

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER Avante Villa at Jacksonville Beach Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 Seabreeze Ave Jacksonville Beach, FL 32250	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and a review of the facility's policies and procedures, the facility failed to provide transfer/discharge notification to the Long-Term Care (LTC) Ombudsman's office prior to or as soon as was practicable for five (Residents #22, #90, #148, #156, and #16) of five residents reviewed for transfer/discharge. Appropriate notification of the LTC Ombudsman's office provides added protection for residents from being inappropriately transferred or discharged, provides residents with access to an advocate who can inform them of their options and rights, and ensures that the LTC Ombudsman's office is aware of facility practices and activities related to transfers and discharges. The findings include: On 05/28/2026 at 11:53 AM, Social Services Director (SSD) G provided a list of resident transfers/discharges from 03/01/2026 through 05/26/2026. 1.A review of Resident #22's medical record revealed an admission date of 05/05/2026 and a discharge date of 05/07/2026. A review of the Transfer/Discharge Report dated 05/07/2026 revealed a planned discharge to another skilled nursing facility (SNF). There was no evidence in the resident's medical record of a Nursing Home Transfer/Discharge Form (CMS (Centers for Medicare and Medicaid Services) Form 3120) or notification of the LTC Ombudsman's office of the discharge. 2.A review of Resident #90's medical record revealed an admission date of 04/27/2026 and a discharge date of 05/26/2026. A review of the discharge order provided by SSD G revealed a physician's order dated 05/22/2026 for the resident to discharge home on [DATE] with skilled home care services. There was no evidence in the resident's medical record of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office of the discharge. 3.A review of Resident #148's medical record revealed an admission date of 02/25/2026 and a discharge date of 03/22/2026. The Nursing Home Transfer/Discharge Form (CMS Form 3120) for Resident #148 was provided by SSD G. A review of the form revealed that the resident was transferred to the hospital on [DATE]. The form was incomplete and revealed no explanation for the transfer, nor did it indicate when the LTC Ombudsman's office was notified of the transfer. There was no evidence in the resident's record verifying that the LTC Ombudsman's office was notified or received a copy of the transfer/discharge form. 4.A review of Resident #156's medical record revealed an admission date of 01/20/2026 and a discharge date of 02/03/2026. A progress note on 02/02/2026, provided by SSD G, revealed that (continued on next page)		

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #156 was to be transferred to another SNF on 02/03/2026. The note was completed by SSD G, and it read, Call to wife, no answer, left message with information. No answer. There was no evidence in the resident's medical record of a Nursing Home Transfer/Discharge Form (CMS Form 3120) or notification of the LTC Ombudsman's office of the discharge. On 05/29/2026 at 12:42 PM, an interview was conducted with SSD G, who stated the LTC Ombudsman's office was notified of planned discharges as they occurred. She stated at the end of the month, the LTC Ombudsman's office received a report/log listing that included hospital transfers and unplanned discharges. On 05/29/2026 at 12:55 PM, a follow-up interview was conducted with SSD G, who stated there was a Performance Improvement Plan (PIP) related to LTC Ombudsman's office transfer/discharge notifications. She stated she monitored the process monthly. SSD G stated the facility was following the regulations regarding notification of the LTC Ombudsman; however, no evidence was provided that a PIP specific to notification of the LTC Ombudsman's office of transfers/discharges had been implemented. A review of the facility's PIP list did not identify a PIP addressing LTC Ombudsman's office notification of transfers/discharges. 5.A review of Resident #16's medical record revealed that the resident was admitted to the facility 2/18/2026. A review of the Discharge, Return Anticipated Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/7/2026, revealed that the resident experienced an unplanned transfer to an acute care hospital on 5/7/2026. A review of the Nursing Home Transfer/Discharge Form (CMS Form 3120) revealed that the resident was transferred to an acute care hospital for evaluation on 5/7/2026. The resident's medical record contained no evidence indicating that the Long-Term Care (LTC) Ombudsman's office was notified of the resident's transfer or received a copy of the transfer/discharge form. On 05/29/2026 at 12:45 PM, an interview was conducted with SSD G. She confirmed that the facility's process for notification of the LTC Ombudsman's office was to fax a monthly report/log listing for residents who were transferred to the hospital. On 05/29/2026 at 12:48 PM, an email was received from the LTC Ombudsman who confirmed that no transfer notification had been received for Resident #16. A review of the facility's policy and procedure titled Notice Requirements Before Transfer/Discharge (issued: 3/2/19, revised: 3/2/19), revealed: Procedure: c. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Written Notice: 2.A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and the local ombudsman council within 5 business days after signature by the resident or resident designee.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, record reviews, and a review of facility policies and procedures, the facility failed to provide adequate fingernail care for four (Residents #57, #72, #118 and #140) of 57 sampled residents. A failure to provide basic nail hygiene can contribute to painful, ingrown nails, skin infections, other injuries and/or a loss of dignity. The findings include: 1. On 05/26/2026 at 11:57 AM, Resident #57 was observed resting in bed. The fingernails on his right hand were elongated with brown matter underneath them. The fingernails on his left hand were not visible. He confirmed that he had not received fingernail care, he desired fingernail care, and he would not refuse fingernail care if offered. (Photographic evidence obtained) On 05/26/2026 at 2:27 PM, Resident #57 was observed resting in bed. He confirmed that he had eaten his lunch and fed himself. The fingernails on his right hand were elongated with brown matter underneath the nails as observed earlier this day at 11:57 AM. The fingernails on his left hand were not visible. (Photographic evidence obtained) A review of Resident #57's medical record revealed an admission date of 04/29/2026 with diagnoses including palliative care, End-Stage Renal Disease (ESRD) and epilepsy. A review of the resident's active physician's orders revealed he was receiving hospice services (ordered 05/11/2026). A review of the admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/05/2026, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were documented. The resident required substantial/maximal staff assistance with personal hygiene tasks. No refusals of care were identified. A review of the resident's active care plan revealed: Focus Area: Activities of Daily Living (ADL)/Self-Care Performance Deficit related to activity Intolerance, hemiplegia (weakness/paralysis on one side of the body), and health status at risk for further decline in ADLs related to hospice care. Date Initiated: 04/30/2026. Revision: 04/30/2026. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 04/30/2026. The resident's care plan did not include/address behaviors or refusal of/resisting ADL care. 2. On 05/26/2026 at 12:08 PM, Resident #72 was observed lying in bed. His fingernails on both hands were elongated. (Photographic evidence obtained) He was interviewed and confirmed that he had not received fingernail care, that he wanted his fingernails trimmed, and would not refuse care if offered. On 05/26/2026 at 2:29 PM, Resident #72 was observed lying in bed. His fingernails remained elongated as they were observed earlier in the day at 12:08 PM. (Photographic evidence obtained) He confirmed that he had not received any fingernail care yet during this shift (7:00 AM - 3:00 PM). A review of Resident #72's medical record revealed an admission date of 04/30/2020 with diagnoses including traumatic brain injury. No refusals of care were documented. A review of the Annual MDS assessment with an ARD of 05/10/2026, revealed a BIMS score of 03/15, indicating severe cognitive impairment. No psychosis or behaviors were documented. The resident was dependent on staff for personal hygiene. A review of the resident's active care plan revealed: Focus Area: Resident has ADL/Self-Care Performance Deficit related to his health status. Date Initiated: 05/11/2020, Revision: 05/03/2021. Intervention: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 05/11/2020. The resident's care plan did not include/address behaviors or refusal of/resisting ADL care. 3. On 05/26/2026 at 12:17 PM, Resident #118 was observed with elongated fingernails with brown matter under them. (Photographic evidence obtained) On 05/26/2026 at 2:29 PM, Resident #118 was again observed with elongated fingernails with brown matter under them. He confirmed he had not received fingernail care during this shift (7:00 AM - 3:00 PM). A review of Resident #118's medical record revealed an admission date of 01/13/2026 with diagnoses including seizures and generalized muscle weakness. The resident had no documented behavior of refusing care. A review of the resident's Quarterly MDS assessment with an ARD of 04/21/2026, revealed a BIMS score of 06/15, indicating severe cognitive impairment. No psychosis or behaviors were indicated. A review of the active care plan revealed: Focus Area: (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADL/Self-Care Performance Deficit related to health status. Date Initiated: 01/14/2026, Revision on 01/14/2026. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 01/14/2026. The resident's care plan did not indicate/address refusal of or resisting ADL care. 4. On 05/26/2026 at 3:01 PM, Resident #140 was observed resting in bed. Her fingernails had jagged edges with brown matter under them on both hands. (Photographic evidence obtained) A review of the resident's medical record revealed an admission date of 04/01/2026 with diagnoses including schizophrenia, bipolar disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of an admission MDS assessment with an ARD of 04/07/2026, revealed a BIMS score of 13/15, indicating intact cognition. No behaviors were documented. The resident required substantial/maximal assistance with personal hygiene tasks. The resident had no documented behavior of refusing care. A review of the care plan revealed: Focus Area: ADL/Self-Care Performance Deficit related to activity intolerance, weakness, dementia, pain, health status. Date Initiated: 04/02/2026, Revision on 04/02/2026. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 04/02/2026. The resident's care plan did not indicate/address refusal of or resisting ADL care. On 05/26/2026 at 2:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) H who was asked if she had received education on ADL care. She stated she had not received any classroom-type education on ADL care, but that her orientation consisted of shadowing another CNA for three days and observing ADL care being provided. She was asked how often fingernail care was provided to the residents. She stated fingernail care was provided weekly. She confirmed that fingernail care was provided by the CNAs. She stated the Activities Department provided some fingernail care and nail polishing; however, she did not know how frequently it was provided. She stated the CNAs were ultimately responsible for the residents' fingernail care. CNA H was accompanied to the bedsides of Residents #57, #72, #118, and #140. She confirmed that these residents required fingernail care. On 05/26/2026 at 12:38 PM, an interview was conducted with Licensed Practical Nurse (LPN) C who confirmed that the licensed nurses and CNAs were responsible for the residents' fingernail care. She stated the Activities Department also provided nail care. When she was asked how often the residents were provided fingernail care, she replied that fingernail care was provided to the residents every 15 days and daily for residents who got food under their nails when they fed themselves. A review of the facility's policy and procedure titled Activities of Daily Living (ADLS) Maintain Abilities (Issued: 03/02/2019, Revised: 03/02/2019), revealed: Policy: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident: and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. Procedure: 3. The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal/oral hygiene.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record reviews, observations and staff interviews, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for two (Resident #89 and #103) of three residents reviewed for safety/accidents, from a total survey sample of 28 residents. The facility failed to properly store and dispose of razors and hair shears used by Resident #89 who shared a room with Resident #103. Resident #103 was severely cognitively impaired and independently mobile. This placed both residents and any other resident who could access this room at risk for accidents with injury. The findings include:1.A review of Resident #89's Quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/24/26, revealed a brief interview for mental status (BIMS) score of 12 out of 15 possible points, indicating moderate cognitive impairment. Resident #89 had no impairments to his upper or lower extremities, used a walker and was independent with all self-care.2.A review of Resident #103's medical record revealed an admission date of 3/6/26 with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the resident's Quarterly MDS assessment with an ARD of 4/3/2026, revealed a BIMS score of 3 out of 15 possible points, indicating severe cognitive impairment.Resident #103 was care planned on 4/22/2026 with a review date of 6/30/2026 for Elopement Risk/Wandering related to disorientation in a new environment. The resident had a history of impaired safety awareness. On 5/26/2026 at 11:40 AM, upon entering Resident #89's and #103's room, Resident #89 was observed in bed with his eyes closed. He did not respond when greeted. Resident #103 was sitting in a chair next to his bed. A razor and hair shears were observed in the residents' shared bathroom in a lidless bin next to the sink. (Photographic evidence obtained)On 5/27/2026 at 10:34 AM, upon entering Resident #89's and #103's room, a razor was observed in the residents' shared bathroom inside a lidless bin next to the sink. (Photographic evidence obtained)On 5/27/2026 at 1:41 PM, the Director of Nursing (DON) was asked to provide the facility's policy for storage and disposal of sharps used for personal care. No policy was received on 5/27/2026. On 5/28/2026 at 1:45 PM, upon entering Resident #89's and #103's room, a razor was observed in the residents' shared bathroom inside a lidless bin next to the sink. (Photographic evidence obtained)On 5/28/2026 at 1:58 PM, Licensed Practical Nurse (LPN) C was interviewed. She stated independent residents could have combs and brushes in their rooms but not fingernail clippers or personal razors because they could be used as weapons. She stated one of her residents had family members who visited and shaved the resident's beard, but they took the supplies with them when they left. Knives or any type of sharp items could not be kept in resident rooms. For residents who required assistance with grooming, staff kept the razors and shaving items in the locked supply closet.On 5/28/2026 at 2:05 PM, Certified Nursing Assistant (CNA) B was interviewed. When he was asked where he stored personal care and grooming supplies, he stated they were kept in the supply closet on the East Wing next to the nurses' station. He said the supply closet stored deodorant, toothpaste, nail files, nail clippers, briefs, and regular razors. For residents who required assistance with ADL (activities of daily living) care or grooming, he provided care, and hazardous supplies like razors were returned to the supply closet and labeled for that resident or were disposed of. Independent residents were allowed to keep razors or nail clippers in their rooms in the personal area but not in the bathroom if they had roommates.On 5/28/2026 at 2:15 PM, CNA B was accompanied to Resident #89's and #103's room. Two razors were observed in the bathroom shared by the two residents inside a lidless bin next to the sink. CNA B stated, This is a problem. He further stated the razors should not be in the residents' bathroom because only one of them was permitted to use personal razors with little supervision.On 5/28/2026 at 2:48 PM, the DON was asked to provide any policy the facility had for the storage and disposal of sharps used for personal care (specifically razors). No policy was received on 5/28/2026.On 5/29/2026 at 10:25 AM, the DON was interviewed. She was asked if (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who were independent could store razors or any type of sharps in their rooms. She stated, No, this is not permitted under any circumstances. She was asked if the facility had a policy stating residents were prohibited from keeping sharps in their rooms. She stated the facility did not have a specific policy addressing how the facility should handle and store razors/sharps for independent residents who did their own grooming.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, record reviews, and a review of facility policies and procedures, the facility failed to ensure its medication error rate was not 5.0% or greater. There were 26 opportunities for error with three identified medication errors resulting in an error rate of 11.0% and involving Residents #59 and #135, two of nine residents observed during medication administration. The findings include: On 5/28/2026 at 9:44 AM, Licensed Practical Nurse (LPN) K was observed preparing Divalproex Sodium 500 milligrams (mg), 1 tablet, to administer to Resident #59. She was asked if she had prepared all medications that were to be administered to the resident at that time. She reviewed the electronic Medication Administration Record (eMAR) and confirmed that she had prepared all medications and treatments that were due to the resident at that time. LPN K administered the above medication to the resident at bedside. After administration, the resident's active physician's orders were reviewed with LPN K in the eMAR. LPN K confirmed that according to the physician's orders, Resident #59 should have received two tablets of Divalproex Sodium 500 mg to equal 1000 mg as well as Voltaren External Gel 1% (to be applied topically BID - twice a day). LPN K acknowledged responsibility for assuring the right residents received the right medications at the right time, at the right frequency, at the right dose and via the right route. On 5/28/2026 at 4:25 PM, LPN I was observed preparing Trazadone Hydrochloride (HCL) 50 mg, 1 tablet, to administer to Resident #135. LPN I was then observed administering the above medication to the resident at bedside. The resident's active physician's orders were reviewed with LPN I in the eMAR, and she confirmed that according to the physician's orders, the resident should have received two tablets of Trazadone HCL to equal 100 mg. LPN I acknowledged responsibility for assuring the right residents received the right medications at the right time, at the right frequency, at the right dose and via the right route. On 05/28/2026 at 5:30 PM, an interview was conducted with the Director of Nursing who stated her expectation for nursing staff when administering medication was that they ensure they were administering medications to the right person at the right time via the right route, at the right frequency and for the right medication and dosage. A review of the facility's LTC (Long-Term Care) Pharmacy Services and Procedures Manual under 6.0 General Dose Preparation and Medication Administration (Effective Date: 12/01/07, Revision Date: 01/01/22), revealed: 4. Prior to administration of medications, facility staff should take all measures required by Facility Policy and Applicable Law, including, but not limited to the following: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct date, at the correct time, for the correct resident, as set forth in the facility's medication administration schedule.		