STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105333	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at MT Dora, Inc	3050 Brown Ave Mount Dora, FL 32757

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observation, interview, and record review, the facility failed to ensure respiratory care services were provided consistent with professional standards of practice for oxygen administration for 1 of 3 residents, Resident #97, reviewed for respiratory care. Findings include: During an observation on 07/08/2024 at 10:53 AM, Resident #97 was lying in bed with a nasal cannula intact in their nares and the oxygen concentrator was administering oxygen at 2 liters per minute (L/min.). (Photographic evidence obtained) During an observation on 07/09/2024 at 8:51 AM, Resident #97 was lying in bed with a nasal cannula intact in his nares and the oxygen concentrator was administering oxygen at 2 L/min. During an observation on 07/09/2024 at 12:40 PM, Resident #97 was lying in bed. The nasal cannula was intact in his nares and the oxygen concentrator was administering oxygen at 2 L/min. Review of the medical record showed that Resident #97 was admitted on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), pleural effusion, kidney failure, and chronic kidney disease Stage 3B. Review of the physician's order dated 06/07/2024, read, Oxygen continuous at 3 liters/min [liters per minute] via NC [nasal cannula]. Medical Diagnosis: RF [respiratory failure]. Every shift. Review of the care plan dated 06/07/2024, read, [Resident #97's name] is ordered oxygen therapy associated with a diagnosis of COPD. Give medications (oxygen) as ordered by physician. During an interview on 07/07/2024 at 1:22 PM, Staff A, Licensed Practical Nurse (LPN) Unit Coordinator confirmed the oxygen concentrator was not administering oxygen at 3 L/min, stating, It's not set at 3 L/min. Staff A, LPN verified the physician's order dated 06/07/2024 read, Oxygen continuous at 3 liters/min via NC. During an interview on 07/09/2024 at 1:52 PM the Director of Nursing (DON) stated, The nurse should check the oxygen settings on the concentrator at the beginning of her shift. The setting should be checked every couple of hours, because they should be checking on the resident every two hours, at maximum they should check the oxygen settings 3-4 times a shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled, Tracheostomy Care and Suctioning/Oxygen, last reviewed on 01/25/2024 read, Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident care goals and preferences. Procedures: 2. The facility will provide necessary respiratory care and services, such as oxygen therapy as ordered by physician, treatments, mechanical ventilation, tracheostomy care and/or suctioning.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48708 Based on observation, interview, and record review, the facility failed to ensure the nursing staff information was posted daily at the beginning of each shift. Findings include: During an observation on 7/8/24 at 9:00 AM of the Nursing Staffing data, located on the wall in the main lobby was dated July 4, 2024. (Photographic evidence obtained) During an interview on 7/9/24 at 1:06 PM the Director of Nursing stated, It's the staffing coordinator's job to post the federal staffing schedule between 6:00 AM -7:00 AM Monday through Friday and on the weekends it's the supervisors responsibility. Review of the of policy and procedure titled Nursing Staffing Information, last reviewed on 3/2/19, read, Policy: It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time. Procedure: 1. The facility will post the following information on a daily basis: a. Facility name b. The current date c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses. ii. Licensed practical nurses or licensed vocational nurses (as defined under state law). iii. Certified nurse's aides 2. The facility will post the nurse staffing data on a daily basis at the beginning of each shift. 3. Data must be posted as follows: a. Clear and readable format b. In a prominent place readily accessible to residents and visitors.

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NAME OF PROVIDER OR SUPPLIER: Avante at MT Dora, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 3050 Brown Ave, Mount Dora, FL 32757	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44571 Based on observation, interview, and policy and procedure review, the facility failed to ensure food and dishes were properly stored, covered, labeled, and dated in the areas of the kitchen's reach-in and walk-in coolers, and walk-in freezer. Findings include: An initial walk-through of the kitchen was conducted on 7/08/24 beginning at 9:10 AM with the Regional Culinary Director (RCD) and the Dietary Manager (DM.) At 9:13 AM there was an observation made of numerous boxes of food on the floor in the walk-in freezer. At 9:17 AM two cases of raw shell eggs were observed stored on the top shelf of the walk-in cooler over a box of produce and a box of opened ready-to-use chocolate chips, there were two large containers of a liquid substance with a clear plastic cover with no identifying label or date, and a large stainless-steel bowl containing a white diced product covered in clear plastic with no label or date. An observation was made in a reach-in cooler of an opened package of what appeared to be butter or margarine lying on the top shelf with the contents exposed. (Photographic evidence obtained). During an interview on 7/08/2024 at 9:25 AM the DM confirmed there were two cases containing 15 dozen eggs in each case on the top shelf of the walk-in cooler directly over produce and a case of chocolate chips. The DM stated the eggs should have been on the bottom shelf under the produce and other products. The DM confirmed there were two large containers of liquid that did not have identifying labels or dates and stated there should have been labels and dates on each of the containers. The DM stated the diced white product was diced pears and should have been labeled and dated, the large clear containers were lemonade and fruit punch and should have identifying labels and dates, the boxes of food in the walk-in freezer remained on the floor and had not been properly stored since the last week's delivery date, the reach-in cooler had a package of margarine that was left opened and exposed and should have been securely wrapped and properly stored and labeled. During an observation on 7/09/2024 at 7:35 AM of the kitchen with the RCD there were numerous dishes to include scooped and regular plates, ramekins, soup and fruit bowls all stored on a shelf that had visible spills and debris without being covered or inverted. (Photographic evidence obtained) During an interview on 7/09/2024 at 9:19 AM the RCD stated his expectations are for the covering, labeling, dating, and storing of food items and dishes, these items are to be stored according to the policy for food safety. Review of the policy and procedure titled Food Safety read, Policy: Dry Storage rooms 1d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 2d. Refrigerated items: d. Should be properly dated, stored, labeled. g. Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. To avoid cross-contamination, store raw or uncooked food and produce away from and below prepared or ready-to-eat food. 3c. Freezer: Store all foods on racks or shelves off the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observation, interview, and record review the facility failed to ensure personal protective equipment was used while caring for 1 of 12 residents, Resident #310, on enhanced barrier precautions; failed to clean and sanitize the multi-use blood pressure cuff and monitor during medication administration for 2 of 6 residents, Residents #72 and #92; and failed to perform proper hand hygiene according to the standards of professional practice for 4 residents, Resident #48, #72, #92, and #153, to prevent the possible spread of infection. Findings include: During an observation on 07/08/2024 at 09:50 AM, there was a sign on the door of Resident #310's room that read, Enhanced Barrier Precautions in addition to standard precautions: STOP. Everyone MUST: Wear gown and gloves for the following high-contact resident care activities: Changing briefs/assisting with toileting . (Photographic evidence obtained) During an observation on 07/08/2024 at 09:50 AM, Staff B, Certified Nursing Assistant (CNA), entered Resident #310's room. The CNA donned gloves but no gown. The CNA then pulled the privacy curtain back at the resident's bedside while holding onto a clean incontinence brief with one hand, and without wearing a gown, initiated incontinence care and changed the soiled incontinence brief for Resident #310. During an observation on 07/08/2024 at 11:25 AM, Staff B, CNA, entered the room for Resident #310. The CNA donned gloves but no gown. The CNA again pulled the privacy curtain back at the resident's bedside and without wearing a gown, initiated incontinence care and changed the soiled incontinence brief for Resident #310. Review of the medical record for Resident #310 documented the resident was admitted on [DATE] with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection), bacteremia (presence of bacteria in the blood), cellulitis (a deep infection of the skin caused by bacteria) of the left lower limb, acquired absence of the right toe, brief psychotic disorder, major depressive disorder, and bipolar disorder. Review of the comprehensive care plan dated 6/9/2024 documented Resident #310 has a Stage 3 pressure ulcer to the coccyx area, a Stage 2 pressure ulcer to the right buttock, and a Stage 3 pressure ulcer to the left and right heels. Review of the physician's order dated 07/10/2024 reads, Enhanced Barrier Precautions: Chronic Wound, every shift for wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/09/2024 at 1:40 PM Staff B, CNA stated, I've taken care of this resident before. She's on enhanced barrier precautions [EBP]; she has wounds on her butt and feet. I really don't know what I am supposed to be wearing for PPE [Personal Protective Equipment] for EBP residents. I wore gloves and washed my hands before and after caring for [Resident #310's name]. I didn't wear a gown when I changed her brief. I asked the nurse later if I was supposed to wear a gown while I was doing that. She didn't seem to know either. I didn't get any real training on it. I guess I'm supposed to look at the sign. Staff B, CNA confirmed the Enhanced Barrier Precautions sign posted on Resident #310's door read, Wear gown and gloves for the following high contact activities: Changing briefs/assisting with toileting. During an interview on 07/09/2024 at 1:52 PM, the Director of Nursing (DON) stated, The staff should be wearing a gown and gloves when doing any type of care with resident's on EBP, direct care or touching their things, and performing hand hygiene before and after care. Review of the policy and procedure titled, Enhanced Barrier Precautions, issued 4/1/2024 read, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wound such as pressure ulcers, diabetic foot wounds .3. Implementation of Enhanced Barrier Precautions: a. Make gown and gloves available immediately near or outside the resident's room. 4. High-contact resident care activities include .f. Changing briefs or assisting with toileting. During an observation on 07/09/2024 at 07:54 AM, Staff D, Certified Nursing Assistant (CNA), exited a resident's room wearing gloves and carrying a closed bag of linen. The CNA discarded the bag of linen in the covered bin, removed her gloves, and without performing hand hygiene, proceeded to the soiled utility room and grabbed a roll of clear bags. Without performing hand hygiene, Staff D, CNA proceeded to the clean linen cart, and without performing hand hygiene, grabbed a clean blanket and put it in a clear bag. Staff D, CNA then proceeded to Resident #153's room. The CNA entered the room, and without performing hand hygiene, set up towels and a basin full of water on Resident #153's bedside table for the resident to do personal hygiene care. Staff D, CNA then exited the resident's room, and without performing hand hygiene entered Resident #48's room. Without performing hand hygiene, Staff D, CNA donned gloves, pulled Resident #48's privacy curtain back, and proceeded to provide incontinence care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/9/2024 at 08:21 AM, Staff C, Licensed Practical Nurse (LPN) pushed Resident #72 in his wheelchair from the common area to his room and administered medications to the resident. Without washing her hands, Staff C, LPN unlocked the medication cart, removed an automatic blood pressure cuff monitor from the drawer, entered Resident #72's room, and without washing her hands, placed the cuff on his arm. Staff C, LPN then removed the cuff, placed it on top of the medication cart, wrote the results on a piece of paper, put the cuff back in the drawer without cleaning or disinfecting the shared equipment after use, and proceeded with preparing the medications. After placing the medications in a cup, without washing her hands, Staff C, LPN entered the room and completed the medication administration with Resident #72. The LPN then returned to the medication cart, and without washing her hands, wheeled the cart down to Resident #92's room. Staff C, LPN unlocked the cart, grabbed the same automatic blood pressure cuff from the drawer, and without washing her hands, entered Resident #92's room. The LPN placed the blood pressure cuff on Resident #92's arm, took the reading, removed the blood pressure cuff from the resident's arm, returned to the medication cart, set the cuff on top of the cart and without washing her hands, proceeded with preparing the medications for administration to Resident #92. After preparing the medications for administration in a medicine cup, the nurse entered Resident #92's room, and without performing hand hygiene, donned a pair of gloves and completed the medication administration. Staff C, LPN then returned to the cart, without performing hand hygiene, put the blood pressure cuff back in the drawer without cleaning or disinfecting the equipment after use, and proceeded down the hall with the medication cart to another resident's room. During an interview on 7/9/2024 at 09:34 AM Staff C, LPN confirmed that she did not clean the blood pressure monitor between resident use and did not perform hand hygiene during care for Residents #72 or Resident #92 and did not perform hand hygiene after providing care to the residents. Staff C, LPN stated, I should have cleaned and disinfected the equipment between each resident and washed my hands before and after medication administration to each resident. During an interview on 7/9/2024 at 1:08 PM Staff D, CNA confirmed she did not perform hand hygiene after discarding the soiled linen bag and removing her gloves this morning and did not perform hand hygiene before or after care for Resident #153 and Resident #48. Staff D, CNA stated, I should have washed my hands before and after care for [Resident #153's name] before I took care of [Resident #48's name]. I didn't wash my hands before putting on gloves to care for [Resident #48's name] either. I should wash my hands before and after care and before and after wearing gloves. During an interview on 7/9/2024 at 1:52 PM, the Director of Nursing (DON) stated, The staff should be performing hand hygiene before and after care and between residents. The nursing staff should be cleaning and disinfecting the blood pressure cuff monitor between each resident using the cleaning wipes. They need to follow the manufactures' instructions on the wipes for cleaning, disinfecting, and dry times. During an interview on 7/11/2024 at 07:55 AM the Director of Nursing (DON) stated, The facility policies for Infection Control need to follow the State and Federal regulations and National guidelines. We cannot override the regulations with our own policy rules. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy and procedure titled, Infection Control - Cleaning and Disinfection/Non-Critical Care and Shared Equipment, last reviewed on 1/25/2024 read, Policy: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines. Review of the policy and procedure titled, Infection Control - Hand Hygiene, last reviewed 1/25/2024, read, Policy: It is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers for Disease Control and Prevention and the World Health Organization. Procedure: 3. The Centers for Medicare and Medicaid State Operations Manual indicates that hand hygiene should be performed: e. Before and after assisting a resident with personal care; i. Upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident); j. Before and after assisting a resident with toileting; m. After handing soiled or used linens, dressings, bedpans, catheters, and urinals . Review of the U.S. Centers for Disease Control and Prevention (CDC) website document titled, CDC Environmental Cleaning Procedures, last updated March 19, 2024, read, Section 4.7 Noncritical patient care equipment: Portable or stationary noncritical patient care equipment includes IV poles, commode chairs, blood pressure cuffs, and stethoscopes. These high-touch items are: Often shared by patients. Table 26. Recommended Selection and Care of Noncritical Patient Care Equipment. Type of Equipment: Shared (e.g., general inpatient wards). Frequency: Before and after each use. Method: Clean and disinfect.