STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105671	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Melbourne Inc	1420 South Oak Street Melbourne, FL 32901

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility neglected to ensure pre-operative testing was completed timely and per physician's orders for scheduled surgical removal of a musculoskeletal (muscle/bone) device (external fixator) for 1 of 1 resident reviewed for neglect, of a total sample of 4 residents, (#1). External fixators are metal devices attached to the bones of the arm, leg or foot with pins or wires from outside the body. Threaded pins or wires pass through the skin and muscles and are inserted into the bone, (retrieved from International Center for Limb Lengthening at limblength.org on 4/11/2025). Infection after fracture fixation (IAFF) in orthopedic surgery is a dreaded complication, leading to non-union, loss of function, and even amputation, (retrieved from pmc.ncbi.nlm.nih.gov on 4/11/2025). Findings: Resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on 1/03/25 with diagnoses that included subsequent encounter of right knee dislocation/reduction, type 2 diabetes mellitus, muscle weakness, and lack of coordination. Additional diagnoses after admission to the facility included leukocytosis (high white blood cells/infection response), right leg wound infection, right Achilles (ankle) tendon (connects muscle to bone) contracture (tightening), and right peroneal (lower leg) nerve palsy (paralysis/weakness). The State Agency hospital transfer form noted on 12/30/24 prior to admission to the facility, resident #1 used a walker to walk with two assistants, and he had good rehabilitation potential. The Body Map section noted moisture associated skin damage, but no other skin impairments other than the presence of the external fixator to the right leg. (continued on next page)

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
	105671	A. Building B. Wing	04/10/2025

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Minimum Data Set (MDS) Comprehensive Admission Assessment with an Assessment Reference Date of 1/09/25 noted resident #1 scored 15 out of 15 on the Brief Interview for Mental Status that indicated he was cognitively intact, and there were no behavioral symptoms or rejections of evaluation or care. The resident had functional Range Of Motion (ROM) limitations to the lower extremity (hip, knee, ankle, foot) that interfered with daily functions and placed a risk of injury; he did not walk, and was dependent on staff to complete Activities of Daily Living (ADLs), and for positioning and transferring in and out of bed. The resident required scheduled and as needed pain medications, had frequent, severe pain that affected his day-to-day activities, was at risk for pressure ulcer development, had one unstageable pressure ulcer present on admission, one vascular ulcer, and surgical wounds. Over the seven day lookback, the resident required medication injections for six days, insulin injections for three days, insulin order revisions for one day, and high-risk anti-coagulant (blood thinner), opioid (narcotic pain), and hypoglycemic (blood sugar lowering) medications. Resident #1 had a care plan dated 1/05/25 for right leg surgical wounds/fixator. The goal was the resident would exhibit healing of surgical site without the onset of infection by the review date. Interventions included for nurses to monitor for infection and circulation complications, provide pressure relief and re-positioning with goals to exhibit healing without infection, dated 1/05/25. There were no interventions for follow up care for the wound/removal of the fixator. On 1/16/25 a new care plan was initiated for an actual pressure injury caused by prolonged pressure related to immobility, decreased mobility and obesity, right pin site #1 and #2. The goal was for the resident to maintain intact skin integrity, will show a reduction in the size/stage of the pressure injury and would show no signs of infection through the review date. Interventions included administer treatments as ordered and monitor for effectiveness, assist with turning/repositioning, ensure specialty mattress in place, and document any changes in skin integrity in the plan of care and notify the licensed nurse of any new open areas. The Order Summary Report revealed physician medication orders for multiple antibiotics ordered over a three month period from January to March 2025, including Intravenous (IV) Cefepime (antibiotic) 1 Gram (GM) every 8 hours for right leg infection from 1/21/25 to 3/08/25; Daptomycin (antibiotic) IV 650 Milligrams (MG) once daily for right leg infection from 2/14/25 to 3/08/25; Vancomycin (antibiotic) IV (dose adjusted 1.5 GM to 2.0 GM) twice daily for right leg infection from 1/21/25 to 3/08/25; Cephalexin (antibiotic) 500 MG by mouth for right leg infection from 2/28/25 to 3/14/25; Doxycycline 100 MG twice daily from 2/28/25 to 3/14/25; Rifampin (antibiotic) 300 MG twice daily by mouth for right leg infection on 1/06/25 to 1/20/25 and again on 2/04/25 to 3/06/25. He had no further antibiotic orders until 4/10/25. Active medication orders also included Lovenox 40 MG injection twice daily for blood clot prevention on 2/04/25; Oxycodone (narcotic/opioid pain) 9 MG extended release every 12 hours for leg pain on 1/09/25; and Oxycodone 10 MG every 4 hours as needed for pain on 1/21/25. Review of an Infectious Disease Progress Note dated 1/22/25 showed a new diagnosis of right lower extremity (leg) wound infection and leukocytosis and read, wound culture obtained and discussed with wound care specialist. Wound was noted to have increased purulent drainage from odor. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An orthopedic physician progress note dated 1/30/25 revealed resident #1 had developed an Achilles tendon contracture and complete peroneal nerve palsy (inability to lift the foot at the ankle). Removal of the device was planned for around 3/27/25, or 12 weeks after it was placed which required pre-operative Venous Doppler testing completed 24-to-48 hours before surgery to identify any blood clot complications that required planning for additional potential surgical interventions. An orthopedic physician Pre-Op Exam progress note dated 3/04/25 indicated resident #1's external fixator device removal surgery was planned for 3/19/25. Noted concerns documented the resident's ankle contracture was, near-fixed and possibly required additional lengthening surgery for the resident to walk again with a flat foot. On 4/09/25 at 11:01 AM, resident #1 was awake in his room, lying in bed. An external fixator device was attached to his right leg. The resident's right foot and toes were pointed downward and the resident said he had developed foot drop since he came to the facility in early January 2025 after surgery. He explained he had missed several follow up appointments with the Orthopedic surgeon that the facility was supposed to help him arrange. The resident was tearful when he explained the facility had not arranged for testing that was needed prior to a second surgery to have the device removed on 3/19/25, in a timely manner so the surgeon had to cancel the surgery. He said the surgery was still currently unscheduled and he was fearful and anxious because the device removal was overdue. Resident #1 explained his movement was worse, and he hadn't been placed back on antibiotics after the surgery was canceled. He recalled on 3/18/25, the South Unit Manager (UM) told him the Doppler test wasn't completed yet for his surgery. The resident was tearful, pointed to the device and stated, they didn't do it (the Doppler test) until the next morning and that was too late; there has been an infection in the pins and they need to come out . In a telephone interview on 4/10/25 at 9:47 AM, the Orthopedic provider's scheduler said she was the primary point of contact with the facility and the Orthopedic physician. She explained resident #1 was supposed to have surgery to remove the hardware from his previous surgery the past December 2024. She confirmed resident #1 was supposed to have the surgery for removal nine to twelve weeks after the first surgery, but had not. The scheduler checked the medical records and said the resident missed his first post-surgical follow-up appointment on 1/17/25, and the next appointment on 3/06/25 due to lack of transportation. She confirmed he did not have a new date scheduled for surgery to remove the hardware at that time. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In a telephone interview on 4/09/25 at 2:01 PM, the South UM recalled she was frequently in telephone contact with surgery schedulers who emphasized the importance of timeliness for completion of the pre-operative Doppler testing to ensure resident #1's surgery was able to be performed on 3/19/25. She explained she entered a physician's order for the Doppler test, approximately one week prior to the scheduled surgery after a telephone reminder from the scheduler. The nurse recalled the scheduler called again on 3/18/25 and indicated the surgeon had not received the Doppler test results yet, so she tried to get it done with a STAT (without delay) order, but it was completed too late and the surgery had to be canceled. She said she checked resident #1's medical record and found the physician's order for the test was processed about a week prior to the scheduled surgery (3/11/25) and was signed off by a nurse as completed. The UM said she checked the records for results and found the test was not actually done, and she knew per physician's orders it should have been completed within 24 to 48 hours before the scheduled surgery, not a week before. She did not explain why the original order she entered was set for eight days (192 hours) before surgery instead of one to two days before. The UM stated, I was in contact with them (surgeon's office) frequently, and there were a lot of pre-op instructions; it got missed and shouldn't have been signed off; we talked about it a lot and in morning meetings. The nurses should have followed up to make sure it was actually done, and that's a lesson learned. Review of the Treatment Administration Record (TAR) included physician's orders for a pre-operative Venous Doppler to be completed 24 to 48 hours before surgery to rule out Deep Vein Thrombosis (blood clot) dated from 3/11/25 to 3/13/25. The order was signed as completed by Registered Nurse (RN) A on 3/11/25 at 11:44 PM, eight days before the scheduled surgery. Another order for a STAT Doppler for pain to the right lower leg was dated 3/19/25 (the day of the scheduled surgery), with a start time of 10:00 AM and signed as completed at 3:45 PM on 3/19/25. In an interview on 4/10/25 at 3:00 PM, RN A explained the process for completion of physician's orders for a Venous Doppler included completion of a handwritten requisition placed in a binder for the technician, and a call to the radiology provider for a scheduled test when the order was entered. The RN said she did not recall entering the order or receiving any information about it from off-going/on-coming report, and she must've signed it off because it was on the TAR and she thought it was completed, but had not actually verified the test was performed. Review of the handwritten radiology provider requisition for a STAT Venous Doppler noted an untimed date of 3/18/25 signed by the South Unit Manager. The technician's signature for exam completion was undated and timed as 9:50 AM. A Progress Note completed by the South Unit Manager dated 3/18/25 at 5:36 PM noted a STAT order for a pre-operative Venous Doppler was obtained that could not be completed STAT, as it was requested at 5:03 PM. The note showed the surgery scheduler had called the facility and the note read, surgery to be re-scheduled. The Radiology Results Report noted resident #1's Venous Doppler exam was completed on 3/19/25 at 8:54 AM, read at 10:38 AM by the Radiologist, and reported to the facility physician at 10:59 AM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In a telephone interview on 4/10/25 at 2:43 PM, with the mobile radiology provider, the Customer Service Representative checked their records and said the only Venous Doppler request for resident #1 from the facility was completed on March 19, 2025 from [name] South Unit Manager at 8:54 AM, and a previous test was done on 2/11/25 at 5:28 PM. She said requests for STAT exams required a two to four hour advance window as long as the request was received by 5:00 PM for same day services. On 4/10/25 at 9:47 AM, in a telephone interview, the orthopedic provider's surgery scheduler said resident #1's surgery was scheduled in advance for 3/19/25. The scheduler explained, she was in frequent contact with the facility during the two weeks prior to surgery and emphasized timeliness of the pre-operative Doppler was required to ensure the surgical procedure was able to be performed. She described the Doppler test was needed within that time frame because additional surgical pre-planning was required in the event the resident had a blood clot. She said their records showed on 3/14/25, the surgeon's nurse called and emailed the facility for a reminder to complete the pre-operative requirements including the Doppler test, and on 3/18/25, she herself spoke to the South Unit Manager and informed her the surgeon had not received the Doppler results yet. On 4/10/25 at 2:30 PM, Licensed Practical Nurse (LPN) B explained Doppler testing was processed by nurses when they entered orders into the computer, completed a handwritten requisition with a face sheet placed in the binder kept at the nurses station, called the radiology provider to schedule the test, and then signed the TAR as completed. The nurse said no further follow up was done by nurses to ensure the order was completed and stated, we assume it gets done. On 4/09/25 at 4:09 PM, the Director of Nursing (DON) conveyed she expected nurses to follow the process to complete physician's orders and pre-operative instructions to ensure residents' care wasn't delayed. The DON said orders were discussed in morning meetings by the clinical team and follow-up was monitored by Unit Managers. She said the nurse shouldn't have signed the TAR for the Doppler order on 3/11/25 because it wasn't actually done. The DON acknowledged resident #1's surgery for 3/19/25 was canceled by the orthopedic provider. On 4/09/25 at 1:25 PM, the North UM stated resident #1 now required another physician's order for antibiotics. She explained, the Wound Care APRN ordered the antibiotics after seeing the resident the previous day. The nurse said she contacted the Infection Preventionist (IP) Advanced Practice Registered Nurse (APRN) who gave orders to continue the oral antibiotic medications until the fixator device was removed. The North UM could not explain why no one at the facility asked the provider about antibiotics for resident #1's right leg infection until today when the surveyor was present for the complaint. An Progress Note dated 4/08/25 noted resident #1 was seen by the IP APRN and treated for leukocytosis (high white blood cell count) and a right lower extremity wound infection which was discussed with a nurse and read, continue antibiotics. Purulent drainage refers to thick, milky discharge that comes out of a wound. It usually means you have infection, so it's important to get prompt medical care. Treatment can prevent cellulitis (skin infection), osteomyelitis (bone infection) and other serious conditions like sepsis, (retrieved from my.clevelandclinic.org on 4/11/2025). (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/10/25 at 2:40 PM, the Director of Nursing (DON) said she checked resident #1's medical records and no wound culture was ever ordered or performed as per the Infectious Disease progress note dated 1/22/25. A wound culture is a test that looks for what type of microorganisms grow from a wound sample to isolate the type of organism that caused the infection. Then the appropriate/effective antibiotics can be ordered to treat the infection, (retrieved on 4/23/25 from www.surgeryencyclopedia.com). On 4/09/25 at 1:45 PM, a joint interview was conducted with the North UM and the IP APRN by telephone. The APRN said he treated the resident since his admission in January 2025 for an infection associated with the external fixator. He explained the resident was at high-risk for serious complications and had already been treated with heavy Intravenous (IV) antibiotics. The APRN said the resident was expected to remain on oral antibiotics until the hardware was removed, but he was not sure why the antibiotics weren't continued after resident #1's surgery was cancelled. He was unaware as facility nurses didn't inform him the antibiotics weren't continued after the surgery was canceled. He confirmed the antibiotics were restarted on 4/09/25, 3 weeks after the surgery was cancelled when the North UM called him for antibiotic orders. He expressed delays in the removal of the device could lead to serious infection and the resident had to remain on preventive antibiotic medications until the device was removed. The APRN explained the orthopedic surgeon wanted the device out and stated, that's the main thing to keep him stable. Review of the Wound Care Specialist's Visit Report dated 2/18/25 noted resident #1's had two new wounds with heavy purulent drainage. The two acute (of abrupt onset) stage IV (deep tissues/muscle, tendon, ligament) pressure ulcers around the fixator pin sites which had developed required debridement. A Visit Report dated 4/08/25 noted the same two wounds still with, moderate purulent drainage and continued wound treatments including antibiotics. In a telephone interview of 4/09/25 at 1:51 PM, the Wound Care APRN recalled resident #1 had two pressure wounds around the pin sites which were caused when the pin clamps with pressure against the leg/skin. She conveyed the resident's morbid obesity contributed to this pressure on his skin. The APRN did not recall obtaining a wound culture to determine what type of treatment was needed. She stated she last saw the resident on 4/08/25 when she asked staff to contact the IP APRN to restart the antibiotics. Review of the Psychiatric Mental Health Nurse Practitioner progress note dated 4/02/25 revealed resident #1 required assessment for depression and anxiety and on the last visit of 3/19/25 he was noted with agitation and frustration. The note read, prior to last visit, patient was doing well. No mood swings and behaviors noted. No other concerns were noted. During last visit, patient was agitated due to situation. Patient was agitated and anxious. A Progress Note completed by the South UM on 4/02/25 noted a discussion with resident #1 about scheduling of his surgery. The note indicated the resident had not received any calls to re-schedule, and he agreed to a joint call with the scheduler the next day. In an interview on 4/09/25 at 4:09 PM, the DON acknowledged resident #1's surgery had not yet been rescheduled but said the facility continued attempts to have it rescheduled. (continued on next page)

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	105671	A. Building B. Wing	04/10/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In a telephone interview with the resident's attending physician on 4/10/25 at 5:40 PM, the physician said he last saw him the day before. The physician said when he saw the resident, he was surprised his surgery had still not been done. He said the facility had not notified him the surgery had been canceled and was not aware the facility had not completed the required pre-operative Doppler test. The physician explained he expected nurses to notify him of surgery cancellations, changes in status, and to follow physician orders to get testing done so residents could get what was needed as he was responsible for the resident's care. The physician stated, I told them initially it will get worse; he really needs to have the fixator removed; he is suffering. Review of the facility's standards and guidelines titled, Diagnostic Services and dated 3/02/19 noted the facility was responsible for the timeliness of services whether provided by the facility or outside resources to ensure residents' needs were met for proper diagnosis and treatment. Review of the Facility assessment dated as reviewed on 12/23/24, 1/14/25, and 3/25/25 noted the facility provided ongoing training for all staff consistent with their expected roles and resident characteristics. Minimum content included identification of resident changes in condition, effective communication, and Abuse, Neglect, and Exploitation with readily accessible resources to all staff at nurses offices and nursing stations.

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to timely assist and provide post-operative follow up transportation for 1 of 3 residents reviewed for Administration, of a total sample of 4 residents, (#1). Findings: Resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on 1/03/25 with diagnoses including subsequent encounter of right knee dislocation/reduction, type 2 diabetes mellitus, adjustment disorder with depressed mood, and anxiety disorder. Additional diagnoses after admission to the facility included leukocytosis (high white blood cells/infection response), right leg wound infection, right Achilles (ankle) tendon (connects muscle to bone) contracture (tightening), and right peroneal (lower leg) nerve palsy (paralysis/weakness). The Minimum Data Set Comprehensive Admission Assessment with an Assessment Reference Date of 1/09/25 noted during the look-back period, resident #1 scored 15 out of 15 on the Brief Interview for Mental Status that indicated he was cognitively intact, and 0 out of 30 on the Staff Assessment of Resident Mood used to identify signs of depression or mood impairment, and there were no behavioral symptoms or rejections of evaluation or care. The resident had functional Range Of Motion (ROM) limitations to the lower extremity (hip, knee, ankle, foot) that interfered with daily functions and placed him at risk of injury; he did not walk and was dependent on staff to complete Activities of Daily Living (ADLs) including positioning and transferring in and out of bed. Resident #1 had care plan focuses for staff assistance with ADL care and mechanical lift dependence, history and risk of falls with injury with an intervention to anticipate and meet the resident's needs as needed, right leg surgical wounds/fixator, and 4 staff required assisted transfers. Resident #1 had no care plan focus for discharge home until 4/09/25 with an intervention to, make arrangements with required community resources to support independence post-discharge (specify-home care, PT/OT/ST [Physical, Occupational, Speech Therapy], MD [Medical Doctor], wound nurse, etc.) On 4/09/25 at 11:01 AM, resident #1 was lying in bed in his room. An external fixator device with surgical pins was observed attached to the resident's right leg. The resident explained he was very upset that the facility caused him to miss follow-up appointments after surgery in January 2025. He said facility staff told him he would have to pay for the transportation services because it was too costly for the facility to cover. The resident said he had to make his own arrangements for stretcher services to and from the doctor's office and to his scheduled surgery. He explained the surgery to remove the hardware in his right leg was scheduled for 3/19/25 but was ultimately canceled because required pre-operative testing wasn't completed by the facility. On 4/09/25 at 2:01 PM, the South Unit Manager said she was very involved with and assisted resident #1 with his follow-up appointments. She recalled in January 2025, there were issues about who was responsible for the transportation cost, and some appointments were canceled and re-scheduled. (continued on next page)

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 4/10/25 at 9:47 AM, the orthopedic provider's scheduler said she was the primary point of contact with the facility and the orthopedic physician. She said resident #1 was supposed to have surgery to remove the hardware from his previous surgery from December 2024. She confirmed resident #1 was supposed to have the surgery for removal nine to twelve weeks after the first surgery. The scheduler said resident #1 had missed some appointments due to transportation issues including one on 3/06/25 for a nerve evaluation, and on 1/17/25 where they were going to put the resident in a temporary immobilizer. She checked the medical records and said the resident missed his first post-surgical follow-up appointment on 1/17/25, and the next appointment on 3/06/25 due to lack of transportation. She confirmed he had no date rescheduled for the surgery he needed to remove the hardware at that time. A Infectious Disease Progress Note dated 1/22/25 noted resident #1 had missed his orthopedic follow up appointment and read, Needs follow-up with surgeon ASAP. Review of the medical record noted a form with instructions for a surgical follow-up appointment set for 1/17/25 at 1:45 PM. On 4/09/25 at 12:05 PM, the Medical Records Coordinator confirmed she was responsible for outside appointment transportation arrangements. She explained the resident required special stretcher transportation and recalled the facility had paid for one re-scheduled ride, but she wasn't sure about his surgery transportation. She said the facility used a handwritten form filled out by nurses then given to her for transportation appointment requests. She said part of her responsibility was to verify the payer source and any insurance benefits. She recalled the cost for resident #1's stretcher transportation was approximately $3,000 per occurrence, that he didn't have benefits to cover it, and any cost to the facility had to be approved by the Nursing Home Administrator (NHA). Review of resident #1's Appointment Reminder form dated 1/16/25 and signed by the Medical Records Coordinator for a 1/17/25 appointment at 1:45 PM, showed handwritten notes that read, Transport not scheduled; [provider name] to reschedule for 1/30/25. The form dated 1/28/25 for a 1/30/25 appointment at 8:30 AM noted the Responsible Party handwritten as self. An undated form for a 3/04/25 appointment at 9:00 AM noted the Responsible Party handwritten as [resident's name]. On 4/10/25 at 12:02 PM, the Medical Records Coordinator said she did not have any other forms nor did she make arrangements for the resident's appointments on 3/06/25 or 3/19/25. On 4/09/25 at 12:58 PM, a request was sent to the transportation provider for resident #1's transportation information. On 4/11/25, the transportation company provided documentation of an unpaid bill to the facility for the resident's services on 1/30/25 in the amount of $3,484.16, and for services provided on 3/04/25 at the resident's request that was paid by a charitable organization. No other requests from the facility for resident #1's transportation were documented in the record. A Progress Note dated 2/22/25 by the Social Services Discharge Planner noted a plan was in place for resident #1's discharge home on 3/04/25. The note read, Patient asked if transportation would be taking him to his appointment and then home. I explained that upon discharging, that family is responsible for setting up transportation and paying for transportation. (continued on next page)

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Avante at Melbourne Inc	1420 South Oak Street Melbourne, FL 32901

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/10/25 at 9:04 AM, the Discharge Planner recalled resident #1 was previously planned for discharge home around the end of February 2025. She explained the discharge was canceled because the resident didn't want to leave until after his surgery and the current plan was for discharge home on 5/01/25. On 4/09/25 at 2:26 PM, the Nursing Home Administrator (NHA) provided an unpaid financial agreement the facility signed on 1/30/25 with the transportation provider for resident #1's transportation services on 1/30/25. The NHA conveyed the document was completed by the previous NHA and she did not provide any information or documents of financial responsibility for transportation to appointments on 1/17/25, 3/04/25, 3/06/25, or 3/19/25. The NHA acknowledged transportation to resident #1's outside appointments was the responsibility of the facility and the resident would not pay for the transportation himself. Review of the facility's standards and guidelines titled Diagnostic Services and dated 3/02/19 noted the facility was responsible for the timeliness of services whether provided by the facility or outside resources to ensure residents' needs were met for proper diagnosis and treatment. Review of the Facility assessment dated as revised 12/23/24, 1/14/24, and 3/25/24 noted the facility offered and provided care to residents with musculoskeletal disorders based on the resident's needs and the resident's chart was reviewed prior to admission to the facility.