

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Avante Villa at Jacksonville Beach Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 Seabreeze Ave Jacksonville Beach, FL 32250	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947 Based on observations, record reviews, and interviews, the facility failed to protect the resident's right to a dignified experience for one resident (#53) related to catheter use and for one resident (#38) related to personal and medical information out of the 40 residents sampled. The findings include: 1. A record review for Resident #53 revealed he was admitted [DATE] with diagnoses of quadriplegia, contracture of muscle, multiple sites, other muscle spasms, anxiety disorder, neuromuscular dysfunction of bladder, and recurrent major depressive disorder. A review of a quarterly minimum data set (MDS) dated [DATE] indicated he had a brief interview for mental status (BIMS) score of 15/15, indicating no cognitive impairment. The MDS indicated he was dependent for bed mobility, toileting and transfer tasks. He required substantial/maximal assistance with eating. The MDS also indicated he had an indwelling catheter. Physician orders included suprapubic catheter: Size #20FR with size 10cc balloon for diagnosis neuromuscular dysfunction of bladder, to be changed at urology office monthly. (5/24/20). Change bedside drainage bag of urinary catheter as needed (3/30/22), suprapubic catheter care every shift and as needed (5/8/22), adaptive equipment: Dressing change to suprapubic site once daily and as needed (9/26/22), may irrigate indwelling suprapubic catheter with 60mL of normal saline every shift as needed for blockage, occlusion, leakage, etc., enhanced barrier precaution for suprapubic catheter (4/2/24). The resident's care plan included a FOCUS: Supra-pubic catheter due to neuromuscular dysfunction of the bladder. (initiated 5/4/2018, revision 4/26/2022). On 09/16/24 at 12:38 PM, the resident's suprapubic catheter urine collection bag was observed hanging on the left side of the bedrail (facing the room door), without a bag cover. On 09/17/24 at 03:55 PM, the resident's urine collection bag was observed on the floor, facing the door without a bag cover. (photographic evidence obtained). On 09/19/24 at 01:50 PM an interview was conducted with certified nursing assistant (CNA) F who was asked if he'd had training/education on how to care for a resident with a catheter. He stated, Yes, through Healthcare Academy. CNA F was asked what his role was in caring for a resident with a catheter. He stated, I make sure the tubing is not kinked, make sure I don't raise the bag above the patient's bladder and make sure the catheter is on the right side of the bed according to which side they are turned. CNA F was asked if he ever gave the resident with a supra pubic catheter any catheter care. He stated, I usually get the LPN to do the cleaning or apply the dressings. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105617	Facility ID: 105617 If continuation sheet Page 1 of 11

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review was conducted for Resident #38 which revealed she was admitted to the facility on [DATE] with diagnosis of Diffuse Traumatic Brain Injury with loss of consciousness of unspecified duration, unspecified injury of the head, dysarthria, anarthria, dysphagia, oropharyngeal, aphasia, quadriplegia, cognitive communication deficit, and seizures. A review of a quarterly minimum date set (MDS) revealed the resident had adequate hearing and vision but no speech. She had a brief interview for mental status (BIMS) score of 0. She was dependent for all ADLs, and she had a gastrostomy tube. An observation on 09/16/24 at 10:56 AM revealed signage that contained the resident's personal medical information that was posted on the wall above the head of the bed, in plain view. (photographic evidence obtained). An observation on 09/17/24 at 09:58 AM revealed the signage posted on the wall above the head of the bed, in plain view which contained the resident's personal medical information. Another observation on 09/19/24 at 01:46 PM revealed the same signage that contained the resident's personal medical information and was posted on the wall above the head of the bed, in plain view, from the door of the resident's room. (photographic evidence obtained). On 09/19/24 at 04:11 PM, an interview was conducted with CNA G who was asked if he could read the sign. He stated, Yes, it says New CNAs, see nurse about (Resident #38's) head, No skull on left side. CNA G was asked how long the sign had been hanging on the wall. He stated, I'm not sure but it's definitely been there for 2 months. CNA G was asked if he knew who hung the sign. He stated, I assume the nurse manager. CNA G was asked if he thought anyone who happened to walk into the room could see the sign. He stated, Yes. On 09/19/24 at 04:16 PM an interview was conducted with licensed practical nurse (LPN) H who was accompanied to the door of Resident #38's room to observe the signage on the wall at the head of the bed. She was asked who put the signs up. She stated, I'm not sure but I believe the family put them up. She was asked how long the signs had been hanging on the wall. She stated, I've worked here for less than a year and they have been there since I've worked here. She was asked if any facility staff had approached the family about an alternative method of communicating the resident's care needs to new staff. She stated, You know, I come to work and mind my business, I really try not to get too involved. She was asked (from where she was standing at the door of the room) if she believed anyone else would be able to view and read the signs. She stated, If they paid attention, they could but I usually pull the curtain so that she can have privacy when I'm on duty. The surveyor observed that the curtain was not pulled.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51228 Based on observations, record review, staff and resident interviews, and facility policy review, the facility failed to provide the necessary care and services to ensure that one of two residents selected for Activities of Daily Living (ADLs) review (Resident #64) did not diminish in their abilities to maintain fingernails and toenails that were clean and neat from 40 sampled residents. The findings include: On 9/16/2024 at 11:19 am, during the initial tour, Resident #64 was observed in his room. He was awake, lying on his right side on his bed, with his hands and feet exposed. It was observed that his fingernails and toenails were dirty, elongated beyond the tip of his fingers and toes, respectively, and thickened, with a yellowish color. When asked about his care, Resident #64 expressed a need for assistance with nail care, emphasizing that he would like to have his nails trimmed. He stated that he had spoken with a staff member about having his nails trimmed. The resident could not recall the name of the staff member he had spoken to about trimming his nails. Record review for Resident #64 revealed that he was most recently admitted to the facility on [DATE], with an initial admitted [DATE]. The resident's diagnoses included but not limited to chronic obstructive pulmonary disease, muscle weakness (generalized), shortness of breath, major depressive disorder, primary insomnia, essential hypertension, gastroesophageal reflux disease without esophagitis, wheezing, and pain. The latest quarterly Minimum Data Set (MDS) was reviewed with an assessment reference date of 7/19/2024. Resident #64 had a Brief Interview for Mental Status (BIMS) score of 10/15, indicating moderately impaired mental status. There were no signs of psychosis, behavioral symptoms, or rejection of care. The MDS showed that Resident #64 had no functional limitations in ADLs and was found to be independent, in terms of mobility. A review of the care plan, initiated on 4/2/2020 and most recently revised on 4/18/2024, indicated that the resident was at risk for decline or fluctuation in ADLs related to health status. The care plan noted that the goal was to maintain the resident's current level of function. Interventions in the care plan included but not limited to checking nail length, trimming and cleaning them on bath day and as necessary, and reporting any changes to the nurse. Relevant physician orders included left U-bar side rail enabler is indicated to enable positional changes and bed mobility (ordered 9/12/2022), podiatry consult (ordered 8/17/2023), and complete weekly skin observation and enter in the Avante weekly summary with skin check assessment 3-11 shift (ordered 4/7/2022). The resident's medical record had evidence that the last podiatry consult note was dated 2/23/2023. The podiatry consult note showed that the provider debrided all of the resident's toenails to reduce their length and thickness. The provider recommended a podiatry follow-up two months from the date of the note (2/23/2023) and noted that care of this patient by a non-skilled professional may be hazardous to the patient's health. No nursing notes or physician progress notes related to fingernails or toenails care or documentation relevant to the resident rejecting care, were found, as reviewed from 2/23/2023 to 9/19/2024. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no record or documentation related to overgrown nails for Resident #64 in the most recently reviewed Avante weekly summary with skin check assessments, dated 8/19/2024, 8/26/2024, 9/2/2024, and 9/16/2024. The weekly summary with skin checks described the skin as intact, and comments/observations were not documented. An interview was conducted with a Certified Nursing Assistant (CNA/ Employee D) on 9/19/2024 at 12:10 pm. When asked to explain the method of completing a resident's assessment and documenting the findings and to whom they are reported, the CNA stated that her routine begins by knocking and introducing herself to the resident before entering the room. The CNA stated that she proceeds to assist the resident with their ADLs depending on the severity of the assistance needed. The CNA added that Resident #64 was mostly independent and preferred to complete his ADLs on his own. When asked if the resident had requested any assistance with nail care recently, the CNA stated that the resident had not requested any assistance for any ADLs recently. The CNA mentioned that the resident usually performed his own nail care, except for his feet, which are cared for by podiatry. The CNA stated that she believed that podiatry came to see the resident recently but was unable to recall the date. The surveyor asked if the CNA was aware of the condition of the resident's nails. The CNA stated that she was aware of the condition of the resident's nails, but the resident always performed his own fingernail care. When asked to perform an assessment of the resident's fingernails and toenails, the CNA and was unable to perform an assessment because Resident #64 was sleeping and covered with his blankets. The CNA told the surveyor that she would remind the nurse about the condition of the resident's nails. When asked where in the record the surveyor would find documentation about nail care needs, the CNA stated that the assessments/observations would be documented under skin assessments, which CNAs and LPNs document. An interview was conducted with a Licensed Practical Nurse (LPN/Employee B) on 9/19/2024 at 12:59 pm. When asked, What can you tell me about Resident #64?, the LPN stated, The resident has severe COPD and is a current smoker. He is generally a pleasant resident. She was then asked, What is the process of assisting a resident with fingernail trimming? The LPN stated, He can trim his fingernails himself. If a resident needs assistance, we can help with fingernail trimming. She was also asked, Has the resident asked for help trimming his fingernails or toenails? The LPN stated, He has not asked me for help with trimming his fingernails. Podiatry will take care of the toenails. Per staff member, social services enter the residents onto a list to see podiatry, if they had a podiatry consult in place. Next, the LPN was asked How often are residents assessed for needs such as fingernail trimming or toenail trimming? She stated that every staff member providing direct care on their scheduled shift, including certified nursing assistants (CNAs), nurses, other providers, or any staff member interacting with the resident, will perform an assessment. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Services Director (SSD), on 9/18/2024 at 1:51 pm. She was asked about the facility's nail care provision for residents. The SSD mentioned that if residents are physically and cognitively capable, they can trim their own fingernails. The SSD added that CNAs and LPNs can assist with fingernail trimming if needed. When questioned about how often residents are assessed for ADL needs such as nail care, the SSD stated that they are assessed daily. The SSD further explained that residents are put on the podiatry consult list after a podiatry consult is requested for toenails care. Further, she stated that the podiatry provider is scheduled to visit the residents on the list every 45-55 days. When asked specifically about the last podiatry consultation date for Resident #64, the SSD provided the date as 2/23/2023, after reviewing the resident's record. This surveyor inquired if Resident #64 had refused care, and the SSD confirmed that the resident had not refused any care, including nail trimming. When asked if the resident should have been seen by podiatry after the last consult, which was placed on 8/17/2023, the SSD stated that Resident #64 should have had at least one visit since the consult was placed. The surveyor then requested the SSD to provide a copy of the most recent podiatry consultation note. The SSD provided a copy of the podiatry consultation note dated 2/23/2023 at 1:57 pm and acknowledged that there were no recent records or documentation of podiatry care since 2/23/2023. On 9/19/2024 at 2:20 pm, a review was conducted of the facility's policy and procedures titled Policies and Procedures: Activities of Daily Living (ADLs) Maintain Abilities, which was issued and revised on 3/2/2019. The facility's policy and procedure included: 1. The facility will provide necessary care and services to ensure that resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure that a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living. 3. The facility will provide care and services for the following activities of daily living: Hygiene - bathing, dressing, grooming, and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Following the survey, on 9/23/24, the facility submitted documentation that Resident #64 received podiatry services on 5/22/24. This was after the request for additional information made on 9/18/24 and after the survey exit on 9/19/24. The podiatry consult on 5/22/24 was three months after the prior visit which recommended a follow up after two months. The appearance of Resident #64's nails during the survey and lack of documentation indicate that the established care plan was not being followed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892 Based upon observations, interview and record review, the facility failed to ensure respiratory services were administered according to a physician's order for five residents receiving respiratory care from 40 sampled residents (#96, 106, 59, 105, and 90). The findings include: 1. Observations made during the tour on 09/16/24 at 11:35 AM, revealed that Resident #96's oxygen concentrator flow was set at 2 Liters per minute (L/min.) (photographic evidence obtained). During an interview on 09/16/24 at 11:35 AM, the resident reported she was unsure what the oxygen flow rate should be set at and noted that she did not manipulate her concentrator's oxygen flow rate. A second observation on 09/17/24 at 9:50 AM, revealed that the resident's oxygen concentrator flow rate was set at 2 L/min. (photographic evidence obtained). Review of the electronic medical record for Resident #96 documented the resident is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, mild intermittent asthma, uncomplicated, muscle weakness (generalized) chronic systolic (congestive) heart failure, diabetes mellitus type II, unspecified atrial fibrillation and major depressive disorder. Review of the electric medical record for Resident #96's physician orders revealed a lack of documentation of a current order for oxygen. 2. Observations made during the tour on 09/16/24 at 11:48 AM, revealed that Resident #106's oxygen concentrator flow rate was set at 2.5 Liters per minute (L/min.) (photographic evidence obtained). The resident was not capable of responding to interview questions. A second observation on 09/17/24 at 9:49 AM, revealed that the resident's oxygen concentrator flow rate was set at 2.5 L/min. (photographic evidence obtained). Review of the electronic medical record for Resident #106 documented a [AGE] year old female admitted to the facility on [DATE] with diagnoses including other cerebral infarction due to occlusion or stenosis of small artery, muscle weakness (generalized), cognitive communication deficit, anoxic brain damage, not elsewhere classified, acute respiratory failure with hypoxia, tracheotomy status, gastronomy status, dysphasia following cerebral infarction, major depressive disorder, dependence on supplemental oxygen. Review of the electronic medical record of Resident #106 documented re Tracheotomy (trach) - Encourage and assist resident with use of humidified oxygen 6.5%/2 liters via trach collar. Order started on 09/08/23. Review of the medication administration record (MAR) for Resident #106 documented oxygen was administered per physician order at 2 liters via trach collar. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observations made during the tour on 09/16/24 at 11:48 AM, revealed that Resident #59's oxygen concentrator flow rate was set at 2.5 Liters per minute (L/min.) (photographic evidence obtained). During an interview on 09/16/24 at 11:48 AM, the resident reported that she was unsure what the oxygen flow should be set at and noted that she did not manipulate her concentrator's oxygen flow rate. On 09/17/24 at 9:55 AM, the resident was observed sitting in a wheelchair in her room waiting to leave for a dialysis appointment. The resident was wearing a nasal cannula attached to a portable oxygen tank adhered at the back of her wheelchair. Review of Resident #59's electronic medical record documented a [AGE] year old female admitted to the facility on [DATE] with diagnoses including end stage renal disease, muscle weakness (generalized), chronic obstructive pulmonary disease, diabetes mellitus type II, paroxysmal atrial fibrillation, heart failure, unspecified, cardiac arrest due to other underlying condition, anemia in chronic kidney disease, hypertension disorder, sclerotic heart disease of native coronary artery without angina pectoris, long term (current) us of anticoagulant, dependence on renal dialysis. Review of the minimum data set (MDS) for Resident #59 dated 08/24/24 documented that the resident had minimal difficulty with hearing, clear speech, made self understood, understood others and had adequate vision. The resident's brief interview for mental status (BIMS) score was 15, which suggested the resident was cognitively intact. Review of the care plan for Resident #59 documented a focus of altered respiratory status/difficulty breathing related to shortness of breath, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea and dry nose. The goal for the resident noted that the resident would maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Interventions included oxygen settings: oxygen care and settings according to medical doctor (MD) order. Intervention created on 06/10/24. Review of the electronic medical record for Resident #59 lacked documented evidence of a current physician order for oxygen (O2). Review of discontinued physician orders documented oxygen saturations (Sat) every shift and as needed. Call medical doctor if Sat is over 90. Every shift for oxygen saturations for shortness of breath (SOB). Order started on 06/27/24 at 22:50 and ended 08/26/24. Change O2 humidifier bottle every night shift every Saturday. Order start on 06/27/24 at 22:50 and ended 08/26/24. Change O2 set up and bag weekly and as needed. Every night shift every Saturday. Place in labeled O2 bag and tie to handle of O2 concentrator. Order started on 06/27/24 at 22:50 and ended 08/26/24. O2 at 2 liters/minute (L/min.) via nasal cannula for SOB and as needed. Order started on 06/28/24 at 22:50 and ended 08/26/24. Review of the medication administration record (MAR) and treatment administration record (TAR) for Resident #59 documented oxygen was administered during the month of September 2024 at 2.5 L/min. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/19/24 11:27 AM, an interview was conducted with Employee A, CNA, who reported he has worked at the facility since 2003. He explained that he was familiar with the Resident # 59's care needs. In regards to the resident's oxygen care needs, he could not remember the prescribed oxygen (O2) liter flow rate. He said that he tries to keep the resident on her oxygen as long as possible. He further explained that sometimes the resident will complain that the oxygen annular is irritating to her nose and ears. The employee said that when he conduct his rounds, he would check the oxygen concentrator flow rate to ensure the flow rate is correct. If the flow rate is incorrect, he would tell the nurse. He said that he always makes sure the concentrator had enough room and that the nasal annular was placed correctly on the resident. If the oxygen bottle needed changing, he would tell the nurse. 09/19/24 11:50 AM Interview was conducted with Employee B, LPN, who reported she has worked worked at the facility for almost one year. She would monitor prescribed oxygen liter flow rates and ensure their oxygen level flow rates were accurate. In regard to Resident #59's oxygen therapy, she could not find a current order in the resident's electronic medical record for an oxygen order. She further explained that she knew there must have been a previous order for oxygen because the picture of the resident in the electronic medical record showed the resident wearing a nasal cannula. She also explained that the resident went to the hospital several times, so the lack of an O2 order may have been an oversight upon return from the hospital. 45153 4. On 09/16/24 at 12:34 PM, Resident #105 was observed lying in bed, with his eyes closed, wearing the nasal cannula. Resident #105's oxygen concentrator located at bedside was observed to be set at 2L/min. (Photographic evidence obtained) On 09/17/24 at 11:39 AM a second observation of Resident #105 lying in bed, with his eyes closed, wearing the nasal cannula with the oxygen concentrator revealed it was set at 2L/min. (Photographic evidence obtained) A review of the medical record active orders included but not limited to oxygen continuous at 3 L/min via nasal cannula for shortness of breath (SOB) every shift dated: 08/15/2024. Further review of the physician's orders revealed: change oxygen humidifier bottle every shift every Sun dated: 09/17/23, rinse or replace oxygen filters on concentrator every shift every sun dated: 9/17/23, vitas hospice services admitted to vitas hospice services on 11/1/23 for cerebral atherosclerosis dated: 3/19/22, enhanced barrier precautions: chronic wound every shift for multiple drug-resistant organism precautions dated 7/25/24, and do not resuscitate dated 5/27/24 (Copy obtained) On 09/18/24 at 02:37 PM, a third observation of Resident #105 lying in bed, with his eyes closed, wearing the nasal cannula with the oxygen concentrator revealed it was set at 2L/min. (Photographic evidence obtained) (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review indicated that Resident#105 was admitted to the facility on [DATE]. Primary diagnoses included: encounter for palliative care. Quarterly MDS dated [DATE] revealed hospice care resident with a brief interview of mental status score (BIMS) 9, indicating moderately impaired. The resident was assessed and required oxygen therapy, substantial/maximal assistance for eating and did not attempt toileting transfer due to medical condition. The care plan focuses and goals included hospice, altered respiratory status/difficulty breathing related to shortness of breath (SOB), and enhanced barrier precautions related to risk for multidrug-resistant organism (MDRO). Interventions included administer medication/puffers/nebs as ordered. Monitor for effectiveness and side effects; oxygen settings: oxygen settings and care per Medical Doctor order. Medication Administration Record for September 2024 indicated oxygen initialed was provided as ordered (copy obtained) On 09/18/2024 at 02:39 PM Employee I, Registered Nurse (RN), verified Resident #105's oxygen concentrator was set at 2L. When asked who provides ongoing monitoring of the resident's oxygen therapy, Employee I replied, nursing. Nurses are also responsible for ensuring that residents receive correct oxygen orders. Correct oxygen settings are identified in the order. Nursing on the night shift change residents' oxygen tubing. Correct oxygen settings are communicated from one staff person to another in reports and on the Medication Administration Record and Treatment Administration Record. Employee I stated Resident #105 does not change his own oxygen levels but will remove the nasal cannula sometimes. When this happens, Resident #105 is educated and nursing will place the nasal cannula back on the resident. On 09/18/2024 at 02:54 PM the ADON confirmed the correct oxygen settings are identified in the orders. 48947 5. A record review of Resident # 90 revealed an admitted [DATE] with diagnoses of encounter for palliative care, hemiplegia and hemiparesis following nontraumatic intracranial hemorrhage affecting right dominant side, dysphagia, aphasia, cognitive communication deficit, Chronic Obstructive Pulmonary Disease (COPD), and Asthma. A record review of a quarterly minimum data set (MDS) dated [DATE] revealed a brief interview for mental status (BIMS) was not conducted and long-term and short-term memory problems were indicated. The MDS review also revealed the resident was dependent for eating, transfers, bed mobility, and toileting tasks. The MDS revealed the resident had a prognosis which indicated a condition or chronic disease that may result in a life expectancy of less than 6 months. Hospice and oxygen therapy were also indicated. A review of the resident's orders revealed the following: head of bed elevated related to shortness of breath (SOB) when lying flat every shift (11/11/2023), rinse or replace oxygen filters of concentrators every night shift, every Sunday (11/12/2023), change oxygen set-up and bag weekly and as needed (11/12/2024), Oxygen continuous at 2 liters/ minute via nasal cannula (NC) for medical diagnosis SOB (11/11/2023), Do Not Resuscitate (11/28/2023), Admit to Hospice services on 12/05/2023 for diagnosis Cerebrovascular Disease (3/19/2024), Nothing by mouth (NPO) diet (11/11/2023). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Avante Villa at Jacksonville Beach Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 Seabreeze Ave Jacksonville Beach, FL 32250	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of progress notes was conducted which revealed a physician progress note dated 9/3/2024 which documented the resident was receiving antibiotic therapy for pneumonia. A review of hospice progress note dated 8/28/2024 which documented resident's bed has to be upright at 30-degree angle to avoid SOB, and for her feedings. A review of dietary progress note dated 8/20/2024 which documented resident had a diet of NPO, with enteral feeds. A review of the resident's care plan was conducted which revealed a FOCUS: DNR (initiated: 12/27/2021, revision: 12/26/2023), a FOCUS: Resident had a cerebrovascular accident (CVA) with right hemiparesis (initiated 9/20/2022, revision 9/20/2022), a FOCUS: Hospice (initiated 12/6/2023, revision: 12/06/2023), and a FOCUS: Altered respiratory status/difficulty breathing related to SOB, wheezing, cough. congestion, history of Pneumonia, vascular congestion, s/p COVID (initiated: 2/20/2023, revision: 9/1/2023). On 09/16/24 at 11:54 AM, the resident was observed to have oxygen infusing at between 2.5 liters and 3 liters via nasal cannula. On 9/17/24 at 03:52 PM, the resident was observed to have oxygen infusing at between 2.5 liters and 3 liters via nasal cannula. (photographic evidence obtained) On 09/19/24 at 01:38 PM, the resident was observed to have oxygen infusing at 1.5 liters via nasal cannula. (photographic evidence obtained). On 09/19/24 at 01:57 PM an interview was conducted with Registered Nurse (RN) E. She was asked to access the physician orders for Resident #90. The orders read, Oxygen continuous at 2 liters/ minute via nasal cannula. RN E was accompanied to the resident's bedside to verify the oxygen concentrator settings. RN E verified the settings as 1.5 liters. On 09/19/24 at 01:50 PM an interview was conducted with certified nurse assistant CNA F. He was asked if he'd had training for how to care for a resident with oxygen. He stated, I've had encounters with the nurse about the oxygen, but I haven't had any training, not since I've been here. He was asked to explain his role in caring for a resident requiring oxygen. He stated, I make sure the tubing is on correctly. I check behind their ears to make sure they don't have any breakdown, and if the patient is using a portable tank, I make sure they have enough oxygen in the tank. CNA F was asked if he ever changed or adjusted the settings on the concentrator. He stated, I ask the nurse about the settings to make sure it's correct, but I don't make any changes or adjustments, I get the nurse for that. Review of the facility's Policy and procedures: Tracheostomy Care and Suctioning/Oxygen revised date: 03/26/21, revealed: 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 goals and preferences .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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Avante Villa at Jacksonville Beach Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 Seabreeze Ave Jacksonville Beach, FL 32250	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50968 Based on observations, record review, and interviews the facility failed to maintain clinical records that were accurately documented for two (Residents 103 and 124) out of 40 sampled residents. The findings include 1. During the initial tour on [DATE] at 12:50 PM, Resident 103 was observed to have a tracheostomy (a surgically created hole in the neck/windpipe that provides an alternative airway for breathing) with humidified oxygen (O2) provided through a trach-mask. The date on the humidification bottle attached to the humidified O2 tubing was [DATE] (photographic evidence obtained). The resident was asleep at the time. Another observation on [DATE] at 11:50 AM found Resident 103 awake and alert but not interviewable. Review of the medical record for Resident 103 indicated an initial admission to the facility on [DATE] and a re-entry on [DATE]. The diagnoses included Huntington's disease, encephalopathy, dependence on supplemental oxygen, extrapyramidal movement disorder, and dysphagia. The resident's annual Minimum Data Set (MDS) from [DATE] revealed that the Brief Interview for Mental Status (BIMS) was not scored related to the resident not being interviewable. Review of the Treatment Administration Record (TAR) for the month of ,d+[DATE] for Resident 103 revealed documentation for the order to change the O2 tubing/humidification bottle/mask, etc. every week and as needed completed on [DATE], [DATE], and [DATE] (photographic evidence obtained). 2. A closed record review of Resident 124 indicated an initial admission to the facility on [DATE], a re-entry on [DATE], and a discharge date (date of death) of [DATE]. The diagnoses included lymphedema, heart failure, atrial-fibrillation, and benign prostatic hyperplasia. The resident was [AGE] years old, and the death was expected. In an interview with the DON on [DATE] at 02:50 PM, she stated that the resident's medical doctor (MD) was notified of Resident 124's death on [DATE]. Review of documentation from Resident 124's chart revealed a witness statement from [DATE] at approximately 12:30 AM that indicated the MD was immediately notified of the resident's change in condition with a new order to pronounce time of death. Review of Resident 124's medical record revealed a progress note created on [DATE] by the Medical Director (Resident 124's Primary Care Physician/MD) which included, Care plan reviewed and shared with patient. It had an effective date of [DATE] (See photographic evidence). An interview with the Medical Director was attempted via telephone twice on [DATE], once at 12:37 PM and again at 12:43 PM, both times the calls ended without going to voicemail.		