PRINTED: 02/14/2010

		ID HUMAN SERVICES MEDICAID SERVICES			.,	FORM APPROVED VIB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MOLT	IPLE CONSTRUCTION		VID INC. 0930-039 ( 3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		COMPLETED	
		105521	B. WING _			01/10/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
AVANTE A	AT BOCA RATON, INC.			1130 NW 15TH STREET BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(XIS) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F0	000		
F 625 SS=D	conducted on Boca Raton, Inc. The with 42 CFR Part 483 Term Care Facilities. Notice of Bed Hold P CFR(s): 483.15(d)(1) §483.15(d) Notice of	bed-hold policy and return-	F 6	25		
	nursing facility transk the resident goes on nursing facility must the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility. (ii) The reserve bed plan, under § 447.40. (iii) The nursing facility bed-hold periods, wh paragraph (e)(1) of it resident to return; and	ich must be consistent with is section, permitting a				
	the time of transfer of hospitalization or their facility must provide to resident representative specifies the duration described in paragraph	old notice upon transfer. At fa resident for rapeutic leave, a nursing or the resident and the re written notice which of the bed-hold policy oh (d)(1) of this section.				

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

/2019

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.

Electronically Signed

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

ENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY		
D PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED		

		105521	B. WING _			01/	10/2019
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	:1	Fe	325			
	by:						
		and record review the			Preparation and/or execution of this pla	n	
	facility failed to provid	e the bed hold policy notice			does not constitute admission or		
	for hospital discharge	for 1 of 4 sampled			agreement by the provider of the truth of	f	
l :	residents (Residents	#4).			the facts alleged or conclusions set forti	1	
					on the statement of deficiencies. This		
l :	The findings included	:			plan of correction is prepared for the so	e	
					purpose of compliance with State and		
		revealed that Resident #4			Federal Regulations.		
	was admitted to facilit						
	facility on; a	nd then discharged to the			F625 (D) - Notice of Bed Hold Policy an	a	
		His diagnoses included			Return		
l :	acute ,	, failure and Review of the Minimum Data			<ol> <li>What corrective action will be accomplished for those residents found</li> </ol>		
		showed that Resident			have been affected by this practice?	ю	
l :	#4 is with a	snowed that resident			" Resident #4 no longer resides in the	ic	
		dicating that he has severe			Facility.	iio i	
l :		of the MDS showed that he			How will you identify other resident	,	
		charge to an acute hospital.			having the potential to be affected by the		
l :		showed that Resident #4			same practice, and what corrective action		
	participates in his ass	essments.			will be taken.		
l :					" On , Executive		
	In an interview condu	cted on at 1:35 PM			Director/designee completed a		
l :	with Staff B, Unit Man	ager, he reported that when			comprehensive audit of discharges to the	e	
	residents are discharg				hospital in the last 30 days. For resider		
		with the bed hold policy and			who remained in the hospital, the facility		
		sfer and discharge notice.			sent a Bed Hold Notice via certified mai		
		ent #4 received the bed hold			to the resident and/or responsible party		
		d that he was not in the			ensuring they were aware of the bed ho	ld	
	facility when the Resident he is not sure if he red	dent was discharged, and			policy.	_	
		asked if he had the bed			<ol> <li>What measures will be put into place or what systemic changes will you take</li> </ol>		
		scharge notice for Resident			ensure that the practice does not reocci		
		Staff B stated that it is the			" By , the Director of Nursing of		
		ocial worker to provide the			designee completed Re-education with		
		ne nursing home discharge			the facility Licensed nursing staff on the		
	notice.	99			components of F625 with emphasis on		
					ensuring the facility completes a Bed Ho	old	
	In an interview condu-	cted on at 1:48 PM			Notification Form at time of discharge of		

Facility ID: 95024

FORM APPROVED

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

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

CERTER	S FUN MEDICANE &	MEDICAID SERVICES				OM DIM	7. 0936-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		SURVEY
		105521	B. WING _	_		01	10/2019
	ROVIDER OR SUPPLIER			11	FREET ADDRESS, CITY, STATE, ZIP CODE I30 NW 15TH STREET OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	residents are dischar responsibility of must paperwork. She furth are discharged to the provides all the disch notices.  In an interview condu- with the Director of N residents are dischar responsibility of nursi policy. She further sts	r, she reported that when ged to the hospital it is the ng to provide all the er stated that if the residents	F€	525	as soon as possible after discharge to resident and/or their responsible party. Newly hired Licensed Nursing St will be educated to the components of F625 with specifications to the above-mentloned areas.  4) How will the corrective actions be monitored to ensure the practice will recocur, what quality measures will be into place?  Director of Nursing/designee to readomly audit 5 resident records of residents transferred to the hospital to ensure that a bed hold was provided the resident/responsible party weekly weeks and then monthly x 2 months.  Findings will be reported at the monthly QA/Risk management meetin until such time substantial compliance been met and committee recommend quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	ot put	
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F6	56			
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefi- medical, nursing, and needs that are identif assessment. The cor- describe the following	cility must develop and hensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's ir mental and , , , , , , , , , , , , , , , , , , ,					

Facility ID: 95024

PRINTED: 02/14/2019

		ID HUMAN SERVICES					RM APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(9/2) 84/417	nev m e	CONSTRUCTION		IO. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		MPLETED
		105521	B. WING _			0-	1/10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				113	30 NW 15TH STREET		
AVANTE	T BOCA RATON, INC.			ВС	DCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	κ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	physical, mental, and required under §483.  (ii) Any services that under §483.  (iii) Any services that under §483.  (iii) Any specialized 3 rehabilitative services provide due to the re under §483.  (iii) Any specialized 3 rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the resident's provide as a result of recommendations. If noting in the passion of th	unt's highest practicable well-being as 24, §463.26 or 8463.40 and would otherwise be required 25 or §463.40 but are not seident's exercise of rights ling the right to refuse 1.10(c)(6). However, the mursing facility will PASARR as facility disagrees with the RR, it must indicate its mits medical record. In the resident and the titude of the record in the resident and the titude of the resident and the titude of the resident and the titude of the resident and the record and potential for illities must document seems of the resident and the record and potential for illities must document seems of the record and preferate to a sandor other appropriate see. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced record review, and ity falled to implement a necessary of the record review, and ity falled to implement a needs eviewed for care plans	Fé	556	Preparation and/or execution of this does not constitute admission or the facts alleged or conclusions set on the statement of deficiencies. Than of correction is prepared for the purpose of compliance with State at Federal Regulations.	th of forth nis e sole	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DAT	E SURVEY IPLETED
		105521	B. WING		01	/10/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1130 NW 15TH STREET BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	In an interview condu PM. Resident #60 sta that he would like to; not able to read the A posted on the wais a that he would like to; not able to read the A posted on the wail ac further reported that I Activity Director while During this interview, reported that he has i was admitted. She fur waiting on a wheelch bed, and that the adm new shipment of whe come in.  Record review reveal admitted on following i effecting the left non- admitted to hospice o care plan dated #60 is at risk for self- balance. He and he uses with bed mobility. Clo showed no plan for a cativity director.  In an interview condu with Staff B, Unit Man Resident #60 has no getting out of bed. He is no care plan done that he has not seen i that he has not seen i that he has not seen i	cted on at 1:00 ted that he has not been out dimitted. He further stated drafticipate in activities but is civity Schedule that is ross from his bed. He us was never seen by the in the facility.  Resident #60's wife to been out of bed since he ther stated that they are air to be able to get out of initistrator told them that a elichairs are expected to  ed that Resident #60 was with diagnoses of: a infraction dominant side. He was n Review of the revealed that Resident	F 6:	F656 (D) - Develop/Implem Comprehensive Care Plan 1) What corrective action accomplished for those res have been affected by this On the Activities Care Resident #60 was added to resident: si individualized a preferences 2) How will you identify of having the potential to be a same practice, and what co will be taken. On , MDS Coordina completed an andit of curre Activity care plans to ensur were in place on admission 3) What measures will be or what systemic changes : ensure that the practice do On , MDS Coordina completed education with II Director on requirements fo plans to be initiated on Adn 4) How will the corrective monitored to ensure the pri recocur, what quality meas into place? DNS/designee to complete audit of Activity care plans; weeks and then monthly x: Audit will be looking for Act initiated on Admission and needed. Findings will be reported at QA/Risk management com such time substantial comple	will be idents found to practice? The Plan for or reflect the citivity ther residents affected by the processor of the plan for or reflect the citivity there are seen and the plan for reflect the citivity there are the plan for reflective action stor/designee and Resident is a put into place will you take to see not reoccur? Sould you have been activity care insistion.  a random weekly x 4 2 months. The plan for p	

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

			01/10/2019				
	105521	B. WING	01/10/2019				
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
CENTERS FOR MEDICARE & MEDICAID SERVICES O							
DELITATION OF THE CHITTED TOWN OF CENTROLO							

		105521	B. WING		01/10/2019	
	ROVIDER OR SUPPLIER 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 APPROPRIA DEFICIENCY)		
F 656	wheelchair with but did not get out of admitted to hospice a Review of the Minimu #60 dated important for him to c Review of the Individual showed that Resident television, and conversand In an interview condu Director on that r[Resident #60 pt when asked if there is said no. She further's refused to go outdoor encouraged. She con	M, she reported that an by He was able to be in a from staff, his room. He was later nd taken off rehab.  In Data Set for Resident revealed that it is somewhat hoose his favortie activities. Lal Resident Activities sheet t. 460 participated in: viewing sing, for the months of coted with the Activity at 1:43 PM, she reported articipated in activities. was a plan for 1 on 1 she tated that Resident #80	F 65	6 quarterly monitoring when conducting quality systems review by the RDCO.		
F 684 SS=D	will have the calendar to read it easier. He w coffee and conversati wheelchair to attend a attend. Quality of Care CFR(s): 483.25	showed that Resident #60 at his bedside so he is able illi have room visits for on as well as using a activities that he may like to	F 68	4		

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE COMP	
		105521	B. WING _	_		01/	10/2019
	ROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	facility residents. Bas assessment of a residents receive accordance with profipractice, the compret care plan, and the res This REQUIREMENT by: Based on interview failed to clarify need medication and notify medication held for 1	ed on the comprehensive tent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. is not met as evidenced and record review, the facility	F 6	5584	Preparation and/or execution of this p does not constitute admission or agreement by the provider of the truth the facts alleged or conclusions set for on the statement of deficiencies. This	of	

The findings included:

#60).

Resident #60 was admitted to the facility on with diagnoses included and . . . . . . . . . . .

A review of the resident's Medication

Administration Record (MAR) revealed Resident #60 received .... (medication to increase ) 2.5 milligrams two times a day at 9:00 AM and 9:00 PM. Further review of the MAR

revealed the medication was held 9:00 AM on ....., and ...... There was no documentation as to why the medication was held, or the physician being notified.

Further review of Resident #60's MAR revealed the resident had vital signs documented every shift. Resident #60's . . . . ranged from . There were no parameters to administer or hold the medication.

An interview was conducted with the Unit

plan of correction is prepared for the sole purpose of compliance with State and Federal Regulations.

F684 (D) - Quality of Care 1) What corrective action will be accomplished for those residents found to have been affected by this practice? Resident #60 s Physician was notified

and a Medication Error Report completed. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken. On ...., DON/designee completed a

comprehensive audit of Residents on ...... Medications to ensure the medication was administered complaint

with Physician s Orders. 3) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? By .... the DON/designee completed Re-education with the

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED STA

ENTERS FOR MEDICARE &	OMB NO. 0938-0391		
EMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED

105521 R MING 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 684 Continued From page 7 F 684 Manager (UM) on at 2:00 PM. The UM administration of medications compliant verified when a medication is held, the reason with Physician s Orders. should be documented and the physician notified. 4) How will the corrective actions be The UM further stated the physician should have monitored to ensure the practice will not been contacted to inquire if the resident still reoccur, what quality measures will be out needed the medication or for parameters to hold into place? the medication DON/designee will weekly audit 5 random Residents on medications to ensure medications are administered compliant with Physician S Orders weekly x 4 weeks and then monthly x 2 months. Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review. F 689 F 689 Free of Accident Hazards/Supervision/Devices SS=E | CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -\$483,25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents This REQUIREMENT is not met as evidenced bv: Based on observation, record review, and .Preparation and/or execution of this plan interview the facility failed to provide a safe does not constitute admission or environment for 6 residents documented as an agreement by the provider of the truth of elopement risk, one of which is also a smoker. the facts alleged or conclusions set forth The residents included Resident #10, #26, #47. on the statement of deficiencies. This #53, #66, and #285, plan of correction is prepared for the sole purpose of compliance with State and

AND

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ID HUMAN SERVICES				APPROVED
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
105521	B. WING		01/	10/2019
•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	1	1130 NW 15TH STREET		
		BOCA RATON, FL 33486		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE
9 8	F 68	9 Federal Regulations.		:
PM an attempt was made to in interview on the second ger suggested that the de of the building either on one were several residents. From the residents was an an open door to the door. The inner door was weld or easy access into the open door from inside the open from the open fr		accomplished for those resident have been affected by this pract Upon discovery of need, Staff m were assigned 24/7 to monitor t affected door 11 until repairs w completed.  2) How will you identify other having the potential to be affect same practice, and what correct will be taken.  On _ED/designee comple comprehensive audit of Facility doors to ensure no other doors to facility doors to ensure no other doors of affected.  3) What measures will be put or what systemic changes will y ensure that the practice does no _By, the ED/designee completed Re-education with the Maintenance Director and Maint Assistants on the components o with emphasis on _Guar and ensuring safe Facility envird.  4) How will the corrective actic monitored to ensure the practice recocur, what quality measures into place? "Maintenance Director/desig "Maintenance Director/desig" _Maintenance Director/desig _Completed _Comp	is found to icice?  enter be a considered to the	
	MEDICALD SERVICES  (XI) PROVIDENSUPPLIERCIA IDENTIFICATION NUMBER  105521  2M an attempt was made to in interview on the second ger suggested that the dee of the building either on to in interview on the second ger suggested that the dee of the building either on to the second second second second second ger suggested that the dee of the building either on to the second second second second second to several residents was an an open door from inside the sunlocked and the exit Further observation shat indicated that the to be left opened. In the second second second second second the second second second second second the second second second second second second the second	MEDICAID SERVICES (X1) PROVIDENSUIPPLERFICIA (DENTIFICATION NUMBER:  105521  A BULLINE  A BULLINE  A BULLINE  A BULLINE  B. WING   IDENTIFICATION NUMBER:  Y MUST BE PRECEDED BY Y JUL. SCI IDENTIFYING INFORMATION)  B. WING  B. WING  PRETA  TAG  PM an attempt was made to in interview on the second gers suggested that the de of the building either on b. b. evere several residents, from the residents was an an open door to the door. The inner door was red for easy access into the popen door from inside the sundock and the exit  Further observation is that indicated that the to be left opened, then visited. An open gate jot was observed. A different was as an another was easy access to the facility, were reported to the Team earn member, both of whom observations at that time, attor and the of the perimeter of the facility to beserved the issues as Quarter of the facility to set off an alarm at the	MEDICAID SERVICES  (xt) PROVIDENSUPPLIERICLIA (DENTIFICATION NUMBER?  105521    STREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL. 3346   STREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL. 3346   STREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL. 3346   STREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL. 3346   STREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL. 3346   PROVIDENS PLAN DC CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  28 B F689  PROVIDENCY PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  29 B FEDERAL REGULATION.  PAGE 130 NW 15TH STREET BOCA RATON, FL. 3346   PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORNECTIVE ACTION SP. CROSS-REFERENCED TO THE AP DEFICIENCY)  PROVIDENCE PLAN C CORN (EACH CORN)  FEGER 7 DROVIDENCE PLAN C CORN (EACH CORN (EACH CORN)  FEGER 7 DROVIDENCE PLAN C CORN (EACH CORN)  FEGER 7 DROVIDENCE PLAN C CORN (EACH CORN (EACH CORN)  FEGER 7 DROVIDENCE PLAN C CORN (EACH CORN (EACH CORN)  FEGER 7 DROVIDENCE PLAN C	MEDICAID SERVICES  (xt) PROVIDENSUPPLIERICIAN (DENTIFICATION NUMBER:  105521    STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET BOCA RATON, FL 3346   STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET BOCA RATON, FL 3346   PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    PROVIDENCE PLAN OF CORRECTION (EACH C

acknowledged this was a serious safety issue

" Findings will be reported at the

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105521	B. WING		01	/10/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET BOCA RATON, FL 33486	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Continued From page and immediately start problem.  Photographic evidence	led to work on correcting the	F 689	monthly QA/Risk management m until such time substantial compl been met and committee recomn quarterly monitoring by the Regic Director of Clinical Services where conducting quality systems revier	iance has nends onal n	
F 692 SS=D	Nutrition/Hydration SI CFR(s): 483.25(g)(1)		F 692			
	(Includes naso- both , endoso fluids). Based	and copic , and and copic , and do not resident's sament, the facility must				
	of nutritional status, s desirable body balance, unless the re	range and electrolyte esident's clinical condition s is not possible or resident				
	§483.25(g)(2) Is offer maintain proper hydra	ed sufficient fluid intake to ation and health;				
	there is a nutritional p provider orders a the This REQUIREMENT by:	is not met as evidenced				
	review the facility fails parameters of nutritio sampled residents (R	esident #65).		Preparation and/or execution of does not constitute admission or agreement by the provider of the the facts alleged or conclusions on the statement of deficiencies.	truth of set forth This	
	The findings included	:		plan of correction is prepared for	the sole	

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DEFAIL	MENT OF HEALTH AN	ID HOMMIN SERVICES			FORM APPRO	NED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	3391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105521	B. WING		01/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	1130 NW 15TH STREET		
AVANTE A	AT BOCA RATON, INC.			BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	TION
F 692	admitted on legal Roman	revealed Resident #65 was with diagnoses of , , , and eview of Resident #65's	F 69	purpose of compliance with State Federal Regulations.  F692 (D) © Nutrition/Hydration S Maintenance  1) What corrective action will b accomplished for those residents	tatus e	
	progress note dated a Resident #65 is readia placer receiving 5 cans of formula that is provid of protein and 1020 n #55 is at suboptimal current regimen not ner dietitian. Estimate following: 1675-2010 grams/protein a day a millimeter/day of fluid recommended to incr regimen to 8 cans a calories/day, 90 gram millilitiers of water. His at	revealed that mitted from the hospital after nent. His is currently feeding ing: 1500 calories, 75 grams illilitiers of fluids. Resident nutrition related to needing estimated needs as ad outritional needs are as calories/day, 67-80 and 1675-2010 s. The dietitian ease the lay which will provide: 1800 is of protein and 1224 is ledeal Body is noted		have been affected by this practic Resident #65 Physician was notic Resident was reassessed by the No loss was noted and Physician is Order was updated include Registered Dietician. Is recommendations.  2) How will you identify other rehaving the potential to be affecte same practice, and what corrective will be taken. On DoN/designee compliaudit of current Residents with ensure accuracy of feed.  3) What measures will be put in or what systemic changes will yo ensure that the practice does not be the DoN/designee.	ce? filed and Dietician; to  sesidents d by the ve action eted an to place u take to resoccur? 3	
	the physician dated dietilian recommenda 1.2 p of the Medication Adr for Resident #65 for t, showed that he from the recommended re; Further record review note dated r	er day. Further record review ninistration Record (MAR) he month of		completed Re-education with the Licensed Nursing Staff regarding Registered Dietician is recommed 4) How will the corrective action monitored to ensure the practice reoccur, what qualify measures v into place?  "DON/designee will weekly a random Residents to en accuracy of Feed Orders 4 weeks and then monthly x 2 m "Findings will be reported at 100 miles of the control of the 100 miles of the control of the 100 miles of 100 miles	endations. ns be will not will be put udit 5 sure weekly x onths.	

per day. Progress note dated

monthly QA/Risk management meeting

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DEFAILI	VICINI OF FIEMETH AN	ID HOMAIN SERVICES				FORM	APPROVED
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105521	B. WING _			01/	10/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AVANTE A	T BOCA RATON, INC.			1	130 NW 15TH STREET		
AVANTEA	I BUCA RATON, INC.			В	OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	had been changed to formula at 65 milliliter providing: 1950 calor day, and 988 millimet In an interview on A, she reported that I nutritional risk. She or care size the provided of the care size the protocol for conshe stated that they or the chart and it gets a According to Staff A, the dietitian's recomm did not see the record dietitian needs to con In an interview on B, he reported that the dietitian on nursing. When asked recommendations we be reported that he dietitian on nursing. When asked recommendations we be reported that he dietitian on nursing. When asked recommendations we described that the dietitian on nursing. When asked recommendations we described that the dietitian on nursing. When asked recommendations we described that the dietitian on nursing states and the states and the states and the states are states and the	Resident #65 Isosurce 1.5 feeding Isosurce 1.5 feed	Fe	692	until such time substantial compliance been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.		
F 755 SS=D	Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(	cedures/Pharmacist/Records (1)-(3)	F	755			

§483.45 Pharmacy Services

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

	105521	R. WANGS				
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED			
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039			
DEFACTIVE OF THE ACTIVATE TIONARY SECURIOES						

		105521	B. WING _			01/10/2019
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE  130 NW 15TH STREET  COCA RATON, FL 33486	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION TE DATE
F755	The facility must prov drugs and biologicals them under an agreer \$483.70(g). The facil personnel to administ permits, but only under a licensed nurse.  \$483.45(a) Procedure pharmaceutical service that assure the accur dispensing, and admi biologicals to meet the \$483.45(b) Service C must employ or obtair pharmacist who-\$483.45(b)(f) Provide aspects of the provisit the facility.  \$483.45(b)(2) Establist receipt and disposition sufficient detail to ena reconciliation; and \$483.45(b)(3) Determorder and that an acc is maintained and per This REQUIREMENT by:  Based on observation review, the facility fail	ide routine and emergency to its residents, or obtain ment described, or obtain ment described in ty may permit unlicensed er drugs if State law ar the general supervision of the state acquiring, receiving, instering of all drugs and re needs of each resident. On substation or all or of pharmacy services in state acquiring and the services of a licensed services in services of a licensed services in services in services of a licensed services in services of a licensed services in services in services in services of a licensed services in service	F7	755	Preparation and/or execution of this pla does not constitute admission or	
	for reconciliar Resident #54). Facility failed to have	for 2 out of 4 carts reviewed tion (Resident #60 and prescribed medication on her for 1 of 5 residents			agreement by the provider of the truth o the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared for the sol purpose of compliance with State and	1

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			Of	VB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	_ (×	3) DATE SURVEY COMPLETED
		105521	B. WING _		_	01/10/2019
	ROVIDER OR SUPPLIER AT BOCA RATON, INC.			STREET ADDRESS, CITY, S 1130 NW 15TH STREET BOCA RATON, FL 334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F755	observed for medicati #78).  The findings included  1. A reconcili Staff M, a Registered 11:30 AM for Residen physician order date milligrams, give two 7 6 hours as needed fo A review of Resident Utilization Record dot to give tablet (7.5 needed for breakthro physician order of two tribe bubble packet of with tabs. The me one tablet remove and 6:30 AM, on AM, on at 1: A review of Resident Administration Record documentation of adr 7.5 mg tablets) of it was docur 9:21 AM (not docume Medication Utilization Utilization Utilization 2. A reconcili	on administration (Resident  ation was conducted with Nurse (RN), on	F7	Federal Regulation F755D Pharmacy Svos/Procedures/ 1) What correct accomplished for have been affecte Resident #560 is F removal of the dis There was not a F the Sample List o the Facility. Howe Residents MARs Resident Whose r description of the in F759 in #1 of th Resident was disc Staff M and Staff regarding 2) How will you having the potenti same practice, an will be taken. On	Pharmacist/Records ive action will be those residents found to dby this practice? "Physician was notified. Count was reconciled." Physician was notified of continued medication, sesident #78 listed on f Residents provided to ever through review of the feelings is sted. That the medications match the medications addressed are findings listed. That charged home on L were re-educated reconciliation, identify other residents ial to be affected by the dwhat corrective action designee completed an scontrolled substance accuracy. And an audit Med to MAR to ensure	
	Resident #54's Contri Record documented as needed. It was do at 9:00 AM, at 6:30 AM a	olled Medication Utilization		ensure that the pr	ractice does not reoccur e DON/designee ucation with the regarding	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2019 CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 ASTATEMENT OF REPICEMENTS. USA PROVIDERSHEDIE BERLIA (22) MILITIPE CONSTRUCTION (23) DES LISSEY

CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105521	B. WING	01/10/2019
MAKE OF BROWINGS OF SUBBLIED		CTDEET ADDDECK CITY STATE 7ID CODE	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 755 | Continued From page 14 F 755 on ...... at 11:30 AM, and on ........... at 4:36 4) How will the corrective actions be PM. monitored to ensure the practice will not reoccur, what quality measures will be put A review of the resident's MAR revealed into place? documentation of administration of 2 mg of DON/designee to randomly audit administered on at 10:40 AM, on controlled substance counts for 5 random . at 12:05 PM, and on ..... at 9:47 Residents weekly x 4 weeks and then AM. monthly x 2 months. And audit 5 random Residents to ensure medication A review of Resident #54's physician orders availability weekly x 4 weeks and then revealed an order for 5 mg every 12 hours monthly x 2 months. as needed for ,, that was discontinued on Findings will be reported at the ..... An order dated ..... for . . . 2 monthly QA/Risk management meeting mg every 24 hours as needed for until such time substantial compliance has days (until ......). been met and committee recommends quarterly monitoring by the Regional A review of the facility's policy on Director of Clinical Services when Disposal/Destruction of Expired or discontinued conducting quality systems review. Medications dated .... documented : Once an order to discontinue a medication is received. facility staff should remove this medication from the resident's medication supply. The above was discussed with the Unit Manager, who confirmed the discrepancies. 3. A medication administration observation was conducted with Staff L on at 9:15 AM for Resident #60. Staff L stated the resident was to be administered ( medication) 25 mg, which was not on .... Staff L stated she would order it from the pharmacy. An interview was conducted with the Unit Manager (UM) on . . . . at 11:45 AM. The UM stated it was the nurse's responsibility to reorder medications from pharmacy when a resident gets down to a 5 day supply left.

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DEFAIL	MENT OF HEALTH AN	ID HOMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105521	B. WING		01/10/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				1130 NW 15TH STREET	
AVANTE A	IT BOCA RATON, INC.			BOCA RATON, FL 33486	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 759	Continued From page	15	F 759		
F 759		ror Rts 5 Pront or More	F 759		
SS=D	CFR(s): 483.45(f)(1)	TOT KIS 5 PTCNI OF MORE	F /58		
	§483.45(f) Medication				
	The facility must ensu	ure that its-			
		tion error rates are not 5			
	percent or greater;	is not met as evidenced			
	by:	is not met as evidenced			
		n, interview, and record		Preparation and/or execution of this	plan
		ed to be free of medication		does not constitute admission or	,,,,,,,
		ore. There were a total of 5		agreement by the provider of the tru	th of
		of 29 opportunities. The		the facts alleged or conclusions set	
	medication error rate Residents #78 and 66	was 33%, and affected		on the statement of deficiencies. The	
	Residents #78 and bu	J.		plan of correction is prepared for the purpose of compliance with State as	
	The findings included	:		Federal Regulations.	this plan truth of set forth This the soile and Rates of e found to ce? sician was ducation impletion
	1. A medication admi	nistration observation was		F759D Free of Medication Errors Ra	ates of
		L, a Registered Nurse (RN),		5% or More	
		M. Staff L prepared		What corrective action will be	
		ent #78. A total number of 5		accomplished for those residents fo	
		verified by Staff L. Included e administered to Resident		have been affected by this practice' Staff L (RN) received immediate	
	#78, was	500 milligrams x 2		re-education from DON/designee	
	tabs. Staff L stated th			regarding medication pass. Physicia	in was
	. (	.) 600 milligrams		notified.	
		at that time, but it was to be		Staff M received immediate re-educ	
		ites before morning and		from DON/designee regarding comp	oletion
		L stated she would give the		of medication pass compliant with	
		och, as the resident had just aff L administered the		Physician s Orders. Physician was notified.	
		an L administered the ent #78. Staff L confirmed		Resident #60@s Physician was noti	ied of
		e was no other medication		the Resident is need for an addition	
	due to administer at t				
				There was not a Resident #78 listed	on
	A medication reconcil	iation was conducted after		the Sample List of Residents provid	ed to

medication administration observation was

the Facility. However through review of

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2019 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105521	B. WING			01/	10/2019
	ROVIDER OR SUPPLIER		•	11	TREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	orders revealed an or 600 mg x 2 tablets da was administered).  Further review of Res an order for at 9:00 AM and 5:00 l specification for the minutes before meals  Further review of the an order for be given daily at 9:00 not observe given to l An interview was con Unit Manager on acknowledged the was given acknowledged the administered. Staff L	of Resident #78's physician der for for the 500 mg x 2 that will y (not the 500 mg x 2 that will y (not the 500 mg x 2 that will y (not the 500 mg two times a day 7M. There was no edication to be given 30 edication to the given 30 edication to the given 30 mg to	F	759	Residents MARs we did identify a Resident whose medications match th description of the medications address in F759 in #1 of the findings listed. The Resident was discharged home on  2) How will you identify other resider having the potential to be affected by the same practice, and what corrective act will be taken.  Staff Nurses L and M will not pass medications until thay have completed medication suntil thay have completed medication suntil thay have completed with the practice does not resource that the practice does not re	sed at the tion a a a a c a to c c u r n	

2. A medication administration observation was conducted with Staff M, a Registered Nurse (RN), on . . . . at 9:40 AM. Staff M prepared medication for Resident #60. A total number of 7 pills and 1 patch to be given was verified by Staff M. Included in the medication to be administered to Resident #60, was a .... softener 100 mg. Staff M stated the resident had

increasing medication) 2.5 mg ordered to be administered at that time, but the resident's was elevated. Staff M stated she would hold the medication. Staff M administered the medications to Resident #60. Staff M confirmed with the surveyor there was no other medication due to administer at that time.

monitored to ensure the practice will not reoccur, what quality measures will be out

into place? DON/designee to randomly audit 5 random Medication Pass Observations to ensure medications administered compliant with Physician S Orders weekly x 4 weeks and then monthly x 2 months.

Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105521	B. WING			01/	10/2019
NAME OF PE	ROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE		
AVANTE A	T BOCA RATON, INC.				I30 NW 15TH STREET OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XIS) COMPLETION DATE
F 759	Continued From page	17	F	759			
F 808 SS=D	medication administration completed. A review orders revealed an oring (not 100 mg that 19:00 AM.  Further review of Res an order for low parameters given to 1 physician was not not An interview was control was administered to 6 acknowledged there was administered to 6 acknowledged there	of Resident #60's physician der for softener 200 was administered) daily at dident #60's orders revealed 2.5 mg twice a day for ). There were no nold the medication. The lifted.  ducted with Staff M and the at 11:30 AM. Staff M ong dose of softener Resident #60. Staff M further were no parameters to hold edication should have been shysician notified.	F	308			
	§483.60(e)(2) The at delegate to a register task of prescribing a r therapeutic diet, to the law.	tending physician:  tending physician may ed or licensed dietitian the resident's diet, including a e extent allowed by State  is not met as evidenced					
		n, interview and record			Preparation and/or execution of this pl	an	

review the facility failed to provide therapeutic

diets that were prescribed by the attending

does not constitute admission or

Facility ID: 95024

agreement by the provider of the truth of

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105521	B. WING		01/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTE A	AT BOCA RATON, INC.		- 1	1130 NW 15TH STREET BOCA RATON, FL 33486	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 808	physician for 2 of 5 si #61 and Resident #2 The findings included 1. Review of the reco was admitted on noted for pureed diet consistency dated showed hot day for supplements. In an observation cor PM Resident #61 was tray at the bedside. T any of the supplement attending physician. T show any supplements. 2. Review of the reco that he was admitted of: type 2 sall nectar thick liquic treats for lunch and d for Resource 2.0 (nut times a day. Record i by the dietitian dated Resident #20 remains	ampled residents (Resident rd revealed Resident #61 with diagnoses of: failure. An order was with nectar thick Another order dated se supplement 4 times a Further record review of the meals showed that Resident meals from	F 804	the facts alleged or conclusions on the statement of deficiencies, plan of correction is prepared for purpose of compliance with State Federal Regulations.  F808D Therapeutic Diet Prescrit: Physician  1) What corrective action will b accomplished for those residents have been affected by this pracif Resident #61 is and Resident #7. Physician is Orders were update include supplements.  2) How will you identify other in having the potential to be affecte same practice, and what correct will be taken.  On , DON/designee complourent Residents on nut supplements as ordered.  3) What measures will be put in or what systemic changes will you ensure that the practice does not "By, the DON/designee completed Re-education with Registered Dietician and Nursing regarding provision of supplement ordered by the Physician.  4) How will the corrective action monitored to ensure the practice recover, what qualify measures into place?  DON/designee to randomly Residents on supolements.	This the sole se and seed by se and seed by se sole sole sole seed by se sole sole seed sole seed sole seed sole seed seed seed seed seed seed seed se

In an observation conducted on . . . . .

at 12:35

weeks and then monthly x 2 months to

ensure Residents ordered supplements

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DEPART	VIENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105521	B. WING			01/	10/2019
NAME OF PR	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	130 NW 15TH STREET		
AVANTEA	T BOCA RATON, INC.			В	OCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERÊNCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
F 808	tray at the bedside. I meat lasagna, vegeta There were no supple frozen treats and Res the attending physicis not show any suppler 3. An interview was c at 12:59, sh has not been eating v call to notify his prima saked by surveyor as Resident #20 did not reported that it comes placed on the food trashe will call the kitched did not get their supplementations of the control of th	s observed with his lunch he lunch tray consisted of: bite medley and a toast, sments on the lunch tray for: ource 2.0 as prescribed by an. The lunch meal ticket did nents on the ticket.  onducted with Staff C on e reported that Resident #61 veil, and that she placed a ry care physician. When to why Resident #61 and get their supplements, she from the kitchen and its sys. She further stated that in to verify as to why they tements.  cted on at 1:00 PM red that the supplements chen are: house shakes, giot cups. The supplements e meal ticket and provided e further stated that are to be given by nursing. Iirector of Nursing on she reported that there are to nutritional supplements.		808	are receiving them.  * Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance been met and committee recommends quarterly montioning by the Regional Director of Clinical Services when conducting quality systems review.	has	
SS=F	\$483.60(i) Food safet The facility must -						

§483.60(i)(1) - Procure food from sources

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	J: 02/14/2019 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE	
		105521	B. WING		01/	10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVANTE A	T BOCA RATON, INC.		1	130 NW 15TH STREET BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(XS) COMPLETION DATE
F 812	approved or consider state or local authorit (i) This may include in from local producers, and local laws or regi (ii) This provision doe from local producers, and local laws or regi (iii) This provision doe from consuming food (iiii) This provision dof from consuming food from consuming food in accords standards for food sexuples of the facility fail requirements in accost standard of food sexuples of the facility fail requirements in accost standard of food sexuples of the facility fail requirements in accost standard of food sexuples of food	ed satisfactory by federal, es.  so ditems obtained directly  subject to applicable State  lateria.  In the second of the second of the second of the second of the  second of the second of the second of the  second of the second of the second of the  second of the second of the  second of the second of the  second of the second of the  second of  sec	F 812	Preparation and/or execution of this does not constitute admission or agreement by the provider of the tru the facts alleged or conclusions set on the statement of deficiencies. The plan of correction is prepared for the purpose of compliance with State an Federal Regulations.  F812F Food Procurement, Store/Prepare/Serve-Sanitary  1) What corrective action will be accomplished for those residents for have been affected by this practice? Areas identified in the 2567 were immediately addressed to ensure compliance with professional star in accordance with professional star	th of forth is sole d	

when cooking in the kitchen.

working. The cook reported that the hood has not

been working for a long time and is not in use

of food service safety. And Lunch bags

2) How will you identify other residents

were purchased with ice packs.

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	0: 02/14/2019 MAPPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105521	B. WING		01/	10/2019
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 130 NW 15TH STREET BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From page	e 21	F 812	having the potential to be affected by	the	
	Broken tiles were not kitchen.	ed on the floor in the main		same practice, and what corrective ac will be taken.  On , CDM/designee completed		
		the front area, surveyor rell as empty boxes all over		audit of kitchen with respect to sanitat such as clean equipment/preparation areas after use and maintenance of kitchen sequipment in working cond		
	A large garbage bin v production area withouthat is not used by sta	out a lid. The CDM reported		On DON/designee conducted a of outpatient Residents to en packs provided with lunch bags.  3) What measures will be put into place.	audit sure	
		or had some dirt and dust the fan area. Closer look		or what systemic changes will you tak ensure that the practice does not reor By, the ED/designee complete Re-education with the Kitchen Staff	cur?	
	bathroom's area reve	s well as the outside of the aled dirt/debris on the floor.		regarding compliance with food safety requirements in accordance with professional standard of food service		
	The dry storage area had a dripping cooling	outside the main kitchen g unit with ice forming		safety, as well as, provision of lunch to with ice packs to Outpatient	ags	

around it. A clear bucket was on the floor underneath the unit to collect the dripping water from the fan. The CDM acknowledged all the findings.

2. An interview was conducted with Resident #1 who reported that he goes to ...., ... 3 times a week and each session takes about 4 hours outside the facility. According to him, the lunch bag that is provided is usually a ham and cheese sandwich and it is never in an ice-pack or insulated.

Review of the record revealed that Resident #1 is with diagnoses of: . Further record , and review showed that he is receiving . . , . . on

- Residents.
- 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place?
- ED/designee to audit kitchen weekly x 4 weeks and then monthly x 2 months to ensure kitchen equipment in working condition, staff have properly cleaned equipment/preparation areas after each use, and Residents are provided lunch bags with ice packs.
- " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when

PRINTED: 02/14/2010

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		105521	B. WING		01/10/2019
NAME OF P	ROVIDER OR SUPPLIER	•	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTE A	IT BOCA RATON, INC.		- 1	130 NW 15TH STREET BOCA RATON, FL 33486	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 812	Continued From page	22	F 812		
	Monday, Wednesday	, and Friday.		conducting quality systems review.	
F 867 SS=D	AM Resident #1 was stretcher on his was observation revealed and cheese sandwich water. The food was with no ice pack. Sun with the Certified Diet regarding holding temperatures.  QAPI/QAA Improvem CFR(s): 483.75(g)(2)	a lunch bag with two ham nest, cookies and a bottle of placed in simple Ziploc bag veyor discussed the issues ary manager, and Staff A foods in the appropriate ent Activities (ii) sessment and assurance.	F 867		
	assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on interview a failed to develop app correct identified defic control. The findings included The facility was cited	must; ement appropriate plans of diffied quality deficiencies; is not met as evidenced and record review, the facility ropriate plans of actions to cliencies related to pest		Preparation and/or execution of this p does not constitute admission or agreement by the provider of the truth the facts alleged or conclusions set for on the statement of deficiencies. This plan of correction is prepared for the supurpose of compliance with State and Federal Regulations.  F867D QAPI/QAA Improvement Activities.	of tth
	The facility was found during the standard re	to have deficient practice ecertification survey		What corrective action will be accomplished for those residents foun	

related to not having an effective pest

have been affected by this practice?

Facility ID: 95024

Pest control was immediately contacted,

PRINTED: 02/14/2019

		ID HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		105521	B. WING			01/	10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
****	T DOOL DATON 1910			113	30 NW 15TH STREET		
AVANTE	AT BOCA RATON, INC.			ВС	DCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	operations manager oplant manager stated pest control log where logged in. The pest or monthly and as needenest control company facility. A review of the the pest control company five times in.  The Plant Operation I would now have the pout to the facility weel residents so a deep or roaches could be don. An interview was con Nursing Home Admin	ducted with the facility plant on at 1:40 PM. The they had implemented a sightings of roaches were sightlings of roaches were outrol company comes ad. With each sightling, the was to be called out to the pest control log revealed any had come to the facility Manager further stated they est control company come (ky, and rearrange the lean and treatment for e. ducted with the Interim istrator (NHA) and Regional rations on at 1:40 the facility was going	F	867	upon arrival their serviced th identified resident rooms, as well as dining and nourishment rooms.  2) How will you identify other residen having the potential to be affected by it same practice, and what corrective act will be taken.  On an Ad Hoc QAA/QAPI Committee Meeting was held to discus survey results of Annual Surve with enhanced emphasis placed upon implementation and monitoring of corrective action plans.  3) What measures will be put into pla or what systemic changes will you take ensure that the practice does not report of the properties of the pro	ts he he his he he his he he his he	

F 925 Maintains Effective Pest Control Program

F 925

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ST

DENTERS FOR MEDICARE & MEDICAID SERVICES O						
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	105521	B. WING	01/10/2019			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 925 | Continued From page 24 F 925 SS=F CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents This REQUIREMENT is not met as evidenced hv Based on observation, interview and record Preparation and/or execution of this plan review, the facility failed to have an effective pest does not constitute admission or control program. agreement by the provider of the truth of the facts alleged or conclusions set forth The findings included: on the statement of deficiencies. This plan of correction is prepared for the sole 1). During the Resident Council meeting, on purpose of compliance with State and at 2:30 PM, Resident #70 in Federal Regulations. stated that he had seen roaches in his bathroom. During a tour of the resident's room, on ... F925F Maintains Effective Pest Control at 5:11 PM, this surveyor observed one roach on the floor under the sink in the resident's Program restroom and live roaches, in all stages of life and 1) What corrective action will be too numerous to count, in the resident's room accomplished for those residents found to

under and behind a piece of furniture used for keeping resident's personal clothing and belongings. On at 5:40 PM, the Director of Maintenance was made aware of the roaches by way of this surveyor showing him the roaches in Resident #70's room and restroom. During an

interview, the Director of Maintenance stated that he was aware of the problem and further stated, "this is one of the four rooms that have been brought to our attention. I will call pest control and have them come out as soon as possible.

During an observation of the Restorative Dining Room, on .... at 7:11 AM, this surveyor observed 4 roaches and 8 live . roaches in the restorative mature and ...

have been affected by this practice? Pest control was immediately contacted. upon arrival the Pest Control serviced the identified resident rooms, as well as the dining and nourishment rooms. 2) How will you identify other residents having the potential to be affected by the same practice, and what corrective action

On .... ED/designee conducted pest control audit of the Facility. No additional pests were identified.

3) What measures will be out into place or what systemic changes will you take to ensure that the practice does not reoccur? . ECO Lab completed in-service with Facility Department Heads regarding immediately reporting the identification of

ΔÞ

will be taken

# DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2019 CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-0391 CATEMENT OF DEPURISHERS 0.00 MB NO. 0938-0391 OWD MILE SERVICES 0.00 MB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
ID DI AN OF CORDECTION		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE COMP		
		105521	B. WING _		01/	10/2019
NAME OF PR	ROVIDER 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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 925	Continued From page	25	FQ	25		

dining room and one . . . . roach on the floor in the hall just outside of the entrance to the Restorative Dining Room.

During an interview with the Dietary Manager, on at 7:23 AM, she stated that there had been no reports of roaches from staff or residents. She further stated that (pest control) comes every two weeks, including during the previous weekend, to treat the kitchen and dining rooms.

During an interview with the Interim Administrator, the Corporate Vice President and the Director of Maintenance, on at 7:38 AM, the Interim Administrator stated that they are going to "close the dining room, give it a deep cleaning and pest control should be here around 8:00. We are going to kep it closed at least for breakfast."

On ..... at 11:38 AM during an interview with Service . from (pest control), he stated. "If some one reports that they have seen a pest, they log it into the (pest control company) log book and call the 1800 number and then I have 24 hours to respond. I usually come out the same day or the next morning. I treat and document in the log book. When we have activitiv we treat the room, I follow up with the Maintenance Director, After I treat, I have 24-48 hours to show up/follow up. We are going to treat one unit each week, even if there is no activity. The facility is moving the residents for the time that I am spraying and treating their rooms. The common areas are treated at night when there is nobody around, they know how to prepare for us to come in at night and they know when we are going to come in for the food and beverage areas including both dining rooms and the kitchen.

5

pests in the Facility, give specific details about the location of the sighting, and logging the sighting in the Pest Control Log Binder located at the Receptionistis Desk. Additionally, Pest Control Log Binders have also been placed at 1st floor Nursing Station, 2nd floor Nursing station, and Seaside Nursing Station on 2nd floor. 4) How will the corrective actions be

- 4) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place?
- " ED/designee to audit Pest Control Binders weekly x 4 weeks and then monthly x 2 months to ensure compliance with pest control program.
- " Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.

### PRINTED: 02/14/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED STA

CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105521	B. WING	01/10/2019		

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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	Continued From page 26 Anything that can be contaminated when we flush (crack and crevice) is covered, we bait, we dust and do residual spray. They (the facility staff) clean up when they come in. It seems to come and go. The problem that I run into is that the residents have to leave the rooms while I am treating the room. I will be	F	92	5		
	3) In an observation conducted on at 9:15 AM in the main dining room on the second floor, revealed the following; a buffet table/beverage counter was observed in the corner of the dining room. In a closer observation it had 3 drawers that were noted to be with pests/roaches in all stages of life. Another drawer was noted with dirty/debris linens and a kitchen mitten. The second drawer to the right had an egg sandwich in a foil paper with a cup of oatmeal, and a cup of opened sugar. The top part of the counter had spilled liquid which may be corflee, but surveyor was not sure. Staff A and the Certified Dietary manager acknowledged the findings and removed the linen and the food from the counter and draws.					

### PRINTED: 02/14/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES ST

CENTERS FOR MEDICARE & MEDICAID SERVICES O					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105521	B. WING	04/40/2040		

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITT, STATE, ZIP CODE		
AVANTE AT BOCA RATON, INC.			1130 NW 15TH STREET		
	- cy - c - c - c - c - c - c - c - c - c		L	BOCA RATON, FL 33486	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREF TAG	XIF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) MPLETION DATE
F 925	Continued From page 27 4) In an observation conducted on	F	92	5	

Agonouf	or Health Care Adminis	tration				: 02/14/2019 APPROVEE
STATEMENT	OF MEALTH CARE AGMINIS FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		95024	B. WING		01/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, ST	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		/ 15TH STREET ATON, FL 3348	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS		N 000			
N 054 SS≘D	Boca Raton, Inc. The the time of the visit. 59A-4.107(5), FAC Fo All physician orders in prescribed, and if not	to at Avante at facility had deficiencies at	N 054			
	Based on observation review, the facility fail error rate of 5% or m medication errors out medication error rate Residents #78 and 6t  The findings included  1. A medication admit conducted with Staff on at 9:20 A medication for Residents for the staff on the staff	nistration observation was ,, a Registered Nurse (RN), M. Staff L prepared in #78. A total number of 5 renfied by Staff L. Included e administered to Resident 500 milligrams x 2		Preparation and/or execution of this p does not constitute admission or agreement by the provider of the trutt the facts alleged or conclusions set fo on the statement of deficiencies. This plan of correction is prepared for the i purpose of compliance with State and Federal Regulations.  N054 Follow Physicians Orders 1) What corrective action will be accomplished for those residents four have been affected by this practice? Staff L (RN) received immediate re-education from DON/designee regarding medication pass. Physician portified.	of rith s sole I	

administered 30 minutes before morning and AHCA Form 3020-0001

ordered to administer at that time, but it was to be LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

) 600 milligrams

(X6) DATE TITLE Electronically Signed /19

Staff M received immediate re-education

from DON/designee regarding completion of medication pass compliant with

Agency f	or Health Care Adminis	stration				: 02/14/2011 APPROVE
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SI COMPLE	
		95024	B. WING		01/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		15TH STREET ATON, FL 3348	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 054	Continued From page	1	N 054			
	medication before lur finished breakfast. St medications to Resid- with the surveyor ther due to administer at t A medication reconcil medication administra completed. A review orders revealed an or	iation was conducted after		Physician us Orders. Physician was notified.  Resident #60 us Physician was notified the Resident us need for an additional.  There was not a Resident #78 listed the Sample List of Residents provided the Facility. However through review. Residents MARs we did identify a Resident whose medications and the description of the medications address in F759 in #1 of the findings listed. Th Resident was discharged home on	on dito of ne sed	
	an order for at 9:00 AM and 5:00 specification for the n minutes before meals Further review of the an order for be given daily at 9:00 not observe given to An interview was con	nedication to be given 30 i. resident's orders revealed (a ) 30 mg to AM, which the surveyor did		2) How will you identify other reside having the potential to be affected by same practice, and what corrective ac will be taken.  Slaff Nurses L and M will not pass medications until thay have complete medication pass observation complete the Pharmacy Nurse.  3) What measures will be put into plor what systemic changes will you take ensure that the practice does not reoc.  "By the DON/designee  completed Readtreation with the Lice	the ction d a led by lace let to ccur?	

acknowledged the wrong dosage of

acknowledged the

to Resident #60, was a

... was given. Staff L further

administered. Staff L stated she had administered

2. A medication administration observation was

conducted with Staff M, a Registered Nurse (RN),

medication for Resident #60. A total number of 7

pills and 1 patch to be given was verified by Staff

M. Included in the medication to be administered

at 9:40 AM. Staff M prepared

Resident #78 earlier in the morning.

should have been

softener 100 ma.

STATE FORM caso Y93H11 If continuation sheet 2 of 21

Nurses regarding medication

Orders.

into place?

administration compliant with Physician

4) How will the corrective actions be

monitored to ensure the practice will not reoccur, what quality measures will be put

DON/designee to randomly audit 5

random Medication Pass Observations to

compliant with Physician S Orders weekly

x 4 weeks and then monthly x 2 months.

Findings will be reported at the

ensure medications administered

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 054 Continued From page 2 N 054 Staff M stated the resident had monthly QA/Risk management meeting increasing medication) 2.5 mg ordered until such time substantial compliance has to be administered at that time, but the resident's been met and committee recommends was elevated. Staff M stated she quarterly monitoring by the Regional would hold the medication. Staff M administered Director of Clinical Services when the medications to Resident #60. Staff M conducting quality systems review. confirmed with the surveyor there was no other medication due to administer at that time. A medication reconciliation was conducted after medication administration observation was completed. A review of Resident #60's physician orders revealed an order for .... softener 200 mg (not 100 mg that was administered) daily at 9:00 AM. Further review of Resident #60's orders revealed 2.5 mg twice a day for ...... (low ......). There were no parameters given to hold the medication. The physician was not notified. An interview was conducted with Staff M and the Unit Manager on at 11:30 AM. Staff M acknowledged the wrong dose of .... softener was administered to Resident #60. Staff M further acknowledged there were no parameters to hold

Class III

STATE FORM caso Y93H11 If continuation sheet 3 of 21

N 072

. The medication should have been

administered, or the physician notified.

The nursing home licensee develop a comprehensive care plan for each resident that

N 072 59A-4.109(2), FAC: 400.021(18), FS

SS=D | Comprehensive Care Plans 59A-4.109(2) FAC

01/10/2019

Agency for Health Care Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING:

B. WING

95024

	95024	D. WING		01/10/2019				
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	STREET ADDRESS, CITY, STATE, ZIP CODE						
AVANTE AT BOCA RATON, INC.	1130 NW 15	1130 NW 15TH STREET						
AVANTE AT BOCA RATUR, INC.	BOCA RATO	ON, FL 33486						
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)					
N 072 Continued From pag	e 3	N 072		AL PROPERTY OF THE PROPERTY OF				
meet a resident's me								
developed, maintains than quarterly by a re participation from oth resident or his or her representative, which assessment of the ne required to provide the resident to attain or re practicable physical, well-being, a listing of	ner facility staff and the designee or legal includes a comprehensive eds of an individual of frequency of services en encessary care for the naintain the highest mental, and, services provided within or meet those needs, and an							
Based on interviews, observations the fact comprehensive personance a resident's me for 1 of 14 residents (Resident #60).  The findings included	itly failed to implement a on-centered care plan to ntal and _ , needs reviewed for care plans		Preparation and/or execution of this pla does not constitute admission or agreement by the provider of the truth the facts alleged or conclusions set for on the statement of deficiencies. This plan of correction is prepared for the sc purpose of compliance with State and Federal Regulations.	of th				
	icted on at 1:00 ated that he has not been out		N072 - Comprehensive Care Plans					

AHCA Form 3020-0001

PRINTED: 02/14/20 Agency for Health Care Administration						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
95024	B. WING		01/10/2019			
STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
1130 NW	15TH STREET					
BOCAR	ATON, FL 3348	6				
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
je 4	N 072					
participate in activities but is Activity Schedule that is cross from his bed. He he was never seen by the e in the facility.  Resident #60's wife not been out of bed since he arther stated that they are nair to be able to get out of ministrator told them that a selchairs are expected to seld that Resident #60 was with diagnoses of:  a infraction doministration of the was on Review of the revealed that Resident care performance and e has limited range of motion side of rails to assist him oser review of the care plan		have been affected by this practice? On the Activities Care Plan for Resident # 60 was added to reflect the resident:s individualized activity preferences? 2) How will you identify other resident having the potential to be affected by same practice, and what corrective activity care plans to ensure that they were in place on admission.  On , MDS Coordinator/design completed an audit of current Resider Activity care plans to ensure that they were in place on admission. 3) What measures will be put into pl or what systemic changes will you tak ensure that the practice does not record on , MDS Coordinator/design completed education with the Activity Director on requirements for Activity or plans to be initiated on Admission. 4) How will the corrective actions be monitored to ensure the practice will in recoccur, what quality measures will be	e  Intis  the  cace  to to  cour?  ee  are  are			
	IXI) PROVIDER/SUPPLERICLA IDENTIFICATION NUMBER:  95024  STREETA 1130 NW BOCA R  TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC DENTIFYING INFORMATION)  19 4 admitted. He further stated participate in activities but is Activity Schedule that is cross from his bed. He he was never seen by the e in the facility.  7. Resident #60's wife not been out of bed since he urther stated that they are nair to be able to get out of ministrator told them that a eetchairs are expected to alled that Resident #60 was with diagnoses of: 1 a infraction -dominant side. He was on Review of the -revealed that Resident -Care performance and has limited range of motion	IXI) PROVIDERSUPPLIERCIA JOENTIFICATION NUMBER:  95024  STREET ADDRESS, CITY, ST 1130 NW 15TH STREET BOCA RATON, FL 3348 TATEMENT OF DEFICIENCES LSC IDENTIFYING INFORMATION)  10 PREFER TAG  N 072  admitted. He further stated participate in activities but is Activity Schedule that is cross from his bed. He he was never seen by the ein the facility.  Resident #60's wife not been out of bed since he uther stated that they are has to be able to get out of ministration told them that a eelchairs are expected to  alled that Resident #60 was with diagnoses of: 1 a infraction -dominant side. He was on Review of the revealed that Resident -care performance and he salimited range of motion side of rails to assist him oser review of the care plan	XT   PROVIDERSUPPLIERCULA   DO   MULTIPLE CONSTRUCTION   A BUILDING   B. WINTO   STREET ADDRESS, CTY, STATE, ZIP CODE   1130 NW 15TH STREET   BOCA RATON, FL 33485   TATEMENT OF DEFICIENCES   PROVIDERS PLAN OF CORRECTION   FLORESCENCY   PROVIDENCE PLAN OF CORRECTION   FLORESCENCE PLAN OF CORRECTION	STREET ADDRESS, CITY, STATE, ZIP CODE   1130 NW 15TH STREET BOCA RATON, FL 33486   13130 NW 15TH STREET BOCA		

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on

and .

In an interview conducted on . . . . at 1:17 PM

Resident #60 has no order that restricts him from

getting out of bed. He further reported that there

is no care plan done for activities. Staff B stated

that he has not seen Resident #60 out of bed in

In an interview conducted with the Rehab Director

at 1:23 PM, she reported that Resident #60 was seen by .....

. , . He was able to be in a

the past few weeks.

with Staff B. Unit Manager, he reported that

of Activity care plans weekly x 4 weeks

and then monthly x 2 months. Audit will be

looking for Activity care plans initiated on

Findings will be reported at the monthly

QA/Risk management committee until

such time substantial compliance has

quality systems review by the RDCO.

been met and committee recommends quarterly monitoring when conducting

Admission and updated as needed.

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 072 Continued From page 5 N 072 wheelchair with from staff. but did not get out of his room. He was later admitted to hospice and taken off rehab. Review of the Minimum Data Set for Resident revealed that it is somewhat important for him to choose his favorite activities. Review of the Individual Resident Activities sheet showed that Resident #60 participated in: viewing television, and conversing, for the months of In an interview conducted with the Activity Director on at 1:43 PM, she reported that rlResident #60 participated in activities. When asked if there was a plan for 1 on 1 she said no. She further stated that Resident #60 refused to go outdoors when asked or encouraged. She confirmed that not creating a care plan on activities was an oversight on her part. Record review of the care plan initiated on for activities showed that Resident #60 will have the calendar at his bedside so he is able to read it easier. He will have room visits for coffee and conversation as well as using a wheelchair to attend activities that he may like to attend.

AHCA Form 3020-0001

SS=D

Class III

N 093 59A-4.112(4), FAC Controlled Drug - Accounting

The pharmacist shall determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

N 093

Agency f	or Health Care Adminis	tration				0: 02/14/2019 1 APPROVE
Agency for Health Care Administration  XI) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:  95024		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		95024	B. WING		01/10/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		15TH STREET ATON, FL 3348	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETE DATE
N 093	Based on observation review, the facility fall medications for reconcilial Resident #54). Facility falled to have in a timely mann observed for medicati #78). The findings included 1. A reconcil Staff M, a Registered 11:30 AM for Resident physician order dated milligrams, give two 7 6 hours as needed for A review of Resident Utilization Record dot to give tablet (7.5 needed for breakthrophysician order of two the bubble packet of with tabs. The me one tablet remove and 6:30 AM, on	sis Statute or Rule is not met as evidenced by seed on observation, interview, and record view, the facility failed to accurately reconcile medications for 2 out of 4 carts reviewed reconciliation (Resident #60 and esident #54).  I colity failed to have prescribed medication on in a timely manner for 1 of 5 residents served for medication administration (Resident 88).  I consider the failed to have prescribed medication on in a timely manner for 1 of 5 residents served for medication administration (Resident 88).  I de findings included:  A reconciliation was conducted with aff M, a Registered Nurse (RN), on at 30 AM for Resident #60. Resident #60 had a yesician order dated for 15 mig every hours as needed for  Treview of Resident #60's Controlled Medication ilization Record documented 15 mg give tablet (7.5 mg) every 6 hours as geded for breakfrough, (different from the hysician order of two 7.5 mg tablets=15 mg).  But tablet 7.5 mg better 15 mg).  But tablet 7.5 mg better 15 mg).  But tablet 7.5 mg tablets=16 mg).		TAG CROSS-REFERENCED TO THE APPROPRIA		
		#60's Medication d (MAR) did not reveal any ninistration of 15 mg (2 of		same practice, and what corrective as will be taken.  On, DON/designee completed		

AHCA Form 3020-0001

2. A

7.5 mg tablets) of . . . on . . . . On

9:21 AM (not documented on the Controlled

Medication Utilization Record).

it was documented as administered at

reconciliation was conducted with

audit of Residents controlled substance

counts to ensure accuracy. And an audit

was conducted of Med to MAR to ensure

or what systemic changes will you take to

availability of medications. 3) What measures will be put into place

Agency f	or Health Care Adminis	tration				0: 02/14/2019 1APPROVED
AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		95024	B. WING		01/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
AVANTE A	IT BOCA RATON, INC.		15TH STREET			
AVAILLE		BOCA RA	ATON, FL 33486	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 093	Continued From page	7	N 093			
	Staff L at 11:45 AM for Resident #54. A review of Resident #54's Controlled Medication Utilization Record documented . 5 mg every 12 hours as needed. It was documented as removed on at 9:00 AM, on at 9:00 AM, on at 9:00 AM, on at 9:00 AM, and 6:00 PM, on at 6:20 PM, on at 6:20 PM, on at 9:57 AM and 6:00 PM, on at 11:30 AM, and on at 4:36 PM.  A review of the resident's MAR revealed documentation of administration of 2 mg of administered on at 10:40 AM, on at 12:05 PM, and on at 9:47 AM.  A review of Resident #54's physician orders revealed an order for 5 mg every 12 hours as needed for, that was discontinued onAn order dated for, for 7 days (until					

AHCA Form 3020-0001

3. A medication administration observation was conducted with Staff L on at 9:15 AM for Resident #60. Staff L stated the resident was to be administered (medication) 25 mg, which was not on Staff L stated she would order it from the pharmacy.

STATE FORM 699 Y93H11 If continuation sheet 8 of 21

01/10/2019

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

NAME OF PROVIDER OR SUPPLIER

95024

B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE

WANTE OF FE		DUNESS, OF 1, ST	NIE, ZIF GODE	
AVANTE A		15TH STREET ATON, FL 3348	6	
(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) COMPLETE DATE
N 093	Continued From page 8  An interview was conducted with the Unit Manager (UM) on at 11:45 AM. The UM stated it was the nurse's responsibility to reorder medications from pharmacy when a resident gets down to a 5 day supply left.	N 093		and the second s
N 111 SS=F	Class III  59A-4.122(2), FAC Physical Environment - Specifics	N 111		n-tan-tan-tan-tan-tan-tan-tan-tan-tan-ta
	The licensee must provide:  (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  (b) Clean bed and bath linens that are in good condition;  (c) Furniture, such as a bed-side cabinet, drawer space;  (d) Adequate and comfortable lighting levels in all areas;  (d) Adequate and safe room temperature levels; in accordance with 42 CFR, Section 483, 15(n)(6), which is effective and, is incorporated by reference and available at http://www.pgo.gov/id/ssy/spic/CFR-2014-titlle42-vol5/smi/CFR-2014-titlle42-vol5/smi/CFR-2014-title42-vol5/smi/CFR-2014-titlle42-volf-sect83-15.xmi;  and,  (f) The maintenance of comfortable sound levels, individual radios, TVs and other such transmitters belonging to the resident will be tuned to stations of the resident's choice.			
	This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have an effective pest		Preparation and/or execution of this plan does not constitute admission or	**************************************

Agency f	or Health Care Adminis	tration				: 02/14/2019 APPROVEE
SATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		95024	B. WING		01/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		15TH STREET			
	.,	BOCA RA	ATON, FL 3348	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 111	Continued From page	9	N 111			
	control program.  The findings included	:		agreement by the provider of the truth the facts alleged or conclusions set for on the statement of deficiencies. This plan of correction is prepared for the s	rth	
	at 2:30 PM,	nt Council meeting, on Resident #70 in en roaches in his bathroom.		purpose of compliance with State and Federal Regulations.		
	at 5:11 PM, this surve roach on the floor und restroom and live roa- too numerous to cour	eyor observed one ter the sink in the resident's ches, in all stages of life and it, in the resident's room lece of furniture used for		N111 Physical Environment  1) What corrective action will be accomplished for those residents foun have been affected by this practice? Pest control was immediately contacte upon arrival the Pest Control serviced the identified resident rooms,	ed,	
	way of this surveyor's Resident #70's room interview, the Directo he was aware of the p "this is one of the four brought to our attention have them come out:	de aware of the roaches by howing him the roaches in and restroom. During an of Maintenance stated that problem and further stated, rooms that have been on. I will call pest control and as soon as possible.		well as the dining and nourishment for 2). How will you identify other resider having the potential to be affected by the same practice, and what corrective ac will be taken. OnED/designee conducted per control audit of the Facility. No addition pasts were identified. 3). What measures will be put into pit or what systemic changes will you take neasure that the practice does not reco OnECO Lab completed in-ser- with Facility becartment Heads recard:	nts the tion st nal ace e to cur? vice	

mature and .

Restorative Dining Room.

surveyor observed 4 . . ... roaches and 8 live

dining room and one .... roach on the floor in

During an interview with the Dietary Manager, on

residents. She further stated that (pest control)

previous weekend, to treat the kitchen and dining

comes every two weeks, including during the

at 7:23 AM, she stated that there had

the hall just outside of the entrance to the

been no reports of roaches from staff or

roaches in the restorative

STATE FORM caso Y93H11 If continuation sheet 10 of 21

immediately reporting the identification of

pests in the Facility, give specific details

about the location of the sighting, and

logging the sighting in the Pest Control

Log Binder located at the Receptionist()'s Desk. Additionally, Pest Control Log

Binders have also been placed at 1st floor

Nursing Station, 2nd floor Nursing station,

and Seaside Nursing Station on 2nd floor.

4) How will the corrective actions be

monitored to ensure the practice will not

reoccur, what quality measures will be put

Agency for Health Care Adminis	stration		FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA AND		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	95024	B. WING	01/10/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AV.

VANTE A	IT BOCA RATON INC.	15TH STREET ATON, FL 3348	6	
(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) COMPLETE DATE
N 111	Continued From page 10	N 111		
	rooms.  During an interview with the Interim Administrator, the Corporate Vice President and the Director of Maintenance, on at 7:38 AM, the Interim Administrator stated that they are going to "close the diring room, give it a deep cleaning and pest control should be here around 8:00. We are going to keep it closed at least for breakfast."  On at 11:38 AM during an interview with Service from (pest control), he stated, "if some one reports that they have seen a pest, they log it into the (pest control company) log book and call the 1800 number and then I have 24 hours to respond. I susually come out the same day or the next morning. I treat and document in the log book. When we have activity we treat the room, I follow up with the Maintenance Director. After I treat, I have 24-48 hours to show upfollow up. We are going to treat one unit each week, even if there is no activity. The facility is moving the residents for the time that I am spraying and treating their rooms. The common areas are treated at night when there is nobody around, they know how to prepare for us to come in at night and they know here we are going to come in for the food and beverage areas including both dining rooms and the kitchen. Anything that can be contaminated when we flush (crack and crevice) is covered, we bait, we dust and for residual spray. They (the facility staff) clean up when they come in. It seems to come and go. The problem that I run into is that the residents have to leave the rooms while I am teresting the room. I will be to morrow to follow up because I was here today."		into place? "ED/designee to audit Pest Control Binders weekly x 4 weeks and then monthly x 2 months to ensure compliance with pest control program." Findings will be reported at the monthly QA/Risk management meeting until such time substantial compliance has been met and committee recommends quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	
	AM, with the Service . from (pest		1	Į.

Agency for Health Care Adminis	tration			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	95024	B. WING	01/10/2019	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AVANTE A	IT BOCA RATON, INC.	1130 NW 15TH STREET BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 111	Continued From page 11 control), he stated, "When there is a room roaches you will find them in the dresser a drawers. I ask them to prep the rooms by it the drawers and items from the furniture. Recently, they haven't been prepping progmaking the room treatable for me to go in a thorough treatment. I come out once a n for regular service and whenever they require the strict of	and the moving moving and do nonth usest.  at scond ne revivation of drawer schen da an top part be and the he add from data as ackers culted did and control of the add and control of		
				4

6550

STATE FORM

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 111 | Continued From page 12 N 111 Class III N 201 400.022(1)(I), FS Right to Adequate and N 201 SS=D | Appropriate Health Care 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. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record Preparation and/or execution of this plan review, the facility failed to clarify need for does not constitute admission or , .... medication and notify MD and document agreement by the provider of the truth of why medication held for 1 of 5 residents observed the facts alleged or conclusions set forth on the statement of deficiencies. This for medication administration observation (Resident #60). plan of correction is prepared for the sole purpose of compliance with State and Based on observation, interviews and record Federal Regulations. review the facility failed to maintain acceptable parameters of nutritional status, for 1 resident of

5 sampled residents (Resident #65).

The findings included:

Based on observation and interview the facility failed to provide a safe environment for 6

residents documented as an elopement risk, one

of which is also a smoker. The residents included

Resident #10, #26, #47, #53, #66, and #285,

1. Resident #60 was admitted to the facility on

.... with diagnoses included .... and

STATE FORM V93H11 If continuation sheet 13 of 21

N201 Right to Adequate and Appropriate

accomplished for those residents found to

A) What corrective action will be

have been affected by this practice?

Resident #60 s Physician was notified and a Medication Error Report completed.

Resident #65 Physician was notified and Resident was reassessed by the Dietician: No loss was noted and

Physician is Order was updated to include

Registered Dietician is recommendations.

Health Care

Agency f	or Health Care Adminis	stration			PRINTED: 02/ FORM APF	
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		95024	B. WING		01/10/20	19
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		15TH STREET ATON, FL 3348	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE CC	(X5) DMPLETE DATE
N 201	Continued From page	e 13	N 201		nonement.	
	#60 received ) 2.5 n 9:00 AM and 9:00 PA revealed the medical documentation as to held, or the physiciar Further review of Res the resident had vital shift. Resident #60's An interview was con Manager (UM) on verified when a medi should be document The UM further state been contacted to inc.	d (MAR) revealed Resident (medication to increase inlitigrams two times a day at 4. Further review of the MAR ion was held \$0.0 AM on ind There was no why the medication was being notified.  sident #60's MAR revealed signs documented every ranged from e were no parameters to emedication.		Upon discovery of need. Staff membe were assigned 24/7 to monitor the affected door 1:1 until repairs were completed.  B) How will you identify other reside having the potential to be affected by same practice, and what corrective as will be taken.  On DON/designee completed comprehensive audit of Residents on Medications to ensure medication was administered complain with Physician: s Orders; and comple an audit of current Residents with an audit of ourrent Residents with an audit of our ensure accuracy of feed.  Com ED/designee completed a comprehensive audit of Facility egres doors to ensure no other doors were affected.  C) What measures will be put into p or what systemic changes will you takensure that the practice does not reover.  By the DON/designee completed Residual Comprehensive audit of section will be put into p or what systemic changes will you takensure that the practice does not reover.  By the DON/designee completed Re-education with the Lice	nts the cition a set the int teted ss set to cocur?	

2. Review of the record revealed Resident #65

.... and

Resident #65 is readmitted from the hospital after

formula that is providing: 1500 calories, 75 grams

of protein and 1020 milliliters of fluids. Resident

, ... Review of the nutrition

was admitted on ...... with diagnoses of

are as following:

progress note dated .... revealed that

a ... \_ placement. His is currently

receiving 5 cans of feeding

medications compliant with Physician s

" By ...., the ED/designee completed

Director and Maintenance Assistants on

the components of F689 with emphasis on

..... Guard doors and ensuring safe

D) How will the corrective actions be

monitored to ensure the practice will not

reoccur, what quality measures will be put

Orders, as well as, regarding notifying

Physician of Registered Dietician ...!s recommendations.

Re-education with the Maintenance

Facility environment.

into place?

PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N Continued From page 14 N 201 #65 is at suboptimal . . . nutrition related to DON/designee will weekly audit 5 current regimen not meeting estimated needs as random Residents on medications to ensure medications are administered per dietitian. Estimated nutritional needs are as compliant with Physician⊟s Orders, as following: 1675-2010 calories/day, 67-80 grams/protein a day and 1675-2010 well as, audit 5 random . . . . Residents millimeter/day of fluids. The dietitian to ensure accuracy of Feed orders recommended to increase the weekly x 4 weeks and then monthly x 2 regimen to 6 cans a day which will provide: 1800 months. calories/day, 90 grams of protein and 1224 Maintenance Director/designee to milliliters of water. His Ideal Body \_\_\_ is noted randomly audit quard doors to ensure functionality weekly x 4 weeks and then monthly x 2 months. Review of the Dietary Communication Form to Findings will be reported at the the physician dated revealed the monthly QA/Risk management meeting dietitian recommendations for 6 cans of until such time substantial compliance has 1.2 per day. Further record review been met and committee recommends of the Medication Administration Record (MAR) quarterly monitoring by the Regional

Director of Clinical Services when

conducting quality systems review.

for Resident #65 for the month of showed that he received 5 cans of from to and not the recommended regimen by the dietitian. Further record review of the nutrition progress note dated . . . revealed that there was a

recent increase in bolus feeding to 6 cans of per day. Progress note dated showed that Resident #65 had been changed to Isosurce 1.5 feeding formula at 65 milliliters times 20 hours and was providing: 1950 calories/day, 88 grams/protein a day, and 988 millimeters of fluids.

In an interview on at 3:48 PM with Staff A, she reported that Resident #65 is at high nutritional risk. She confirmed that the , regimen needed to be increased to 6 cans a day. When asked by surveyor as to what is the protocol for communicating with the doctor. she stated that they out the recommendation in the chart and it gets picked up by nursing.

According to Staff A, nursing calls the doctor with

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PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 15 N 201 the dietitian's recommendations. If the physician did not see the recommendations then the dietitian needs to contact the physician directly. In an interview on . . . . at 4:00 PM with Staff B. he reported that the recommendations by the dietitian on ... was never picked up by nursing. When asked as to why the recommendations were never implemented Staff B reported that he didn't know. Review of the \_ Change Communication Form dated . . . . by Staff A showed that Resident #65 had a % in 90 days. Staff A is requesting the physician to consider future management, and order .... lab with next set of labs. Resident #65 is with ..., of 20.0 which is 3. On . . . . at 3:30 PM an attempt was made to locate a resident for an interview on the second floor. The Unit Manager suggested that the resident may be outside of the building either on the front or ... patio. At the front patio there were several residents.

Approximately 10 ... from the residents was an open gate that lead to an open door to the stairwell and an inner door. The inner door was unlocked, which allowed for easy access into the facility. A check of the open door from inside the facility revealed it was unlocked and the exit alarm was not active. Further observation revealed written signs that indicated that the exterior door was not to be left opened. patio was then visited. An open gate leading to the parking lot was observed. A continued walk around the perimeter was performed, where it was noted that there were no security cameras and there was easy access to

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PRINTED: 02/14/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ B MING 95024 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1130 NW 15TH STREET AVANTE AT BOCA RATON, INC. BOCA RATON, FL 33486 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 16 N 201 the street in front of the facility. These observations were reported to the Team Leader and another team member, both of whom made all of the same observations at that time. The Facility Administrator and the ... of Maintenance were notified. The Maintenance walked the perimeter of the facility with the surveyor and observed the issues described. A test of the . . . Guard system was conducted by the Administrator with the of Maintenance present. The Guard sensor failed to set off an alarm at the door in question. The same sensor worked on all other doors. The Administrator and . . . of Maintenance both acknowledged this was a serious safety issue and immediately started to work on correcting the problem. Photographic evidence obtained. Class III N 209 400.022(1)(u), FS Right to Bed Hold Policy N 209 SS=D

The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it

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					PRINTED: 02/14/ FORM APPRO	
Agency for	or Health Care Adminis	tration				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95024	B. WING		01/10/2019	,
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
41/41/77	T DOOL DATON 1910	1130 NW 1	5TH STREET			
AVANTE	IT BOCA RATON, INC.	BOCA RAT	ON, FL 33486	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	LETE
N 209	resident will not need return to the nursing the determines that the nate ensures the avail resident. Notice shall of the hospitalization.	ad by the agency that the it or will not be able to nome, or if the agency ursing home's occupancy ability of a bed for the be provided within 24 hours	N 209			
	of the hospitalization.  This Statute or Rule is not met as evidenced by: Based on interviews and record review the facility failed to provide the bed hold policy notice for hospital discharge for 1 of 4 sampled residents (Residents #4).  The findings included:  Review of the record revealed that Resident #4 was admitted to facility on ; and he was discharged to the hospital on His diagnoses included acute , failure and Review of the Minimum Data Set (MDS) dated showed that Resident #4 is with s ) score of 03 indicating that he has severe Section A of the MDS showed that he had an unplanned discharge to an acute hospital. Section Q of the MDS showed that Resident #4 participates in his assessments.			Preparation and/or execution of this p does not constitute admission or agreement by the provider of the truth the facts alleged or conclusions set fo on the statement of deficiencies. This plan of correction is prepared for the 1 purpose of compliance with State and Federal Regulations.  N209 - Right to Bed Hold Policy What corrective action will be accomplished for those residents four have been affected by this practice?  Resident # 4 no longer resides in Facility.  What corrective action residents for those present the facility of the practice?  Resident # 4 no longer resides in Facility.  What corrective action corrective action will be taken.	of rith is soole and to this mits the	

In an interview conducted on . . . . at 1:35 PM

with Staff B, Unit Manager, he reported that when

facility provides them with the bed hold policy and

When asked if Resident #4 received the bed hold

the nursing home transfer and discharge notice.

policy. Staff B reported that he was not in the facility when the Resident was discharged, and

paperwork. Surveyor asked if he had the bed

he is not sure if he received the correct

residents are discharged to the hospital the

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Director/designee completed a

comprehensive audit of discharges to the

hospital in the last 30 days. For residents

sent a Bed Hold Notice via certified mail to

ensuring they were aware of the bed hold

3) What measures will be put into place

or what systemic changes will you take to

ensure that the practice does not reoccur?

who remained in the hospital, the facility

the resident and/or responsible party

Agency for Health STATEMENT OF DEFIC AND PLAN OF CORREC	IENCIES	tration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 95024	1	E CONSTRUCTION	PRINTED: 02/14/2018 FORM APPROVEE (X3) DATE SURVEY COMPLETED 01/10/2019
NAME OF PROVIDER O	OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
		1130 NW	15TH STREET		
AVANTE AT BOCA	RATON, INC.		TON, FL 3348	3	
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 209 Continu	ed From page	18	N 209		And and a second
#4 and respon- bed hold notice.  In an in with the residen respon- are dist provide notices.  In an in the residen respon- are dist provide notices.  In an in with the residen respon- policy.	he replied no, sibility of the s d policy and the terview conducts as social worker to social worker to sacial worker to sail the disch terview conduct to the to to the to the to the to to to to to to to to to to	scharge notice for Resident Staff B stated that it is the  boolal worker to provide the  ne nursing home discharge  coted on		"By the Director of Nursing designee completed Re-education will acality Licensed nursing staff on the components of F625 with emphasis o nesuring the facility completes a Bed Notification Form at time of discharge to resident and/or their responsible party." Newly hired Licensed Nursing St will be educated to the components o F625 with specifications to the above-mentioned areas.  4) How will the corrective actions be monitored to ensure the practice will recocur, what quality measures will be into place?  5 Director of Nursing/designee to readed the staff of the staff	in the  n Hold or the // the // the // or the // o pot o to the

N 903 SS=D 400.147(1)(b), FS Risk Mgmt & Q A Committee

shall meet at least monthly.

A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director and at least three other members of the facility staff. The risk management and quality assurance committee

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N 903

Director of Clinical Services when conducting quality systems review.

Anency f	or Health Care Adminis	stration				0: 02/14/2019 1APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	E CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLI	
		95024	B. WING		01/1	0/2019
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE 710 OOOF	1 000	OI EU I S
NAME OF P	ROVIDER OR SUPPLIER		/ 15TH STREET	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		ATON, FL 3348	6		
(X4) ID		ATEMENT OF DEFICIENCIES	4D	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	KIAIE	DATE
			-			
N 903	Continued From page	e 19	N 903			
		is not met as evidenced by:				
		nd record review, the facility		Preparation and/or execution of this p	ilan	
		ropriate plans of actions to		does not constitute admission or		
		iciencies related to pest		agreement by the provider of the truth		
	control.			the facts alleged or conclusions set for		
				on the statement of deficiencies. This		
	The findings included	E		plan of correction is prepared for the		
				purpose of compliance with State and	1	
		for not having an effective		Federal Regulations.		
		in the last standard survey				
	dated .					
				N903 Risk Mgmt & QA Committee		
		to have deficient practice		What corrective action will be		
	during the standard r			accomplished for those residents four	nd to	
		ot having an effective pest		have been affected by this practice?		
	control program.			Pest control was immediately contact upon arrival their serviced		
	An intendent was some	ducted with the facility plant		upon arrival their , serviced identified resident rooms, as well as of		
	operations manager			and nourishment rooms.	anary	
		I they had implemented a		How will you identify other reside		
		e sightings of roaches were		having the potential to be affected by		
		ontrol company comes		same practice, and what corrective a		
		ed. With each sighting, the		will be taken.	Alon	
		was to be called out to the		On an Ad Hoc QAA/QAPI		
		e pest control log revealed		Committee Meeting was held to discu	.00	
		pany had come to the facility		Survey results of Annual Sur		
	five times in	Jany nao come to the lactilly		with enhanced emphasis placed upor		
	1110 UINDS 81	•		implementation and monitoring of	1 1/10	
	The Plant Operation	Manager further stated they		corrective action plans.		
		pest control company come		What measures will be put into p	lace	
		kly, and rearrange the		or what systemic changes will you tal		
		clean and treatment for		ensure that the practice does not reo		
	roaches could be don			By the RVPO/designee comp		
				education with the Executive Director		

through a transitional stage.

AHCA Form 3020-0001

An interview was conducted with the Interim

PM. The NHA stated the facility was going

Vice President of Operations on

Nursing Home Administrator (NHA) and Regional

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at 1:40

QAA Committee regarding implementation

and monitoring of Quality Assurance and

Performance Improvement Activities.

4) How will the corrective actions be

monitored to ensure the practice will not

Agency f	or Health Care Adminis	tration				: 02/14/2019 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95024	B. WING		01/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
AVANTE A	AT BOCA RATON, INC.		15TH STREET ATON, FL 33486	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 903	Continued From page	9 20	N 903	reoccur, what quality measures will be into place?  * ED/designee to review, during m scheduled QAA Committee Meetings, results of corrective action plans in pil. Findings will be reported at the monthly QA/Risk management meetin until such time substantial compliance been met and committee recommend quarterly monitoring by the Regional Director of Clinical Services when conducting quality systems review.	onthly ace. ng has	
				4		