STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105310	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Ormond Beach, Inc	170 N Kings Road Ormond Beach, FL 32174

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30905 Based on observations, resident and staff interviews, and a review of policies and procedures, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable living environment, by failing to 1) Keep resident care equipment functioning for one resident (#8) whose bed controls did not work, and 2) Keep the rooms clean for four (Residents #54 #39, #302, #59) of five residents receiving enteral nutrition, in a total survey sample of 36 residents and a facility census of 102. The facility failed to clean and maintain the enteral nutrition (tube feeding) pumps and poles, walls, floors and floor boards surrounding the air conditioning (AC) units and the AC units themselves in four resident rooms. These concerns could negatively impact residents' enjoyment of their environment. A clean living environment is necessary to reduce the spread of infection and promote the highest well-being of the facility's residents. The findings include: A tour of the facility was conducted on 03/18/2025 at 10:30 AM with the following findings: In room [ROOM NUMBER]C, Resident #54's enteral nutrition pump and pole were observed with dried-on enteral food product on them. (Photographic evidence obtained) In room [ROOM NUMBER]A, Resident #83's floor had a large rust stain on the tile floor under the AC. (Photographic evidence obtained) At 10:43 AM, Resident #8 stated her bed did not rise when the remote control was pressed. She was asked to press the button on the remote control and nothing happened. In room [ROOM NUMBER]C, Resident #52's wall around the AC unit was in disrepair. The paint had bubbled up and cracked around the unit. (Photographic evidence obtained) In room [ROOM NUMBER], Resident #30's AC unit had dirt and black biological growth on the vent and a small pile of sand under the AC unit. The unit cover was broken and hanging away from the wall. (Photographic evidence obtained) In room [ROOM NUMBER], Resident #78's AC unit had black biological growth under the AC unit. (Photographic evidence obtained) (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In rooms 210B and 102A and B, Residents #39, #302, and #59's enteral nutrition pumps and poles were observed with dried-on, encrusted enteral food product on them. (Photographic evidence obtained) A review of Resident #54's 03/20/2025 physician's order revealed: Enteral Feed Order every shift. Isosource 1.5, 45 ml (milliliters)/hour (hr.) x 20 hours. On at 2:00 PM, off at 10:00 AM. (Copy obtained) A review of Resident #39's 03/20/2025 physician's order revealed: Enteral Feed Order every shift. DiabetiSource 1.2 at 45 ml/hr. x 20 hours. On at 2:00 PM, off at 10:00 AM. (Copy obtained) A review of Resident #302's 03/20/2025 physician's order revealed: Enteral Feed Order every shift for nutrition. DiabetiSource 1.2 at 70 ml/hr. continuous. (Copy obtained) A review of Resident #59's 03/20/2025 physician's order revealed: Enteral Feed Order every shift. Isosource 1.5 at 60 ml/hr. x 24 hours. (Copy obtained) During a follow-up tour on 03/20/2025 at 10:33 AM with the Maintenance Director, he stated the staff were trained to enter work orders into the electronic building management system the facility used to track maintenance requests and work orders. The following observations were made: In room [ROOM NUMBER]C, Resident #54's enteral nutrition pump and pole were observed with dried-on enteral nutrition product on them. In room [ROOM NUMBER]A, Resident #83's floor had a large rust stain on the floor under the AC unit. Resident #83 stated when it rained, the ceiling leaked in her room. The maintenance director stated sometimes the drip pan on the AC unit would leak, and the pan was rusty so the water was a brown color that stained the floor. Resident #8's bed did not rise when the remote control was pressed. The maintenance director laid down on the floor, so he could see under the bed. He tried to fix the problem, but then stated he would have to take the bed out of the room to work on it. In room [ROOM NUMBER]C, Resident #52's wall around the AC unit was in disrepair. The paint had bubbled up and cracked around the unit. In room [ROOM NUMBER], Resident #30's AC unit had dirt and black biological growth on the vent and a small pile of sand under the AC unit. The unit cover was broken and hanging away from the wall. The Maintenance Director took the cover and re-attached it to the unit. In room [ROOM NUMBER], Resident #78's AC unit had black biological growth underneath of it. In rooms 210B and 102A and B, Residents #39, #302, and #59's enteral nutrition pumps and poles were observed with dried-on, encrusted enteral food product on them. All of the above identified concerns were confirmed with the Maintenance Director during the follow-up tour. He reviewed the work orders in the electronic building management system on his phone and stated he had not been notified of any of the problems identified. He confirmed that any staff member could enter a work order in the system. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Supervisor of Housekeeping on 03/20/2025 at 11:02 AM, she was informed of the above identified concerns for housekeeping. She left the interview to inspect the rooms. She returned to the interview at 12:10 PM and confirmed that the enteral nutrition product had been stuck to the poles and pumps for some time. She stated, It's like glue. I have to scrape it off when it dries on. She confirmed it was the responsibility of the housekeeping department to clean the enteral food product off the poles when it spilled/splattered. During an interview with the Administrator at 03/20/2025 at 11:20 AM, she stated the maintenance of the AC units and the repair of the walls around them should be done. There was a plan for building renovations to begin in May 2025, but the ongoing maintenance should still be done. The staff were to enter the identified problems in the electronic building management system so the Maintenance Director would see that there was a work order that needed to be completed. A review of the facility's policy and procedure titled Preventative Maintenance Program (implemented 2016, revised 01/05/2024) revealed: A preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2. The Maintenance Director shall assess all aspects of the physical plant to determine if preventative maintenance is required. Required preventative maintenance may be determined from manufacturer's recommendations, maintenance requests, grand rounds, life safety requirements, or experience. 4. The Maintenance Director shall develop a calendar to assist with keeping track of all tasks. 5. Documentation shall be completed for all tasks and kept in the Maintenance Director's office for at least three years. (Copy obtained) A review of the facility's policy and procedures titled Routine Cleaning and Disinfection (Undated), revealed: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. 4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high tough areas to include: IV poles. 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. (Copy obtained)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30905 Based on kitchen food service observations, staff interviews, facility document review, and facility policy and procedure review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety, by failing to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. The facility failed to ensure that the dietary staff practiced proper procedures for hand hygiene, disposable glove use, and proper sanitation practices when cleaning the meat slicer in the kitchen. Appropriate hand hygiene, food handling, and sanitation is important in health care settings serving nursing home residents due to the risk of serious complications from foodborne illness as a result of their compromised health status. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: During the initial kitchen tour on 03/17/2025 at 10:44 AM, the dish machine was observed with the Certified Dietary Manager (CDM). Dietary Aide G tested the machine with a test strip. The dish machine was a high-temperature machine. The machine was operated through both cycles four times, and the temperature gauge for the rinse cycle did not reach 180' F (Fahrenheit) during any of the cycles. The wash cycle temperature was 160' F. The rinse cycle only reached 173' F. Dietary Aide G stated the required temperature should be 180' F. During an interview with the CDM at 10:50 AM, she stated the dish machine was working fine this morning, and she did not understand why it was not reaching the required temperature now. She confirmed the rinse cycle should reach 180' F. During a second tour of the kitchen on 03/19/2025 at 11:20 AM, the lunch meal service was observed. From 11:20 AM to 11:40 AM, Dietary [NAME] E, the evening cook, was observed washing the meat slicer off with soapy water and a rag. She did not remove any parts of the slicer. She finished cleaning it, wiped it off, and covered it with a plastic bag. She then rolled it into the dry storage room and returned to the kitchen to assist with the lunch meal service. On 03/19/2025 at 12:00 PM, Dietary [NAME] E was observed changing gloves without washing her hands. She was preparing pureed food in a blender. During an interview with Dietary [NAME] E on 03/19/2025 at 1:43 PM, she expressed that she would need to use the translator on her phone because her first language was Russian. She used a translator to understand the questions she was being asked. She stated she remembered changing gloves when she was preparing the pureed beef in the blender. She confirmed that she did not wash her hands in between. She confirmed she had been trained to wash her hands between glove changes. The CDM was standing nearby and nodded her head in agreement. On 03/19/2025 at 12:10 PM, Dietary [NAME] F was observed changing gloves without washing her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Dietary [NAME] F on 03/19/2025 at 1:38 PM, she stated she had gravy dripping off of her glove. She did not want to walk all the way across the kitchen to take her gloves off and wash her hands, so she just took the dirty glove off, discarded it and donned a new pair of gloves. She did not want to leave the tray line to go wash her hands, so she just continued serving the meals. On 03/19/2025 from 1:20 PM to 1:41 PM, observations of the dish washing operations were made. Dietary Aide G was observed donning gloves and then began washing off dirty dishes and stacking them in dish machine racks. She loaded the trays into the dish machine and ran them through. She then pulled the tray of clean dishes out of the machine and went back over to the dirty side of the dish room and continued to rinse dirty dishes from the lunch meal service. At 1:24 PM, she went to the clean side of the dish room and pulled the trays out of the dish machine. She did not change gloves in between or wash her hands. She then proceeded to unload the clean dishes from the racks placing them on a cart with other clean dishes. After she finished unloading the clean dishes, she returned to the dirty dishes and continued to rinse and load them in racks. Another aide brought over two large orange trays and asked her to run them through the machine. She took them and ran them through. She then removed them from the machine with the same gloves on and put them up against the wall to drip dry. She returned to the dirty side and continued to rinse and rack the dirty dishes. At 1:28 PM, she returned to the clean side and pulled a rack of clean dishes out of the machine. She continued to wash the dishes going back and forth between the clean and dirty side without changing gloves or washing her hands. During an interview with the CDM on 03/19/2025 at 1:38 PM, she observed Dietary Aide G washing dishes without stopping to change her contaminated gloves and wash her hands. The CDM confirmed that the aide should not be going back and forth between the dirty and clean side without washing her hands and changing her gloves. She was then asked to observed the meat slicer in the dry storage room. She went to the meat slicer and removed the plastic cover. The food support plate and underside of the blade were encrusted with food debris. (Photographic evidence obtained) The CDM confirmed that the meat slicer was still not clean. At 1:51 PM, the CDM provided the policy and procedure and trainings for the dietary staff on hand washing and glove use. She was informed of the observations during the lunch meal service of Dietary [NAME] F not changing gloves when required (moving from one task to another) without washing hands in between. She confirmed that she should wash her hands between glove changes. A review of the Food and Nutrition Services In-Services sign-in sheet revealed that Dietary Cooks E and F, and Dietary Aide G received training on 12/02/2024 on hand hygiene. (Copy obtained) A review of the manufacturer's specifications for cleaning the meat slicer revealed: Cleaning and Sanitizing the Slicer: 3. Use a clean cloth to remove all coarse residual food and liquids from the slicer surfaces. Sanitize all the removable parts and the slicer. 10. In a clean basin or sink, in a solution of clean warm water and correctly diluted sanitizing solution, soak and wash the removable parts. Remove the parts form the basin or sink and allow them to air dry. 11. Wipe the slicer with correctly diluted sanitizing solution. The slicer shall be cleaned and sanitized at intervals to comply with national state and/or local health codes. (Copy obtained) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's procedure for properly cleaning a food slicer (Undated) revealed: To properly clean a food slicer, disassemble it, wash all parts with hot, soapy water, rinse thoroughly, and sanitize with a food-safe solution, then dry all components before reassembling. 2. Disassembly: Remove removable parts: Disassemble the slicer by removing the blade, carriage, food pusher, and any other removable parts. 3. Cleaning: Wash with hot, soapy water: Wash all disassembled parts with hot soapy water, using a soft-bristled brush to remove any stubborn food particles. Clean the blade thoroughly, paying attention to both sides and any crevices. Ensure the carriage is thoroughly cleaned to remove any residue or buildup. After washing, sanitize all parts with a food-safe sanitizer according to the manufacture's instructions. Rinse all parts thoroughly with clean water to remove any sanitizer residue. Dry all parts thoroughly. Clean after each use. Regularly clean the slicer after each use to prevent food buildup and bacterial growth. (Copy obtained) A review of the facility's policy and procedure titled Infection Control - Food Handling (issued 03/02/2019, revised 03/02/2019) revealed: 1. Food staff are to wash hands when: before putting on gloves; when changing tasks, after handling soiled dishes, utensils and equipment. 4. Single use gloves are not to be used for more than one task. Change gloves and perform hand hygiene between tasks. (Copy obtained)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50369 Based on observations, interviews, and reviews of the facility's Infection Control Program and Hand Hygiene policies, the facility's staff failed to offer or assist residents with hand hygiene before meals for five (Residents #66, #63, #102, #57, #29) of five residents who received meal trays and were unable to perform hand hygiene independently in a manner to prevent cross contamination. The findings include: On 03/17/2025 at 12:20 PM, an observation was made of lunch meals served in the south dining room. The staff was observed using hand hygiene before serving trays to residents but none of the residents were offered hand hygiene before their meal was served. On 03/19/2025 at 12:14 PM, an interview was conducted with Resident #66. When asked, she stated she was not offered hand hygiene before meals. Her roommate, Resident #102, a new admission on 03/18/2025, stated she was not offered hand hygiene either. On 03/19/2025 at 12:18 PM, an observation was made of lunch meals served in the north dining room. The staff was observed using hand hygiene before serving trays to residents but none of the residents were offered hand hygiene before their meal was served. On 03/20/2025 at 12:10 PM, Resident #57 was asked whether she was offered hand hygiene before meals. She stated it had never been offered. On 03/20/2025 at 12:12 PM, Resident #29 was asked whther she was offered hand hygiene before meals. She stated hand hygiene had not been offered to her before any meal. On 03/20/25 at 12:21 PM, Certified Nursing Assistant (CNA) A was interviewed. When asked about resident hand hygiene before meals, she stated she did ask the residents about hand hygiene before mealtime most of the time. On 03/20/25 at 12:26 PM, Therapist B was interviewed. When asked about hand hygiene for residents before meals, she stated it was not offered but should be. On 03/20/25 at 12:27 PM, CNA C was interviewed. When asked about hand hygiene for residents before meals, she stated she would usually wash the residents' hands before serving them. On 03/20/2025 at 12:32 PM, a hand hygiene policy for residents was requested from the Director of Nursing. On 03/20/2025 at 1:46 PM, a hand hygiene policy for residents was requested from the Administrator. On 03/20/2025 at 2:40 PM, Resident #63 was asked if she was offered hand hygiene before her meals. She stated no, she could not do it herself and needed assistance with the task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/20/2025 at 2:45 PM, the facility's policy and procedure titled Activities of Daily Living (ADLs) - Maintain Abilities (issued: 3/2/19, revised: 3/2/19) was provided for review. It contained no specific language for resident hand hygiene before meals; however, paragraph number three read: The facility will provide care and services for the following activities of daily living: a: Hygiene - bathing, dressing, grooming, oral care, and hand hygiene. (Photographic evidence obtained) On 03/20/2025 at 3:09 PM, an interview was conducted with the Director of Nursing (DON) regarding hand hygiene for residents before meals. When asked about the process for hand hygiene before meals, she stated the ADL (activities of daily living) policy was what they used for this procedure; there was no separate policy for mealtime hand hygiene. She stated, Staff is expected to offer the resident hand hygiene and assist dependent residents with hand hygiene before meals. When asked if she completed any surveillance for hand hygiene for residents, she stated she had not.