

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Avante at Ormond Beach, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 170 N Kings Road Ormond Beach, FL 32174	

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)
<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442</p> <p>Based on record review and interviews, the facility failed to develop a discharge plan that addressed all of the resident's needs post discharge, by failing to reconcile medication after discharge for one (Resident #1) of three residents reviewed for discharges, from a total sample of 8 residents.</p> <p>The findings include:</p> <p>A review of Resident #1's medical record revealed an admitted [DATE], and the resident was discharged home on 10/24/24. The resident's medical diagnoses included Nonrheumatic mitral valve insufficiency, Fibromyalgia, Chronic Systolic (congestive) Heart Failure, and Major depressive disorder. An admission Minimum Data Set (MDS) assessment, dated 10/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points, indicating intact cognition.</p> <p>A review of Resident #1's physician orders dated 10/16/24 revealed the following medications Apixaban (Eliquis) 5 milligrams (mg) two times a day (BID) for cardiac arrhythmia, Furosemide (Lasix) 20 mg every day (QD) for cardiac Arrhythmia, Metoprolol 25 mg BID for blood pressure, Sertraline 50 mg QD for depression, Celecoxib 100 mg BID for pain, and Amiodarone 200 mg BID for cardiac Arrhythmia.</p> <p>A review of the Resident #1's Interdisciplinary discharge summary note dated 10/24/24 included a statement that read, medications were released to family per state regulations. (Photographic evidence obtained) Per the discharge orders, the resident was to go home without medications and the pharmacy for ordering medications was listed. (Photographic evidence obtained) Medications were not sent home with resident. A signed copy of the last page of the medication list was in the medical record (Photographic evidence obtained).</p> <p>Further record review for Resident #1 found no documentation that a discharge meeting was held with the resident.</p> <p>(continued on next page)</p>

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
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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/2024 at 1:32 PM, an interview was conducted with Employee A, Licensed Practical Nurse (LPN). She was asked to explain the facility's process for reconciliation of post-discharge medications. She stated that during the discharge process, the nurse will educate the resident/family on discharge medications, use of equipment, and making sure they call their primary physician for follow-up. During this time, the nurse will also answer any questions they may have. The discharge paperwork is printed out by the nurse and given to the resident on the day of discharge. The nurses go over their medications and how to take them, each department will go over their part of the discharge. Nurses will call the resident's pharmacy to order any prescriptions they may need. The physician's discharge orders are reviewed by the nurse, to determine if the resident has orders to go home with medications, prescriptions or just a medication list. The nursing staff also check to see if home health services needs to be set up and they will call the residents' provider of choice if they have one. Finally, the nurse will put a note in the resident electronic record that the discharge has been completed, questions answered, and paperwork is given to the resident.</p> <p>On 12/19/2024 at 2:40 PM, an interview was conducted with the Social Services Director (SSD) regarding the discharge process. She stated that discharge planning starts on admission. She is usually made aware of the possibility of long-term or short-term residents. Upon receiving the projection discharge, the date is put on the discharge calendar, and the interdisciplinary team (IDT) is notified during clinical meeting. The clinical team (Nurses) and provider manage the discharged medications. The residents are told they cannot be discharged with controlled substances. The residents do not get a copy of the discharge order, but they get a copy of the IDT discharge summary. The nurse completes the discharge and has the resident sign the IDT discharge summary. The resident receives a signed copy and then a copy will be uploaded by the nurse into the record. She explained that Medicare residents will have their left-over medication sent back to the pharmacy and medications will be called into their pharmacy of choice. If a person is on Medicaid, usually the resident will go home with left over medications. Social services coordinates contacting providers for services and the residents can ask to use their preferred provider. Should the resident have a question after going home, they can call the social services here for assistance. The SSD stated she did not document in the medical record her conversations with the resident post discharge.</p> <p>On 12/19/2024 at 3:30 PM, an interview was conducted with Director of Nursing (DON). The DON stated that she had been in the position less than a month. When asked about medications and discharges, the DON stated the facility will send narcotics home with residents along with regular medications according to what insurance they currently have. They go by Medicare and Medicaid guidelines. She stated the nurse discharging the resident should explain discharge instructions, go over the medication list, inform the residents of any medical equipment that was ordered, and review any home health needs that were ordered. The nurse should also answer all the residents' or resident representative questions before they leave the building. She confirmed that Resident #1 was not sent home with the medication because of the type of insurance resident had and was not sure how she would verify if the orders were sent to the pharmacy. When asked what the facility protocol was for ensuring that residents who were discharged without the medication received the medication at home. She said she was not sure and would have to follow up.</p> <p>On 12/19/24 at 4:48 PM, a follow up interview was conducted with the DON. She explained that she spoke with Resident #1's physician who told her that no orders were sent to the pharmacy because the resident was not on narcotics. The DON confirmed that there was no process in place for residents that were discharged home without medication.</p> <p>(continued on next page)</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/2024 at 5:00 PM, an interview was conducted with the Administrator. She was asked to explain the facility process for discharge medications. She stated that they are identified in the discharge paperwork. She explained that if the resident or family member asked them, they would contact the residents' physician on discharge for him to call in the needed prescriptions for the residents. She acknowledged that they do not document their attempts to contact the physician, and do not have a means to ensure the prescriptions were called in for the resident.</p> <p>The facility policy titled Transfer and Discharge Requirements revised 3/2/19. The Policy indicated that the facility would ensure residents are treated equally regarding transfer, discharge and the provision of services, regardless of their payment source in accordance to state and federal regulations.</p> <p>The policy indicated that 3. Information provided to the receiving provider must include a minimum of the following:</p> <ul style="list-style-type: none"> a. Contact information of the practitioner responsible for the care of the resident; b. Resident representative information including contact information; c. Advance Directive information; d. All special instructions or precautions for ongoing care, as appropriate; e. Comprehensive care plan goals; f. All other necessary information, including a copy of the resident's discharge summary and any other documentation, as applicable, to ensure a safe and effective transition of care. <p>(Photographic evidence obtained)</p> <p>50369</p>