

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/28/2025
NAME OF PROVIDER OR SUPPLIER  Avante at Melbourne Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide intravenous (IV) care and services per standards of practice and plan of care for 3 of 3 residents reviewed for IV care, (#4, #5, and #6), of a total sample of 9 residents. Findings: A midline catheter is put into a vein by the bend in the elbow or the upper arm .a midline catheter may allow you to receive long-term intravenous (IV) medicine or treatments, (retrieved on 8/08/25 from www.drugs.com). A peripherally inserted central catheter (PICC) is a long, thin tube that's inserted through a vein in the arm. The tube is passed through to the larger veins near the heart. It is often referred to as a PICC line. A PICC line gives your healthcare professional access to the large central veins near the heart. It's generally used to give medicines or liquid nutrition, (retrieved on 8/08/25 from www.mayoclinic.org). 1. Resident #4 was admitted to the facility from an acute care hospital on 7/16/25 with diagnoses that included cellulitis of the left lower limb, sepsis due to Escherichia coli, type 2 diabetes mellitus and acquired absence of the left foot. Resident #4 had a Midline IV catheter in her right upper arm for administration of IV antibiotics. The physician's orders read, resident #4 received 1-gram (gm) Meropenem solution intravenously every 8 hours and would continue to receive it for nine days for cellulitis. The physician's orders for the midline were to change the dressing to the insertion site (right arm) every seven days and as needed using sterile technique. On 7/28/25 at approximately 10:00 AM, resident #4 was sitting up in bed. A midline IV with transparent dressing on resident #4's right upper arm was undated. Resident # 4 stated the midline dressing had not been changed since coming from the hospital. A review of the Treatment Administration Record (TAR) for July 2025 showed no documentation of dressing changes since 7/18/25. (Photographic evidence provided). 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included encounter for surgical aftercare, venous insufficiency, cardiac arrest, seizures, major depressive disorder and muscle weakness. Resident #5 had a PICC Intravenous IV line in his left upper arm for administration of antibiotics. The physician's orders showed resident #5 received 1 gram of Ertapenem Sodium Solution Reconstituted intravenously daily for infection, and he would continue to receive it until 7/30/25. There were physician orders to change the PICC line dressing every seven days and as needed using sterile technique. On 7/28/25 at approximately 10:20 AM, resident # 5 was observed sitting up at the side of his bed and spoke about the IV dressing on his left upper arm. He said the IV was inserted in the hospital and had never been changed since he was admitted to the facility. On examination of the site, the date on the dressing was marked as 7/10/25. A total of eighteen days had passed since the dressing had been changed. (Photographic evidence provided). 3. Resident # 6 was admitted to the facility on [DATE] from the hospital and had diagnoses which included Wernicke's encephalopathy (brain dysfunction related to vitamin deficiency), chronic obstructive pulmonary disease, cellulitis of the right and left lower leg, and myositis (inflammation of the muscles). Resident #6 had a PICC IV line in his right arm for administration of IV antibiotics. The physician's orders showed resident #6 received 500 milligrams (mg) Daptomycin Intravenous Solution Reconstituted intravenously daily and would continue to receive it until 7/31/25. The physician also ordered the PICC line dressing should be changed every seven days and as needed using sterile technique. On 7/28/25 at 10:30 AM, resident # 6 was observed in the common area sitting in his wheelchair. He spoke about his IV dressing, which was a little loose. The resident said he had to constantly press it down so that it would not fall off. He did not remember when it was last changed, and the date was illegible. Another nurse working nearby was unable to read what date was written on the dressing and said she could not say for sure. The nurse explained that IV dressings should be changed weekly or per the doctor's orders. The assigned nurse looked at the dressing and verified it needed to be changed. A review of the Medication Administration Record (MAR) revealed the last date documented by nurses of a dressing change was on 7/17/25, eleven days since the dressing was changed. (Photographic evidence provided). On 7/28/25 at 11:00 AM the facility's North Wing Unit Manager (UM) assisted as the Director of Nursing was unavailable. The North Wing UM confirmed all the findings for resident #4, #5 and #6's IV dressings. She looked at all three dressings and agreed that they should have been changed. She said that the expectation was for the nurses to follow the physician's orders for dressing changes and that she would take care of it. The Nursing Home Administrator along with the Regional Nurse consultant stated that it was the expectation that the dressings be changed per physician's orders. The Facility's Policy on PICC/Midline Dressing Change revised</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain accurate documentation for Intravenous (IV) catheter dressing change for 1 out of 3 sampled residents with IV lines, (#5), of a total sample of 9 residents. Findings: Resident #5 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included encounter for surgical aftercare venous insufficiency, cardiac arrest, seizures, major depressive disorder and muscle weakness. Resident #5 had a peripherally inserted central catheter (PICC) IV line in his left upper arm for administration of antibiotics. The physician's orders indicated resident #5 received 1 gram of Ertapenem Sodium Solution Reconstituted intravenously daily for infection and he would continue to receive the medication until 7/30/25. The physician also ordered the PICC line dressing to be changed every seven days and as needed using sterile technique. A PICC IV is a long, thin tube that's inserted through a vein in the arm. It is often referred to as a PICC line. The tube is passed through to the larger veins near the heart. A PICC line gives your healthcare professional access to the large central veins near the heart, usually to give medication or liquid nutrition, (retrieved on 8/08/25 from www.mayoclinic.org). On 7/28/25 at approximately 10:20 AM, resident #5 was alert and oriented, sitting up at the side of his bed. He spoke about the dressing on his left upper arm and explained it was inserted in the hospital. Resident #5 said the IV dressing had not been changed since before he was admitted to the facility. On examination of the site, the date on the dressing was marked as 7/10/25. A total of eighteen days had passed since the dressing had been changed. (Photographic evidence provided). A review of the Treatment Administration Record (TAR) showed that nurses documented that the PICC IV-line dressing was changed on 7/13/25, 7/20/25 and 7/27/25, even though the dressing itself had a date of 7/10/25. On 7/28/25 at 11:00 AM, the North Wing Unit Manager (UM) said that the facility expectation was for nurses to follow the physician's orders for dressing changes. The Nursing Home Administrator along with the Regional Nurse consultant confirmed it was the expectation that dressings be changed according to physician order. On 7/28/25 at 12:20 PM, the North Wing UM acknowledged the documentation in the TAR for resident #5's PICC line dressing changes. She identified the two nurses by their initials who documented the dressing was changed when in fact it was not. Licensed Practical Nurse (LPN) A documented that the dressing was changed on 7/13/25 and 7/20/25 and LPN B signed that the dressing was changed on 7/27/25. The North Wing UM stated she could not answer for those nurses, but said it was unacceptable to sign that treatment was done when it was not. On 7/28/25 at 1:17 PM, in the presence of the North Wing UM, LPN B stated she remembered she hung the IV medication for resident #5 but did not change the dressing. She explained that she had worked in the facility for about three years and knew that IV dressings should be changed every seven days. LPN B further explained the TAR would prompt the nurses on the day the dressing should be changed for them to document it was changed but was unable to say why she documented it had been done when it had not. The UM said that it was the expectation for nurses to document with accuracy in the medical record. Two attempts were made to contact LPN A, without result. The Facility's Policy on PICC/Midline Dressing Change revised 1/20/25 indicated it was the facility policy to change PICC, and midline IV dressings weekly or if soiled in a manner to decrease potential for infection, and /or cross-contamination. The document detailed physician's orders would specify the type of dressing and frequency of changes. In section 24, the policy indicated nurses were to document the procedure upon completion of the dressing change. The facility did not have a policy in regard to accuracy of documentation.</p>		