STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105308	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Inverness Inc	304 S Citrus Ave Inverness, FL 34452

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident assessments were accurate for 1 (Resident #54) of 6 residents reviewed for medication management.Findings include: Review of Resident #54's admission record showed the resident was admitted on [DATE] with the diagnoses including dementia, major depressive disorder, and other specified anxiety disorder, with the diagnosis date of 5/28/2025. Review of Resident #54's Minimum Data Set (MDS) assessment dated [DATE] showed anxiety disorder was not included as a diagnosis under Section I- Active Diagnoses. Review of Resident #54's physician order dated 5/28/2025 read, [Name of psychiatric services provider] Psychiatrist/Psychologist to eval [evaluate] and treat upon admission and PRN [as needed] (DX [diagnosis] anxiety, depression, PTSD [Post Traumatic Stress Disorder]). Review of Resident #54's physician order dated 5/28/2025 read, Clonazepam Tablet 0.5 MG [milligram], Give 1 tablet by mouth every 8 hours as needed for anxiety for 30 days. End Date: 06/27/2025. Review of Resident #54's physician order dated 5/28/2025 read, Clonazepam Tablet 0.5 MG, give 2 tablet by mouth every 8 hours as needed for anxiety for 30 days. End Date: 06/27/2025. Review of Resident #54's Psychiatry Subsequent Note dated 6/4/2025 read, Chief Complaint: Depression, anxiety, PTSD, dementia, and psychosis. During an interview on 7/8/2025 at 1:07 PM, the Minimum Data Set Coordinator stated, [Resident #54's name] medication section has an indication to code anxiety and depression. The diagnosis was not included in the MDS. It did not trigger to the anxiety because it was attached to the dementia diagnosis and did not pull over. During an interview on 7/8/2025 at 3:30 PM, the Director of Nursing (DON) stated, The facility follows the RAI [Resident Assessment Instrument] manual.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, record review, and interview, the facility failed to develop and implement a baseline care plan within 48 hours of a resident's admission for 1 (Resident #345) of 3 residents reviewed for new admission. Findings include: Review of Resident #345's admission record showed an admission date of 7/1/2025, with diagnoses that included malignant neoplasm of uterus, acute respiratory failure, trochanteric fracture of left femur, pressure ulcer of left hip, constipation, dependence on supplemental oxygen, generalized anxiety disorder, lymphedema, malignant melanoma of right upper extremity, and obstructive and reflux uropathy. Review of Resident #345's record titled Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 6/27/2025 showed the resident was incontinent of bladder and has a Foley catheter inserted on 6/26/2025 under section P. Patient Health Status. Review of Resident #345's admission evaluation dated 7/1/2025 read, Section L: Gastrointestinal/Genitourinary. L1. Urinary (select all that apply). b. incontinent [checked]. f. Foley [unchecked]. l. Obstructive uropathy [not checked]. Review of Resident #345's baseline care plan dated 7/1/2025 did not show a focus, goal or intervention related to urinary catheter care. During an interview on 7/8/2025 at 1:10 PM, Staff F, Licensed Practical Nurse (LPN), stated, I'm not sure why we don't have any orders for her [Resident #345] catheter or a care plan. We usually do the admission assessment and that will trigger a baseline care plan. During an interview on 7/9/2025 at 6:30 AM, the Director of Nursing (DON) stated, I reviewed her [Resident #345] admission to try and figure out how we missed a catheter and saw that on her admission assessment. It was not documented that she had a Foley or obstructive uropathy. So, it did not trigger a baseline care plan for her catheter. I really can't say how that happened, but she [Resident #345] did come here with the catheter. She does not have a baseline care plan for her catheter and should. During an interview on 7/9/2025 at 6:55 AM, the Minimum Data Set (MDS) Coordinator stated, The baseline care plan will generate from the nursing admission assessment and physician orders. She [Resident #345] did not have orders for her catheter and so I wouldn't know she [Resident #345] needed to have a baseline care plan for catheter care. The care plan should have been developed for the catheter. Review of the facility policy and procedures titled Baseline Care Plan with the last approval date of 1/15/2025 read, Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure comprehensive care plan was developed for 1 (Resident #394) of 5 residents reviewed for medication management, and comprehensive care plan was implemented for 1 (Resident #6) of 2 residents reviewed for falls.Findings include: 1) Review of Resident #394’s admission record showed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses including anxiety disorder, depression, and unspecified dementia. Review of Resident #394’s physician order dated 6/10/2025 read, Buspirone HCl Oral Tablet 5 MG [milligram] (Buspirone HCl), Give 1 tablet by mouth three times a day for anxiety… Status: Active. Review of Resident #394’s care plan showed no focus, goal or intervention related to anxiety management. During an interview on 7/8/2025 at 1:02 PM, the Minimum Data Set (MDS) Coordinator stated, [Resident #394's name] anxiety focus was resolved on 2/25/2025. I will need to fix that. Every day we review orders, but we would have 14 days, which is still late.” 2) Review of Resident #6’s admission record showed the resident was most recently admitted on [DATE] with diagnoses including unspecified convulsions, age-related osteoporosis without current pathological fracture, arthropathy, unspecified spastic hemiplegia affecting right nondominant side, contracture of left elbow, contracture of muscle multiple sites, personal history of traumatic brain injury (TBI), and epilepsy. Review of Resident #6’s care plan dated 5/23/2025 read, Focus: [Resident #6’s name] is at risk for falls r/t [related to] poor safety awareness r/t TBI, spastic hemiplegia, Seizure disorder… Interventions… Floor Mats at bedside.” During an observation on 7/7/2025 at 12:47 PM, Resident #6 was sitting upright in a chair at his bedside. There was no floor mats placed on either side of the resident's bed. One floor mat was standing upright against a dresser and another floor mat was behind a chair leaning up against the wall, not on the floor. During an observation on 7/8/2025 at 8:30 AM, Resident #6 was sitting upright in a chair at his bedside. There was no floor mats placed on either side of the resident's bed. One floor mat was standing upright against a dresser and another floor mat was behind a chair leaning up against the wall, not on the floor (Photographic evidence obtained). During an interview on 7/8/2025 at 8:45 AM, Staff C, Certified Nursing Assistant (CNA), stated, I must have just forgotten to put them [floor mats] back down. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/2025 at 8:55 AM, Staff B, Licensed Practical Nurse (LPN), confirmed Resident #6 should have floor mats on the left and right side of the bed and stated, I expect them [staff] to make sure the floor mats are in place every shift. During an interview on 7/9/2025 at 9:49 AM, the Director of Nursing stated, Staff should be logging in to the Kardex daily to review the plan of care for each resident they are caring for. Review of the facility policy and procedures titled Comprehensive Care Plan with the last review date of 1/15/2025 read, Policy: It is the policy of this facility to develop and implement a comprehensive person centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the residents' comprehensive assessment and meet professional standards of quality.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician ordered parameters for administering hypertension medications were followed for 3 (Residents #3, #90 and #394) of 7 residents reviewed for medication management. Findings include: 1) Review of Resident #3's admission record showed the resident was most recently admitted on [DATE] with diagnoses including congestive heart failure, ischemic cardiomyopathy, acute respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), dependence on supplemental oxygen, pleural effusion, and pneumonia. Review of Resident #3's physician order dated 6/4/2025 read, Metoprolol Tartrate Tablet, Give 12.5 mg [milligram] by mouth two times a day related to essential (primary) hypertension… Hold for SBP [Systolic Blood Pressure] < [less than] 110 or HR [Heart Rate] <60. Review of Resident #3's Medication Administration Record (MAR) for June 2025 for administration of Metoprolol Tartrate Tablet showed the resident was administered the medication on 6/5/2025 at 9:00 PM for BP (blood pressure) of 105/60 [systolic/diastolic], on 6/8/2025 at 9:00 AM for BP of 108/62, on 6/9/2025 at 9:00 PM for BP of 97/60, on 6/10/2025 at 9:00 AM for BP of 102/64 and at 9:00 PM for BP of 102/64, on 6/11/2025 at 9:00 AM for BP of 99/62 and at 9:00 PM for BP of 107/53, on 6/13/2025 at 9:00 AM for BP of 98/58 and at 9:00 PM for BP of 106/56, on 6/14/2025 at 9:00 AM for BP of 106/56, on 6/15/2025 at 9:00 AM for BP of 107/63 and at 9:00 PM for BP of 93/56, on 6/16/2025 at 9:00 PM for BP of 107/66, on 6/18/2025 at 9:00 PM for BP of 106/57, on 6/20/2025 at 9:00 PM for BP of 86/55, on 6/22/2025 at 9:00 AM for BP of 105/65, on 6/23/2025 at 9:00 PM for BP of 105/70, on 6/26/2025 at 9:00 PM for BP of 106/65, on 6/29/2025 at 9:00 PM for BP of 95/48, and on 6/30/2025 at 9:00 PM for BP of 106/54. Review of Resident #3's Medication Administration Record (MAR) for July 2025 for administration of Metoprolol Tartrate Tablet showed the resident was administered the medication on 7/4/2025 at 9:00 AM for BP of 100/53 and at 9:00 PM for BP of 100/53, and on 7/7/2025 at 9:00 AM for BP of 108/67 and at 9:00 PM for BP of 108/67. During an interview on 7/9/2025 at 9:00 AM, Staff G, Licensed Practical Nurse (LPN), stated, “Metoprolol has been given out of parameters [Systolic is less than 110]. Metoprolol should have been held and the doctor notified.” During an interview on 7/9/2025 at 10:00 AM, the Director of Nursing (DON) reviewed Resident #3's MAR for June and July 2025 and confirmed Metoprolol Tartrate 12.5 mg was administered out of parameters and stated, Medications should be administered as ordered and parameters should be followed. 2) Review of Resident #90's admission record showed the resident was admitted on [DATE] with diagnoses to include cerebral infarction due to thrombosis of right middle cerebral artery, myocardial infarction, bacteremia (a bloodstream infection), and endocarditis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's physician order dated 6/11/2025 read, Nifedipine ER [Extended Release] Oral Tablet Extended Release 24 hour 30 MG (Nifedipine), Give 1 tablet by mouth one time a day for HTN [hypertension], hold for SBP <120. Review of Resident #90's MAR for July 2025 for administration of Nifedipine tablet showed the resident was administered the medication on 7/2/2025 at 9:00 AM at for BP of 106/58. Review of Resident #90's physician order dated 6/28/2025 read, Metoprolol Tartrate Tablet 25 MG, Give 0.5 tablet by mouth two times a day for HTN, Hold for SBP <120. Review of Resident #90's MAR for June 2025 for administration of Metoprolol Tartrate tablet showed the resident was administered the medication on 6/20/2025 at 9:00 PM for BP of 119/70, and on 6/25/2025 at 9:00 PM for BP of 112/65. Review of Resident #90's MAR for July 2025 for administration of Metoprolol Tartrate tablet showed the resident was administered the medication on 7/2/2025 at 9:00 AM for BP of 106/58 and at 9:00 PM for BP of 115/76, and on 7/5/2025 at 9:00 PM for BP of 117/63. During an interview on 7/8/2025 at 12:45 PM, the Assistant Director of Nursing (ADON) stated, That is out of parameters. It's a med error. The nurses should have contacted the Doctor. I don't see there was any contact documented with the Doctor.” During an interview on 7/8/2025 at 2:00 PM, Staff B, LPN, stated, I made a mistake. I know what the parameters are for Metoprolol and Nifedipine. I should not have given the medication. I did not contact the Doctor.” 3) Review of Resident #394’s admission record showed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses including muscle weakness, anxiety disorder, depression, unspecified dementia, and essential (primary) hypertension. Review of Resident #394’s physician order dated 6/11/2025 read, Metoprolol Succinate Oral Capsule ER 24 Hour Sprinkle 25 MG (Metoprolol Succinate), Give 1 capsule by mouth one time a day for HTN, Hold for SBP <120. Review of Resident #394’s MAR for June 2025 for administration of Metoprolol Succinate capsule showed the resident was administered the medication on 6/13/2025 at 9:00 AM for BP of 104/77, on 6/14/2025 for BP of 119/91, on 6/23/2025 for BP of 112/55, and on 6/25/2025 for BP of 107/68. During an interview on 7/8/2025 at 12:10 PM, Staff I, LPN, stated, Parameters are shown on the system. I am not sure what the checkmark mean. I don't remember. I don't know if I made a mistake or vitals were not given to be in time. Usually, we have an alert go off if the vitals are out of the parameters. During an interview on 7/8/2025 at 1:45 PM, the Advance Registered Nurse Practitioner (ARNP) #1 stated, “If a medication has parameters, I expect nurses to take the BP and use the parameters to give the medication.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/8/2025 at 1:50 PM, Staff J, LPN, stated, A checkmark means that medication was given. Normally, I take my own blood pressure. I cannot recall what happened that day. Sometimes, blood pressure will self-populate from the day. I always follow parameters and patient safety is number one. During an interview on 7/8/2025 at 3:30 PM, the Director of Nursing (DON) stated, I was talking to staff and they stated they take their own blood pressures. The system will not self-populate the blood pressures from the other section of the vital signs. The nurses have to input it themselves into the system. The nursing staff should follow parameters and if they feel that they need to use their nursing judgment, they need to contact the provider and document the interaction.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure residents received respiratory care as ordered by physician for 4 (Residents #35, #58, #3 and #15) of 5 residents reviewed for respiratory care. Findings include: 1) During an observation on 7/7/2025 at 9:38 AM, Resident #35 was in bed with, receiving oxygen at 4 liters per minute via nasal cannula. The oxygen concentrator was on the right side of the bed outside of the residents’ reach. During an interview on 7/7/2025 at 9:38 AM, Resident #35 stated, I can't really reach that machine. I never touch that [the oxygen concentrator]. I let the nurses do that. They will take it off and put it on for me. Review of Resident #35's physician order dated 5/23/2025 read, Oxygen at 2 liters/min [minute] via NC [nasal cannula] for SOB [shortness of breath] as needed for SOB. During an interview on 7/7/2025 at 2:55 PM, Staff E, Licensed Practical Nurse (LPN), stated, I am not sure why she has her oxygen is that high. It should be at 2 liters. During an interview on 7/9/2025 at 6:20 AM, the Director of Nursing (DON) stated, All nurses should be checking what oxygen flow rates are at least once a shift. They should be following the orders and making sure it is accurate. 2) During an observation on 7/7/2025 at 9:26 AM, Resident #58 was sitting in bed with a midline tracheostomy with a speaking valve in place and oxygen via a nasal cannula. The oxygen concentrator was set at 4 liters per minute. The oxygen concentrator was on the right side of the resident’s bed not within the resident’s reach. During an interview on 7/7/2025 at 9:26 AM, Resident #58 stated, I do not change my oxygen on the machine. I will take my cannula on and off myself.” Review of Resident #58's physician order dated 6/10/2025 read, Oxygen at 2 liters/min via NC for SOB as needed. During an interview on 7/8/2025 at 7:53 AM, Staff F, LPN, stated, Her [Resident #58] oxygen should be at 2 liters. 3) During an observation on 7/7/2025 at 9:20 AM, Resident #3 was receiving oxygen through oxygen concentrator at 4 liters per minute via nasal cannula (Photographic evidence obtained). During an interview on 7/7/2025 at 9:20 AM, Resident #3 stated, I should have oxygen delivered at 2 liters. I never change the rate myself, but I do put my oxygen on and off as needed. Review of Resident #3's physician order dated 6/5/2025 read, Oxygen at 3 liters/min via NC for SOB as needed related to Acute Respiratory Failure with Hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's physician progress notes dated 6/6/2025 read, O2 [oxygen] per NC 2-3 liters to keep sats [saturation] above 92%, continue to monitor. During an observation on 7/7/2025 at 9:56 AM, Staff A, Certified Nursing Assistant (CNA), confirmed that oxygen setting was at 4 liters per minute for Resident #3. During an interview on 7/9/2025 at 9:16 AM, Staff G, LPN, stated, Physician orders are for oxygen at 3 liters via NC for [Resident #3's name].” During an interview on 7/8/2025 at 2:19 PM, the DON confirmed that oxygen orders were written for 3 liters per minute as needed for Resident #3 and stated that orders were to be followed as written. 4) During an observation on 7/7/2025 at 10:22 AM, Resident #15’s room was empty. There was a nebulizer mask not bagged on top of the drawer next to the nebulizer treatment machine (Photographic evidence obtained). During an observation on 7/8/2025 at 8:52 AM, Resident #15 was not in her room. There was a nebulizer mask lying on top of the drawer that was not bagged. Review of Resident #15’s physician order dated 2/20/2025 read, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML [milliliter] 3 ml inhale orally four times a day for SOB related to chronic obstructive pulmonary disease… Must administer for 15 mins. Review of Resident #15’s physician order dated 2/20/2025 read, Change nebulizer set up and bag weekly and as needed every night shift Sun [Sunday], Place in labeled O2 bag and tie to handle of nebulizer machine. During an observation on 7/8/2025 at 11:45 AM with Staff I, LPN, Resident #15 was lying in her bed with eyes closed. The nebulizer mask was lying on top of the drawer with no bag. During an interview on 7/8/2025 at 11:45 AM, Staff I, LPN, stated, The nebulizer mask should be bagged when not in use. I will get her a new one and a bag because I don't see one. The bag normally is hanging from one of the drawers. During an interview on 7/8/2025 at 1:00 PM, the DON stated, If the nebulizer mask is not in use, it should be bagged. Review of the facility policy and procedures titled Oxygen Administration with the last approval date of 1/15/2025 read, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences… Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency… 5. Staff shall perform hand and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include… e. Keep delivery devices covered in plastic bag when not in use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure the physician/prescriber documented the rationale for declining the pharmacist's recommendations for 2 (Residents #33 and #53) of 5 residents reviewed for unnecessary medications and failed to ensure the nursing department responded to the pharmacist's recommendation in a timely manner for 1 (Resident #54) of 5 residents reviewed for unnecessary medications. Findings include: 1) Review of Resident #33's consultation report showed a consultant pharmacist's recommendation dated 11/4/2024 that read, Comment: [Resident #33’s name] has received Cymbalta 30 mg [milligram] qd [once a day]; Alprazolam 0.5 mg qhs [every night at bedtime]; Trazadone 100 mg qhs. Recommendation: Please attempt a gradual dose reduction (GDR). Rationale for recommendation: Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence (e.g., GDR is attempted in 2 separate quarters, with at least 1 month between attempts, within the first year in which an individual is admitted on a psychotropic medication or after the prescriber has initiated such medication, unless clinically contraindicated)… Response Requested. Physician's Response… 1. Continued us in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability be exacerbating an underlying medical condition or psychiatric disorder as documented below, or… Please provide CMS [Centers for Medicare and Medicaid Services] required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual: [No rationale or reason was documented]. During an interview on 7/8/2025 at 1:25 PM, the Director of Nursing (DON) stated, The expectation is that they [physicians/providers] will provide an explanation or reason why they are not accepting the pharmacist's recommendation. In a perfect world, they provide an explanation, but that doesn't always happen, and they don't always respond to my requests. Review of Resident #33's progress notes showed no notes from Advanced Practice Registered Nurse (APRN) #2 on or around 11/4/2025 regarding declined recommendation. During an interview on 7/9/2025 at 10:55 AM, APRN #2 stated, “The medications listed on Resident #33's MRR [Medication Regimen Review] were managed by psych [the Psychiatric Physician/Provider], but that she did sign the MRR indicating rejection of the pharmacist's recommendations. 2) Review of Resident #53's consultation report showed a consultant pharmacist's recommendation dated 4/8/2025 that read, Comment: [Resident #53’s name] has an order for an opioid oxycodone acetaminophen 5/325 mg every 4 hours as needed for x 7 days, as the sole “as needed” analgesic. Recommendation: Please initiate an order for acetaminophen 650 mg every 6 hours as needed for mild or moderate pain. Document the maximum daily dose of acetaminophen from all sources based on product labeling and the clinical profile (e.g. maximum of 3 grams/24hr [hour] and clarify that the opioid oxy/APAP [oxycodone/acetaminophen] 5/325 mg every 4 hours PRN [as needed] therapy is “for severe pain”… Response Requested: Declined.” The form was signed by APRN #2 on 4/9/2025 with no rationale or reason documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105308	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Inverness Inc	304 S Citrus Ave Inverness, FL 34452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #53's consultation report showed a consultant pharmacist's recommendation dated 4/8/2025 that read, “Comment: [Resident #53's name] receives Atorvastatin 40 mg daily. Recommendation: Please monitor a fasting lipid panel on the next convenient lab day and every 12 months thereafter. Response requested: Declined.” The form was signed by APRN #2 on 4/9/2025 with no rationale or reason documented. During an interview on 7/9/2025 at 10:00 AM, the DON stated, The doctors will not give a reason. During an interview on 7/9/2025 at 11:05 AM, APRN #2 stated, [Resident #53’s name] has a history of coronary heart disease and there is no reason to complete a lipid profile and his history is documented in the chart. 3) Review of Resident #54's consultation report showed a consultant pharmacist's recommendation dated 6/11/2025 that read, T: Nursing… Comment: [Resident #54's name] receives a medication containing an inhaled corticosteroid, Trelegy Ellipta. Recommendation: To reduce the risk of thrush, please update the order to include the directions: Rinse mouth with water after use. Do not swallow… Response Requested. Director of Nursing’s Comments: [blank]. The form was signed by the Assistant Director of Nursing (ADON) on 7/7/2025. Review of Resident #54’s physician order dated 6/11/2025 read, Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT [microgram/activated clotting time] (Fluticasone-Umeclidinium-Vilanterol) 1 inhalation inhale orally one time a day for SOB [shortness of breath]. ” The order had no further instructions. During an interview on 7/8/2025 at 12:38 PM, the DON stated, Usually when there are recommendations, they come in 48-72 hours when they are printed, addressed, and changed. They come to me, ADON, Charge Nurse [Staff G, LPN’s name], 3-11 supervisor [Staff H, LPN’s name]. I am not sure why it was not done earlier. Review of the facility policy and procedures titled “Medication Regimen Review” with the last approval date of 1/15/2025 read, Applicability: This policy 9.1 sets forth procedure relating to the medication regimen review (MRR). Procedure . 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. 7.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 7.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record.”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105308	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Inverness Inc	304 S Citrus Ave Inverness, FL 34452

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure wound care was accurately documented for 1 (Resident #14) of 2 residents reviewed for wound care. Findings include: Review of Resident #14's physician order dated 5/1/2025 read, Right ischial- cleanse with Dakin's 1/4 solution, pat dry, protect peri wound with skin prep, pack with gauze soaked in Dakin's 1/4 strength solution, cover with a bordered foam. Review of Resident #14's Treatment Administration Record (TAR) for June 2025 and July 2025 for right ischial wound treatment showed no entries documented for 6/3/2025, 6/12/2025, 6/17/2025, 6/19/2025, 6/24/2025, and 7/1/2025. Review of Resident #14's physician order dated 5/21/2025 read, Left ischial- cleanse with Dakin's 1/4 solution, pat dry, protect peri wound with skin prep, pack wound depth and undermining with Medi honey gel and silver alginate and cover with a superabsorbent bordered foam. Review of Resident #14's Treatment Administration Record (TAR) for June 2025 and July 2025 for left ischial wound treatment showed no entries documented for 6/3/2025, 6/12/2025, 6/17/2025, 6/19/2025, 6/24/2025, and 7/1/2025. Review of Resident #14's physician order dated 5/23/2025 read, Right Heel- cleanse with wound cleanser, pat dry. Protect peri wound with skin prep, pack wound depth with Medi honey gel and collagen fiber, and cover with border gauze. Review of Resident #14's Treatment Administration Record (TAR) for June 2025 and July 2025 for right heel wound treatment showed no entries documented for on 6/4/2025, 6/13/2025, 6/18/2025, 6/20/2025, 6/25/2025, and 7/2/2025. Review of Resident #14's physician order dated 5/26/2025 read, Right posterior thigh- cleanse with wound cleanser, pat dry, protect peri wound with skin prep, apply Medi honey gel, cover with bordered foam. Review of Resident #14's Treatment Administration Record (TAR) for July 2025 for right posterior thigh wound treatment showed no entries documented on 7/2/2025. Review of Resident #14's physician order dated 6/11/2025 read, Left posterior thigh- apply house barrier cream every shift. Review of Resident #14's Treatment Administration Record (TAR) for June 2025 for left posterior thigh wound treatment showed no entries documented on 6/12/2025. Review of Resident #14's physician order dated 6/11/2025 read, Coccyx- cleanse with wound cleanser, pat dry, protect peri wound with skin prep, apply Medi honey fiber, cover with bordered foam. Review of Resident #14's Treatment Administration Record (TAR) for June 2025 and July 2025 for coccyx wound treatment showed no entries documented on 6/12/2025, 6/17/2025, 6/19/2025, 6/24/2025, and 7/1/2025 During an interview on 7/8/2025 at 12:39 PM, the Assistant Director of Nursing (ADON) stated, The nurses should have documented on those days. [Resident #14's name] sometimes refuses. The nurses did not document any refusals. During an interview on 7/8/2025 at 12:57 PM, Resident #14 stated, The nurse wakes me up to do my wound care. I don't refuse. The nurse usually wakes me up at 6 AM; that is when the nurse comes in to do my wound care. During an interview on 7/8/2025 at 3:49 PM, the Director of Nursing (DON) stated, I have a wound care nurse that does all wound care in the facility. I cannot speak to why the night nurses are signing off on [Resident #14's name]. I see there are holes in the documentation. My expectation is that wound care is documented all the time. During an interview on 7/8/2025 at 3:51 PM, Staff D, Licensed Practical Nurse (LPN), Wound Care Nurse, stated, I work 6:30 AM to 3:15 PM, Monday through Friday. All nurses know if a dressing is soiled, they can do a dressing change. Wound care orders are input to [name of medical records software] by the APRN [Advanced Practice Registered Nurse]. If the order was entered in error and scheduled for 11 PM - 7 AM, the night shift nurse would do the wound care. Those nurses like to do wound care for [Resident #14'name] since they are familiar with the resident and resident has been here a long time. I go up and say hi to the nurses on the floor, they would tell me if they forgot or did not do the wound care. I see the holes in the TAR that means the wound care did not get done. There is no consistency for me getting report from a night nurse when the wound care does not get done or any consistency in checking if wound care is done for [Resident #14's name].