STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106027	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at Orlando Inc	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to ensure the garbage storage area was maintained in a sanitary condition to ensure garbage was properly contained in dumpsters and trash cans with lids to prevent the harborage and feeding of pests, for one of one garbage storage area reviewed.Findings: On 2/17/26 at 10:10 AM, a tour of the outside garbage storage area was conducted. Three dumpsters and one 55-gallon trash can without lid was present. There were clear used gloves, straws, empty snack wrappers, and a clear trash bag with blue pads and masks on the ground around the dumpster area. A 55-gallon trash can with no lid was over filled with clear garbage bags filled with brown bags, snack wrappers, and blue pads. The Certified Dietary Manager who was present during the tour, confirmed the findings. She stated she was not sure who was responsible to keep the area clean. The Dietary Manager explained, everyone was responsible to keep the area clean. (photo evidence obtained) On 2/18/26 at 10:00 AM, the Plant Operations Manager acknowledged the unsanitary garbage storage area and explained that housekeeping and maintenance staff should keep the area clean but said it was also all staff's responsibility.

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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(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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to maintain cleanliness and sanitation of frying pans and failed to ensure the pureed meal was maintained at the correct hot holding temperature for 5 out of 45 residents who received pureed foods. Findings: 1.On 2/17/26 at 9:50 AM, the initial kitchen inspection was conducted. On the clean pan rack there were two pans with scratched and dried food on the non-stick surfaces. The Certified Dietary Manager (CDM) placed her finger on the non-stick surface and tried to scratch off the dried food. She confirmed the pans should not be used due to their condition. (photo evidence obtained) On 2/19/26 at 11:15 AM, review of the lunch menu revealed, Chicken & Dumplings was the lunch main entree. The cook was checking the hot holding temperatures on the steam table. The hot holding temperature of potentially hazardous foods was confirmed with the cook to be 135 degrees Fahrenheit (F) or above. The cook used a digital system bayonet instant read thermometer which was inserted into the pureed chicken. The reading on the thermometer was below 135 degrees F. The cook stated she did not check the pureed chicken's temperature prior to placing the pan in the warming cabinet earlier in the morning. She confirmed she did not check the temperature before placing the chicken on the steam table.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices were followed during medication pass and before meals for both staff and residents on one of one dining area; and failed to ensure approved alcohol-based hand sanitizer was available for use for residents on enhanced barrier precautions and/or contact isolation precautions on one of one units of the facility.Findings:1. During dining room observation on 2/17/26 at approximately 12:05 PM, staff served residents the noon meal in the North wing dining area. Staff were observed not consistently performing hand hygiene during meal distribution between each resident. Speech Therapist (ST) D assisted residents with their meal and was observed not to practice hand hygiene consistently between residents she served. At 12:07 PM, the lunch cart arrived in main dining area on the North wing. Staff failed to offer hand hygiene to residents and no residents in the dining area cleaned or sanitized their hands in the dining area before eating lunch. At 12:16 PM, ST (D) was observed washing her hands at the sink, but she failed to rub her fingers, thumbs and wrists with soap and rushed through the process of hand hygiene, prior to and after assisting residents.On 2/17/26 at 12:17 PM, and again at 12:20 PM, Certified Nursing Assistant (CNA) E washed her hands with soap and water for less than five seconds, shook the water on her hands off on top of the trash can next to the sink then dried her hands with a paper towel. CNA E's hand washing did not include washing between her fingers, thumbs or wrists vigorously for at least 15 seconds. CNA (E) was observed as she assisted residents with their meals and moved throughout the unit near the dining room.Handwashing protects both the healthcare worker and the resident/patient using either soap and water or antiseptic hand rub. Rub hands together vigorously for 15 to 20 seconds, covering all surfaces of the hands. Rinse, use a disposable towel to dry, then use the towel to turn off the faucet, (retrieved on 3/06/26 from www.cdc.gov).2. On 2/17/26 at 12:59 PM, hand sanitizer in wall mounted dispensers used throughout the facility was non-alcohol based, (see photo evidence). On 2/17/26 at 3:15 PM, the Nursing Home Administrator, Infection Preventionist (IP) and Director of Nursing (DON) acknowledged the hand sanitizer in the wall mounted dispensers was not alcohol-based.On 2/17/26 at 10:12 AM, enhanced barrier precaution and contact isolation sign from Florida Health on the doors of room [ROOM NUMBER] and 144 indicated to use a 60-90% alcohol-based hand rub. The instructions indicated that Everyone MUST: Perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water before entering and exiting.On 2/18/26 at 9:30 AM, alcohol-based hand sanitizer bottles were placed on top of the non-alcohol-based dispensers throughout the facility. A short time later at 9:45 AM, the DON and IP explained they were not involved in the decision to use non-alcohol-based product dispensers for hand sanitizing. Both the IP and the DON stated they were unaware the dispenser's product was not alcohol-based. The DON stated on 2/17/26 during the evening, she placed a bottle of alcohol-based hand sanitizer on top of every dispenser on the North wing.On 2/18/26 at 3:15 PM, in a joint interview with the Nursing Home Administrator and DON, the DON provided a sheet from the Material Safety Data Sheets (MSDS) binder, but it was not for the product actually in the dispensers. MSDS sheets provide detailed safety information about chemicals used in the facility. It was brought to the Administrator's attention that the information supplied was for another product, not the product in the dispensers. The Administrator stated they didn't have a different MSDS sheet nor did she have a Safety Data Sheet (SDS) for the product in the dispensers. The Administrator said she was not involved in the decision to use a product for hand hygiene that was not alcohol based. She said the facility also used ABHR gel supplied from another manufacturer that was 70% alcohol that was supplied in small bottles located on the medication carts on the North wing. On 2/19/26 at 3:15 PM, the IP and DON stated staff were educated on proper hand hygiene with education completed every time there was an infection. Per the IP, there were three infections in the month of January, and staff was educated twice in January. For the month of February, the IP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified 10 current infections. The IP said she used an application of a fluorescent product that showed up if handwashing was inadequate for on-the-spot training when she observed staff not performing adequate hand hygiene. She also used it for random hand hygiene audits. The IP conveyed that staff received infection control education including hand hygiene upon hire, during town hall meetings and during skills fair. The IP said she performed the competencies for hand hygiene with staff and competency sheets were observed. The IP provided three sign-in sheets for staff education for a Town Hall meeting held on 1/22/26, which included for staff to follow Personal Protective Equipment (PPE) use, hand hygiene, and isolation protocols at all times. There was a total of 24 staff present for the training, with six non-direct care staff, 14 direct hands-on care staff (therapy department staff and nursing staff), three nurses and six CNAs attended. There were no other signature pages for infection control education provided. The IP said that was the only education form she had signed by staff. 3. On 02/18/26 at 10:45 AM, an observation of a medication pass was conducted for resident #37. Registered Nurse (F) donned a contact gown and gloves prior to entering the resident's room to administer his medications. After administration, RN F removed the gown; however, did not perform hand hygiene after removing her gloves. A few minutes later, outside resident #37's room, the nurse confirmed the resident in the b bed, (#37) was on contact isolation. RN F confirmed the sign on the door indicated contact isolation. She was unsure if this applied to both the a and b bed and said she would have to check. On 2/18/26 at 1:55 PM, in a joint interview with the IP and DON, the IP said she was responsible for the facility isolation signage and education to residents, families and staff. Initially, the DON and IP said there was no need to wear gowns and gloves when entering the room of a resident on contact isolation. The DON said the only requirement for entering the room was to perform hand hygiene and staff need only wear PPE, if care was provided. She explained that resident #37 was on contact isolation but was not contagious because his wound was contained. Per the IP and DON, the nurse passing medications was expected to wear PPE. On 2/19/26 at 1:58 PM, Licensed Practical Nurse (LPN) G said there were different classes of isolation- droplet, contact, and enhanced barrier precaution. LPN G said she was not sure what the difference was between the signs. She said she knew that for contact isolation a gown and gloves were to be used and hand hygiene performed with ABHR before entering the room and when leaving the room. LPN G said enhanced barrier precautions were used for people with VRE and MRSA and contact isolation for people with open wounds. On 2/19/26 at 3:15 PM, in a joint interview with the IP and DON, the IP said she monitored the antibiotic stewardship program, hand washing, she checked the sharps containers and was responsible for education related to infection control. She confirmed PPE was used when personal care was performed on a resident on enhanced barrier precautions. Per the DON and IP, staff used gowns and gloves as soon as they entered the room of a resident on contact isolation. The DON said there was no need for the use of PPE if the wound was contained. The DON clarified that if the resident was assisted and close care was needed, PPE would be used. She said hand hygiene was required before entering a room and then exiting a room. The IP stated the DON was not correct, staff should wear PPE for a resident on contact isolation. The IP said she educated staff on wound containment. The IP said she educated non-nursing staff during orientation on wound containment. The IP said she was responsible for the signage for both EBP and all other transmission-based precautions including contact isolation. Review of the facility's policy, revised on 3/02/19, titled, Infection Control- Hand Hygiene revealed it was the policy of the facility to perform hand hygiene in accordance with national standards form the Centers for Disease Control and Prevention and the World Health Organization. The policy indicated hand hygiene should be performed before and after entering isolation precaution settings, before and after assisting a resident with meals, and prior to caring for residents, prior to performing a procedure, when moving from a contaminated body site to a clean body site, after caring for a resident including after glove removal, and after contact with the resident's environment.A second policy for hand hygiene provided by the facility on 2/18/26 at 10:00 AM, was dated 3/02/19 and revised 10/20/25. The policies were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identical except for the second hand hygiene policy revised 10/20/25, did not include use of alcohol-based hand rub. It was removed from the policy but indicated the use of hand sanitizer was to be used for hand hygiene opportunities.