell bulb at the end of the cord for the resident to press. During an interview at 1:50 PM the evening shift 1st floor Unit Manager confirmed the findings. 3) During the environmental tour on /2 /20 at 9:12 AM, it was noted that the call bell in the bath c roo 2 was not functional. The cord was pulled but the light indicator did not turn on and the alarm did not ring. Both the Maintenance Director and the Housekeeping Director confirmed the finding. 4) On / / at 3:12 PM, a tour was	F 463	**4) Monitoring:** Plant Operations Director or Designee will conduct random weekly audits of call bells for functionality for 3 months and monthly going forward. Audit results will be reviewed with QAA committee for corrective action as needed. **5) Date of Correction:** , 2016	

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F 463	Continued From page 28 conducted with the Unit Manager of the second floor. The call light for # bed #1 was not operable. On at 3:14 PM, an interview was conducted with the Unit Manager, who confirmed that the call light was not working at the time.	F 463		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the handrail on 1 of 3 units (Second Floor) was safe for the residents to use. The findings included: During observation conducted on at around 11:00 AM, it was noted that the end of the handrails next to the entrance door of was not covered. The uncovered part was noted to be rigid and sharp causing a hazard. During the Environmental tour conducted with the Maintenance Director and the Housekeeper Director on at 9:27 AM, the Maintenance Director reported that the facility had recently replaced all the handrails and they are constantly monitoring and making necessary repairs. He also reported that the facility's plan to repair the handrails is ongoing. The Director said that he would take care of the handrail's corner piece immediately.	F 468	**F468** 1) **Corrective actions for Residents affected:** The necessary parts were obtained and the handrail end caps were repaired on 2) **Identify other Residents potentially affected:** The facility maintenance staff checked all handrails throughout the facility. 3) **Measures Implemented:** The maintenance staff will check handrails on a specific hall monthly in-order to ensure that handrails are secure and intact.	

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F 468	Continued From page 29	F 468		

Observation conducted on 8/24/2016 at 2:03 PM and 4:00 PM revealed that the corner piece was not replaced. Observation made on at 10:00 AM revealed that the handrail next to 209 was still not repaired.

During an interview with one of the Maintenance employees on at 10:16 AM, he reported that the facility had the handrails parts and corner pieces in storage in the facility because the handrails are always breaking down.

Observation conducted on at 12:47 PM revealed that the handrail was not repaired. The sharp edge of the handrail to the entrance of was still exposed.

Reeducation of staff to report any broken or equipment in TELS preventative maintenance system will be completed by /

4) **Monitoring:**
Plant Operations Director or Designee will conduct random weekly audits of handrails for security for 3 months and monthly going forward. Audit results will be reviewed with QAA committee for corrective action as needed.

5) **Date of Correction:**
, 2016

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	95024	A. BUILDING: ______ B. WING ______	08/25/2016

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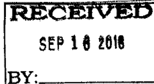
N 000	INITIAL COMMENTS An unannounced Relicensure survey was conducted on 08/22/16 - 08/25/2016 at Avante At Boca Raton Inc. License #1023095. The facility had deficiencies found at the time of the visit.	N 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of alleged deficiencies but is prepared for the sole purpose of compliance with State and Federal regulation	
N 072 SS=D	59A-4.109(2), FAC; 400.021(18), FS Comprehensive Care Plans 59A-4.109(2) FAC The nursing home licensee develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment. 400.021(18) FS "Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident, the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, a listing of services provided within or outside the facility to meet those needs, and an explanation of service goals. This Statute or Rule is not met as evidenced by:	N 072	**N072** 1) **Corrective actions for Residents affected:** Resident #32 experienced no negative outcome and plans of care for and integrity were revised. 2) **Identify other Residents potentially affected:** A Plan of Care audit of current Residents with and integrity was conducted to ensure care plans were revised. Appropriate interventions were implemented if needed.	

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-16-16



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N 072	Continued From page 1 Based on observation, interviews and record review the facility failed to ensure Resident comprehensive care plan for , and integrity was revised for 1 out of 21 sampled residents (32) who developed new The findings included: Resident #32 was originally admitted to the facility on and a readmission on with the following diagnoses: of and Right one - left side, Acute failure. On at 9:00 AM an observation of care performed by the Care Nurse (WCN) for Resident #32 was conducted. Observation made revealed Resident #32 had a dressing on the right and on the right dated . Additional observation revealed the WCN proceeded to remove the dressing in place and performed care as ordered. After resident was turned, observation revealed Resident #32 had two (2) on the right and right Further observation at 10:35 AM revealed when the WCN cleaned the right Resident #32 pulled away the right The WCN stated that she had to stop care because resident is pulling away and had On 08/24/16 at 11:30 AM an interview was conducted with one of the facility Minimum Data Set (MDS) coordinator, Staff J. She stated Resident #32 has been in the facility since	N 072	**3) Measures Implemented:** Reeducation of Interdisciplinary Care Plan Team was completed 9/8/16 by Clinical Reimbursement/MDS Specialist or Designee re: completing revision of care plans. **4) Monitoring:** MDS Nurse or Designee will conduct random weekly audits of Care Plans for 3 months to ensure Care Plan revisions are completed. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** September 25, 2016	

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N 072	Continued From page 2 / . Staff J stated that Resident is at risk for and a "Potential for integrity" care plan was developed. Staff J added that the resident came into the facility with no . Side by side review of Resident #32's care plan "Potential for integrity" was conducted with Staff J. Review of above mentioned care plan revealed that the care plan was created on with a revision date of . Further review of "Potential for integrity" care plan revealed that Resident #32's right were not addressed. Staff J confirmed and agreed that Resident #32's "Potential for integrity" care plan did not address any . Side by side review of "Resident has a to left " care plan for Resident #32 was conducted with Staff J. Staff J stated that the care plan was created on due to the development of a left . Further review of left care plan revealed a revision date of and did not address that Resident #32's left was healed on . Side by side review of Resident #32 quarterly MDS completed on with Staff J was conducted. Review of the quarterly assessment revealed that "Resident has a or greater " and "resident has one or more (s) at or higher." The assessment did not list the numbers of , or the Side by side review of Resident #32 weekly care progress report dated was conducted with Staff J. Review of the above mentioned report revealed a left and right acquired in house. Staff J stated Resident went out of the facility due to) on / and returned on	N 072		

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N 072	Continued From page 3 and went out again due to on and returned on . Side by side review of Resident #32 nursing admission/readmission data collection form dated with Staff J was conducted. Review of the above mentioned form revealed under conditions- right and region multiple noted, and left outer Staff J stated that MDS coordinators are responsible for creating and revising resident care plans. Staff J stated the provides them with a weekly written report for them to update the resident's care plan. Staff J stated that they have up to 72 hours to update the care plan once the care assessment is completed. Staff J acknowledged that Resident #32 active/current care plan was not revised. On 08/24/16 at 3:33 PM an interview was conducted with the facility The stated that she started to see Resident #32 for a left on acquired in house. The stated that the care physician saw the resident on and , and Resident 32's left healed/resolved on The stated that Resident #32 acquired in house a right and a right , which were identified on The stated that treatment was started, then resident went to the hospital on and returned on The stated that the in house acquired got while in the hospital. The WCN added that Resident #32 went out again on to the hospital and returned	N 072		

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N 072	Continued From page 4 on with the following right with measurement as 3 cm x 2 cm x 0.5 cm with and ( ), right with and right beefy 1 cm x 1.5 cm, right 1 cm x 1 cm x 0.5 cm beefy and lef 1 cm x 1 cm intact in color. The stated that the MDS coordinator, Dietary, Assistant Director of Nursing (ADON), and the Director of Nursing (DON) receive a weekly QA & A log every Wednesday or Thursday in addition to resident report and the physician report. The stated that resident care plan is done by the MDS coordinator even when is identified over the weekend. The acknowledged that Resident #32 care plan was not revised and is not updated. On 08/24/16 at 4:38 PM an interview with the facility Registered Dietitian (RD) was conducted. The RD stated that she receives and reviews a copy of the care report weekly. Review of Resident #32 clinical record revealed the following physician orders for care: Cleanse right , with or cleanser. Dab dry. twice daily until resolved. Cleanse right with or cleanser. Dab dry. edges twice daily until resolved. Cleanse Left with cleanser or . Dab dry. edges bid until resolved. Cleanse Right with cleanser or . Dab dry. Apply cover with dry dressing daily until resolved. Cleanse Right with	N 072		

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N 072	Continued From page 5 cleanse or . Dab dry. Apply cover with dry dressings daily until resolved. Class III	N 072	**N095** **1) Corrective actions for Residents affected:** A permanently affixed compartment in the medication refrigerator for storage of a controlled drug in the second floor unit medication room will be installed by 9/25/16. **2) Identify other Residents potentially affected:** An audit was conducted of the two remaining refrigerators, one on first floor and one in the Courtyard unit. Appropriate interventions will be implemented by 9/25/16. **3) Measures Implemented:** Reeducation of Nurses will be completed by 9/25/16 by DON or Designee re: drug storage with special emphasis placed upon locking	
N 095 SS=E	59A-4.112(6), FAC Drug Storage Prescription drugs and non-prescription medications requiring refrigeration must be stored in a refrigerator. The refrigerator must be locked or located within a locked medication room and accessible only to licensed staff. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to secure 2 of 3 medication rooms and 1 treatment cart as evidenced by the facility failed to have a permanently affixed compartment for the storage of a controlled drug in the second floor unit medication room; the facility failed to lock the first floor treatment cart and the facility failed to lock the refrigerator in the first floor medication storage room. The findings included: 1) During observation on 8/25/16 at 2:30 PM of the 2nd floor medication room in the presence of the day shift 2nd floor Unit Manager there was a clear box with a lock on it laying on the shelf in the medication refrigerator. Further observation showed the Unit Manager was able to lift and show the clear box containing 3 to this surveyor. During an interview on 8/25/16 at 2:50 PM the Unit Manager confirmed the box was not permanently affixed. 2) On 08/22/16 at 7:48 AM Initial tour was	N 095		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95024	A. BUILDING: ______ B. WING ______	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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N 095	Continued From page 6 conducted on the facility first floor unit and an unattended and unlocked treatment cart was observed parked in the hallway next to Room 112. On 08/22/16 at 8 AM further observations revealed that the treatment cart continues to be unlocked and unattended. On 08/22/16 at 8:05 AM an interview was conducted with first floor Staff H-RN. Staff H confirmed the treatment cart was unlocked and unattended. Staff H stated the treatment cart must be locked at all times. Side by side review of medications in the treatment cart was conducted with Staff H. The medications in the treatment cart were as follow: one tube of cream, one tube of gel, two tube of 5 % cream, one tube of ointment locate in the first drawer; a jar of OP sulfur-Vaseline, one tube of one box of Vitamin D packets, two opened gauze-impregnated gauze dressing (note on packaging read sterile unless opened or damaged) package located in the third drawer; two opened bottles of one dated 08/17/16 the other one was not dated, were observed in the fourth drawer, two opened dressing gauze package one dated 08/17/16, the other one was not dated, but opened were also located in the fourth drawer. 3) On 8/25/16 at 2:42 PM, medication storage review on the first floor was conducted with the day shift LPN. Observed locked refrigerator. Temperature at 48 degrees. Review of the refrigerator log posted revealed temperature logged at 46 degrees for 6 out of 25 days. She acknowledged the temperature on the log.	N 095	treatment/medication carts, medication refrigerators, and containers of controlled substances mounted in medication refrigerators. **4) Monitoring:** DON or Designee will conduct random weekly audits for 3 months of medication refrigerators, treatment and medication carts, and containers of controlled substances mounted in medication refrigerators to ensure medications are secured. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** September 25, 2016	

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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 095	Continued From page 7 On 08/25/16 at 4:21 PM the first floor medication room was observed again, with Staff G, LPN. Observed medication refrigerator unlocked. Observed label on top of refrigerator states "lock refrigerator." LPN confirmed and locked the refrigerator after temperature was rechecked. Refrigerator temperature revealed 44 F degrees. Class III	N 095	**N202** 1) **Corrective actions for Residents affected:** Residents #32 and #172 experienced no negative outcome and were provided privacy upon discovery of need.	
N 202 SS=D	400.022(1)(m), FS Right to Privacy The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Resident's personal and medical records shall be confidential and exempt from the provisions of s.119.07(1). This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure the privacy of 2 of 4 residents reviewed for as evidenced by the care nurse failed to provide privacy to 2 residents during care treatment (Resident #172 and Resident #32). The findings included: 1) During observation of care on beginning at 12:00 PM for resident	N 202	2) **Identify other Residents potentially affected:** Audit was conducted of current Residents to ensure Residents were provided privacy. Appropriate interventions were implemented if needed. 3) **Measures Implemented:** Nursing staff reeducation will be completed by 9/25/16 by the DON or Designee re: providing Residents Privacy.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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N 202	Continued From page 8 #172 whose windows provide direct visual of the first floor shared outdoor courtyard and other first floor rooms surrounding the courtyard. Further observation the care nurse and aide repositioned Resident #172 with her thigh; leg and heel uncovered and in view of the courtyard. The care nurse pulled over Resident #172's gown; undid the and the skin on her hip was revealed. After surveyor intervention the care nurse was asked to close the blinds on the windows to prevent further visual of Resident #172 from the courtyard during care. During an interview on 8/24/16 at 3:00 PM the care nurse acknowledged the findings. 2) On at 9:00 AM Observation of care performed by the Care Nurse ( ) for Resident #32 was conducted. The was assisted by Staff N, C.N.A. At 9:40 AM was observed leaving the resident's room. Upon her return at 9:45 AM the stated that she was waiting for housekeeping to bring napkins and remove the trash. Observation of the resident room trash can overflow was made. On at 9:54 AM the housekeeper knocked on the closed door, entered Resident #32 room. The housekeeper had a full visual view of the resident who was lying in bed without the privacy curtains pulled and uncovered. After the housekeeper entered the resident's room, Staff N and were observed covering the resident's body with a white sheet. Additional observation revealed housekeeper came out of Resident #32's bathroom and proceeded to empty the overflow trash can next to the resident's cabinet located against the wall facing the resident. Further observations revealed while the	N 202	**4) Monitoring:** DON or Designee will conduct random weekly audits of Residents during the routine provision of care and services for 3 months to ensure that Residents are afforded privacy. Audit results will be reviewed with QAA committee monthly thereafter. Any concerns or trends will be addressed with corrective action as required. **5) Date of Correction:** September 25, 2016	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486

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N 202	Continued From page 9 housekeeper was in the room attempting to emptying the trash can, the and Staff N were observed removing the resident's white sheet, pulled resident up in the bed and turned the resident over the left side without the privacy curtains pulled. Class III	N 202		
N 433 SS=C	400.191(5)(a)2, FS Nursing Home Guide Posted (5) Every nursing home facility licensee shall: (a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public: 2. A copy of all of the pages that list the facility in the most recent version of the Nursing Home Guide. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to make available the most recent version of Nursing Home Guide pages specific to the facility, accessible to all residents and the general public for three of three units (First floor, Second floor, Courtyard). The findings included: On 8/24/16 at 12:02 PM, an observation of the three Avante at Boca Survey Results Binders located near the nursing stations in each of the three nursing stations, revealed the pages from the Florida Nursing Home Guide were not included. The surveyor reviewed the Nursing Home Guide at the Florida Health Finders web site and obtained an August 2016 update	N 433	**N433** 1) **Corrective actions for Residents affected:** The most recent guide was immediately printed and posted the facility Survey Results book. 2) **Identify other Residents potentially affected:** See #1 3) **Measures Implemented:** The Administrator or designee will review the Florida Health Finders website to ensure that the most recent Nursing Home Guide is posted in the facility Survey Results book.	

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N 433	Continued From page 10 awarding the facility one star. In an interview, the administrator confirmed the Nursing Home Guide was not included in the binders. Class IV	N 433	**4) Monitoring:** The Administrator or designee will review the Florida Health Finders website to ensure that the most recent Nursing Home Guide is posted in the facility Survey Results book. **5) Date of Correction:** September 25, 2016	

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Avante At Boca Raton, Inc.
1130 NW 15th Street
Boca Raton, FL 33486

RE: Recertification, Relicensure & Life Safety Code Survey

Dear Administrator:

On , 2016 through , 2016, Recertification, Relicensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit. **You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed or electronic report.**

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than , 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed **, 2016** if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **, 2017** if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

R6WB