

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Avante at Orlando Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 North Semoran Boulevard Orlando, FL 32807	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide medications as ordered by the prescriber, to meet the needs of 4 of 4 residents sampled for medication administration, (#1, #2, #3, and #4). Findings: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included an unspecified fracture of the upper end of the right humerus, an acute embolism and thrombosis of the deep veins of the right upper extremity, type 2 diabetes mellitus (T2DM), and an unspecified mood disorder. Review of the most recent assessment dated [DATE], using the Brief Interview for Mental Status (BIMS), showed that resident #1 was cognitively intact. On 6/29/26 at 9:21 AM, resident #1 said that often while at the facility, she did not receive her prescribed medications and had asked to be sent to the hospital on 3/02/26. She explained she did not receive her insulin, blood pressure medication, blood-thinning medication, and other medications. She said staff told her, We don't have it. A review of the Medication Administration Record (MAR) showed that on 3/01/26, the following physician ordered medications were not administered: Amlodipine 10 milligrams (mg) once daily in the morning for hypertension. Enoxaparin sodium injection, prefilled syringe 80 milligrams/0.8 milliliters (mg/ml), one intramuscular injection daily for blood clots. Fluticasone propionate nasal spray 50 micrograms (mcg) per actuation, two sprays in each nostril once daily for allergies. Insulin deglu[DATE] units per milliliter (units/ml), 50 units subcutaneously at bedtime. Lisinopril 20 mg once daily in the morning for hypertension. Naltrexone hydrochloride 50 mg once daily for alcohol or opioid use disorder. Sertraline hydrochloride oral tablet, prescribed as 100 mg (MAR instructions Give 1.5 mg once a day appear incorrect), for anxiety. Thiamine hydrochloride 100 mg once daily. Albuterol sulfate hydrofluoroalkane (HFA) inhalation solution 108 micrograms (mcg) (90 mcg base) per puff, two puffs every four hours as needed for wheezing or shortness of breath. 2. Resident #2 was admitted to the facility on [DATE] with diagnoses that included lumbar spinal stenosis, postoperative after-care following nervous system surgery, low back pain, and cauda equina syndrome (compression of nerves in spinal cord). A review of the facility's grievance logs showed that resident #2's daughter reported in a care plan meeting her mother was not receiving her pain medication. The investigation showed that staff believed the resident did not have a prescription from the hospital. However, the medical record included a hospital prescription dated 5/01/26 for oxycodone-acetaminophen (Percocet) 5-325 mg, with instructions to take one tablet every four hours as needed, with a quantity of 12 tablets. A review of the May 2026 MAR showed the resident did not receive the medication until 5/04/26 at 9:29 PM, almost two days after admission. 3. Resident #3 was admitted on [DATE] with diagnoses that included sequelae following unspecified cerebrovascular disease, type 2 diabetes mellitus, end-stage renal disease (ESRD), dependence on renal dialysis, and major depressive disorder. The most recent BIMS assessment on 6/09/26 revealed resident #3 was cognitively intact. On 6/29/26 at 9:58 AM, resident #3 said, They ran out of my medications Cymbalta and Wellbutrin last week. A review of the June 2026 MAR showed multiple missed doses of: Wellbutrin (bupropion) 300 mg once daily for depression Cymbalta (duloxetine) 60 mg twice daily for depression Sevelamer carbonate 800 mg three times daily for hyperphosphatemia Some entries were marked as refusals, and others referred to (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing notes. Most nursing notes for Sevelamer stated on order. Review of resident #3's current care plan did not show behavioral refusals of medication or preferences not to take medications on dialysis days. There were no nursing notes showing communication to the physician about refusals or preferences. 4. Resident #4 was admitted on [DATE] with diagnoses that included muscle wasting and atrophy, obstructive sleep apnea, and type 2 diabetes mellitus. The BIMS assessment on 6/26/26 showed the resident was cognitively intact. On 6/29/26 at 5:00 PM, resident #4 said, When I first came, they were missing my Xanax. I came Thursday and they said they had no Xanax. A review of the June MAR showed resident #4 missed four doses of Xanax (alprazolam) 0.25 mg twice daily for anxiety. The resident received the first dose on 6/27/26 at 9:00 PM, even though the medication was ordered on 6/25/26 at 9:00 PM. On 6/29/26 at 6:11 PM, in a joint interview, Licensed Practical Nurses (LPN)s A, B, and C explained that when new admissions arrived in the evening, orders sent to the pharmacy often did not arrive until the 2:00 AM delivery or the next day. They said the ordering system was slow because they had to send orders by email. They said the pharmacy often reported not receiving the orders, and delays occurred when residents did not arrive with their hospital prescriptions. LPN C said resident #4's Xanax prescription was sent on 6/25/26 and she showed a text message documenting communication with the physician. She said the pharmacy reported that it never received the order. She also said there were no Xanax 0.25 mg tablets in the facility's Pyxis machine. LPN A added that residents sometimes called 911 to return to the hospital in order to receive their medications. On 6/29/26 at 6:25 PM, during a joint interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and [NAME] President of Clinical Quality Operations, leadership acknowledged that resident #1 did not receive medications on 3/01/26. They said LPN D was the assigned nurse that day and no longer worked at the facility. They were unable to contact the nurse for additional information. The ADON said they did not remember resident #1, and the DON said they would not have known the resident because they had not been employed in March and had only been working at the facility for less than two months. The ADON said for resident #2, prescriptions were sent on 5/02/26, but the pharmacy said they did not receive them. The ADON said for resident #3, the dialysis center supplied Sevelamer 800 mg, and the center was not sending it at the time when nurses documented on order. They said the missed doses of Wellbutrin and Cymbalta were due to the resident refusing them on dialysis days. Regarding resident #4, they said the delay was similar to resident #2's situation and confirmed that LPN C showed evidence that orders were sent to the pharmacy on 6/25/26. The NHA and DON said they identified pharmacy issues during their daily report in the last week of May and contacted the pharmacy. They said the pharmacy did not give a clear response, and the orientation visit was still pending. They said the issue was still in progress. The facility's Pharmacy Services Policy, issued and revised 3/02/19, indicated the facility would provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, administration, and disposal of all drugs and biologicals to meet the needs of each resident.		