

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 06/06/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086</p> <p>Based on observation, interview and record review, the facility failed to ensure respiratory therapy was provided as per physician orders for 1 of 2 residents reviewed for respiratory care, of a total sample of 5 residents, (#4).</p> <p>Findings:</p> <p>Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. Her diagnoses included acute and chronic respiratory failure, epilepsy, anoxic brain damage, dysphagia, and attention to tracheostomy.</p> <p>A tracheostomy is a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing (retrieved on 6/14/24 from https://www.mayoclinic.org).</p> <p>On 6/06/24 at 10:55 AM, resident #4 was observed lying in bed, she was nonverbal with her eyes open. Her oxygen was connected to her tracheostomy (trach) collar and the tubing was connected to an oxygen concentrator next to her bed set on a flow rate of 0 liters per minute (LPM).</p> <p>On 6/06/24 at 11:13 AM, the resident was observed similarly to prior observation with the oxygen concentrator now set at 4 LPM.</p> <p>On 6/06/24 at 2:00 PM, the assigned Licensed Practical Nurse (LPN) A went to resident #4's room to provide care and suctioning with a tonsil tip catheter around the resident's tracheostomy neck stoma area. Pre and post suctioning LPN A verified that resident #4's oxygen was set to deliver 4 LPM as this was the current physician ordered flow rate. LPN A said she noted the oxygen delivery earlier this morning was set at 4 LPM as well.</p> <p>On 6/06/24 at 4:54 PM, Registered Nurse (RN) B said she had cared for resident #4 the past few weeks on the 3-11 shift and was familiar with her care. RN B went to resident #4's room and verified the resident's oxygen concentrator was presently delivering 3.5 LPM via the trach collar.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/06/24 at 5:00 PM, the South Unit Manager (UM) reviewed resident #4's medical record and said the facility currently had no physician's order for resident #4's oxygen flow rate. The South UM explained the only thing they had were instructions from the hospital from 4/11/24 which instructed them to give oxygen at 28%, equivalent to 2 LPM. The Unit Manager explained that nurses should check physician orders for flow rate every shift to ensure the resident received what was ordered by the physician. The UM added, the residents' last oxygen order was prior to her hospitalization in April 2024, when she was ordered to receive 2 LPM. The Unit Manager explained the resident was in the hospital from 4/02/24 until 4/11/24 and her oxygen orders were never reordered upon her return for nearly 2 months.</p>