STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105670	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at St Cloud Inc	1301 Kansas Ave Saint Cloud, FL 34769

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to conduct a medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medications, of a total sample of 53 residents, (#1). Findings: Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Chronic atrial fibrillation, and hypertensive chronic kidney disease with stage 1 through 4. Her most recent Minimum Data Set assessment, dated 8/05/24, revealed a Brief Interview for Mental Status exam score of 13 out of 15, which indicated intact cognition. On 8/12/24 at 11:55 AM, resident #1 was lying on her bed with the overbed table across her. A white plastic bin on the table contained personal items, including Hydrocortisone 1% cream. Resident #1 stated she had applied the cream herself for over one year to her private area. On 8/12/24 at 5:21 PM, the East Wing Unit Manager acknowledged two tubes of Hydrocortisone cream, were present on the resident's bed. The East Wing Unit Manager said the resident's husband had been to visit today, and she thought he must have brought the medications in. She explained the resident had an order for cream because she had a rash between her legs. The East Wing Unit Manager acknowledged the nurse should apply the treatment, as the resident was not approved or assessed to have medications at the bedside. On 8/12/24 at 5:27 PM, the Director of Nursing (DON) stated, A resident must be assessed for self-administration [of medications], and if appropriate, then we get physician orders for the resident to perform the treatment. The DON acknowledged those protocols were not in place for resident #1. A review of the facility's policy and procedure for self-administration of Medication program dated 3/2/19 read, It is the policy of the facility to allow the resident and or legal representative of the resident the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview and record review, the facility failed to ensure the resident was free from physical restraint for 1 of 1 resident reviewed for restraints, of a total sample of 53 residents, (#65). Findings Resident #65, an [AGE] year-old- female was admitted to the facility on [DATE] and readmitted on [DATE]. The resident was admitted to Hospice Services on 1/17/24. Her diagnoses included convulsions, cerebral atherosclerosis, repeated falls, major depressive disorder, and generalized muscle weakness. Review of the resident's physician orders revealed an order dated 3/12/21 for bilateral upper grab bars to enable positional changes, bed mobility or to determine bed perimeters. The resident's quarterly Minimum Data Set assessment with Assessment Reference Date of 8/02/24 revealed the resident was rarely/never understood and was dependent on staff assistance with activities of daily living, and mobility. A Side Rail Evaluation dated 10/20/22 indicated the recommended type of side rail(s) for resident #65 were left and right upper side rails at all times when the resident was in bed. On 8/12/24 at 12:12 PM, and on 8/13/24 at 9:40 AM, resident #65 was lying in bed with bilateral upper, and bilateral lower bed rails up. On 8/13/24 at 10:48 AM, Registered Nurse (RN) A, confirmed he was the resident's assigned nurse. He stated resident #65 was at risk for falls, and four side rails were implemented approximately four months ago when the resident started on Hospice services. RN A stated the use of the four side rails were implemented because of a request by the resident's family. On 8/14/24 at 9:39 AM, resident # 65 was lying in bed positioned to her left side facing the bathroom. The resident's eyes were open, but there was no response from the resident when spoken to. Bilateral upper and lower side rails were up. On 8/14/24 at 9:59 AM, the [NAME] Wing RN/Unit Manager (UM) stated resident # 65 was on Hospice services, and her bed was provided by Hospice. The UM stated she observed the four side rails on resident #65's bed on 8/13/24. She stated she did not know why the resident had four side rails in place, and recalled she called the Hospice nurse on 8/13/24 to establish the reason for the four side rails. The RN/UM said documentation in the resident's clinical records was for two side rails. On 8/14/24 at 12:18 PM, Certified Nursing Assistant (CNA) C stated that approximately a month ago she noted the resident in bed with four side rails up. The CNA said she was questioning the use of the four side rails, but was told it was a hospice bed, so she did not dig any further. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 12:56 PM, the Director of Nursing (DON) stated the [NAME] Wing UM made her aware of the four side rails being used on resident #65's bed. The DON said the bed was a hospice bed, and the [NAME] Wing UM was trying to call Hospice to find out why that bed was sent to the facility. She said four side rails were considered restraints, and if a resident was to have four side rails up, the Interdisciplinary Team (IDT) had to assess, and identify the reason for the four side rails. She stated if use of the side rails falls in the category of restraints, the family would be notified, and asked to sign a consent for the use of the four side rails. The DON stated she knew the hospice bed was delivered for the resident, but she did not know that four side rails were being utilized at the facility. The DON reviewed the resident's clinical records and acknowledged there was no documentation regarding the use of four side rails, or a consent for the use of the four side rails identified. She stated a side rail release consent dated 3/06/20, did not address the use of four side rails. Review of the Side Rails Informed Consent and Release dated 3/06/20 revealed the consent did not address the use of four side rails, and the document read, I understand that the side rails are used as a mobility aid and not as a physical restraint. Documentation on the form revealed verbal consent via telephone was obtained from the family. The DON confirmed no additional consent was obtained when the resident received the bed from Hospice, an assessment for the use of the four side rails was not identified, and there was no documentation in the resident's clinical records regarding the request of the family for the use of four side rails. On 8/14/24 at 1:27 PM, the [NAME] Wing RN/UM stated if family requested four side rails, an assessment for the side rails was required. The RN/UM stated she was aware four side rails were considered restraints, but explained she was not aware resident #65 had four side rails in place until made aware by RN A on 8/13/24. Additional information provided to the field office status post exit from the survey revealed a restraint evaluation was completed for the resident on 8/19/24. The facility's policy Freedom from Physical and Chemical Restraints issued/revised 3/02/19 read, When the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview and record review, the facility failed to report allegations of abuse to State agencies as required for 2 of 5 residents reviewed for abuse, of a total sample of 53 residents, (#110 and #276). Findings: 1. Review of resident #110's medical record revealed she was admitted to the facility on [DATE] with diagnoses including osteomyelitis (infection in the bone), pressure ulcer of the sacrum and bipolar disorder. Review of resident #110's Admission Minimum Data Set assessment with Assessment Reference Date of 7/17/24 revealed a Brief Interview for Mental Status score of 15 which indicated intact cognition. The assessment showed resident #110 required substantial assistance with toileting and personal hygiene. The assessment indicated resident #110 did not reject evaluation or care needed to achieve her goals for health and well-being. On 8/13/24 at 10:21 AM, resident #110 stated 2 Certified Nursing Assistants (CNAs) flipped out on her because she had diarrhea, and she had to be cleaned multiple times. She explained she apologized to the CNAs and told them she was taking an antibiotic which caused the diarrhea. With tears in her eyes, resident #110 indicated the CNAs were disrespectful to her and added the way they cleaned her was abuse because they were very rough. She shared she told her assigned nurse, but she could not identify the CNAs. She stated her nurse said she was going to report it to upper management. She recalled the nurse even told her they were handling it but did not tell her how. She stated the CNAs seemed to have a chip on their shoulders. On 8/13/24 at 12:20 PM, Registered Nurse (RN) O stated resident #110 needed a lot of support. She recalled resident #110 expressed concerns regarding the diarrhea while taking antibiotics. She explained the diarrhea was ongoing and, sometimes, she had multiple episodes during a shift. She mentioned resident #110 got discouraged and sad when calling the CNAs often because she needed toileting assistance. RN O indicated resident #110 mentioned some CNAs had different attitudes toward her, rolling their eyes or answering disrespectfully. She indicated she told resident #110 she appreciated she told her because there were residents who could not speak for themselves, so she was not only speaking for herself but helping others. She stated she sometimes would address concerns directly with CNAs, but she did not this time and took it, up the chain of command. She indicated she reported resident #110's abuse allegations to her supervisors but did not recall when exactly. RN O mentioned resident #110 told her CNAs were rude to her, stared at her, or made comments we shouldn't say. RN O recalled resident #110 was crying while sharing this with her, because her feelings were hurt. Review of the Abuse Log for July and August 2024 did not show a report for resident #110. On 8/13/24 at 12:34 PM, the Administrator stated she was not aware of any abuse allegations for resident #110. She indicated her expectation was to be notified by staff when they received any abuse allegation from residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of resident #276's medical record revealed she was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, anemia and depression. Review of resident #276's medical record revealed Progress Notes dated 8/05/24 and 8/06/24 which showed she was alert and oriented to person, place and time. On 8/12/24 at 12:54 PM, with her husband at bedside, resident #276 said she was physically abused last Wednesday at approximately 3:00 AM. She explained she was not asked if she could go to the bathroom for an urine sample but was told she had to. Resident #276 shared her assigned nurse was, yanking her hands around and told her, If you do not give me a urine sample, I know how to get it. She indicated the nurse collected the urine sample by inserting a catheter into her urethra without her consent, forced it, and it hurt her. They indicated after the incident they spoke with the Social Services Director. Resident #276 repeated she was grabbed by her arm and was told to get up from the bed by the nurse and was taken to the bathroom for a urine sample. She stated when she could not urinate, the nurse told her she would get the urine sample another way. Review of a Resident Concern/Grievance Form dated 8/07/24 revealed it was filed by resident #276's spouse due to a care concern with the CNA and nurse. The follow-up section of the document included a hand-written statement entered by the Assistant Director of Nursing (ADON) which read, ADON and Unit Manager spoke with resident and spouse about care concern, resident request that she don't [sic] want that nurse and CNA to take care her [sic]. ADON removed CNA and nurse to [sic] that assignment and offer to resident to be move to another room or she wants to start a reportable. Resident verbalized NO she is fine. Just to remove that [sic] staff the [sic] assignment. On 8/12/24 at 2:37 PM, the Social Services Director indicated she was the Grievance Officer, and all grievances were discussed in morning or afternoon meetings. She explained resident #276's husband came to her office last week and reported a care issue concern. She mentioned she did not know the extent as it was assigned to nursing and handled by their ADON. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 2:54 PM, the ADON joined the interview with the SSD and confirmed she handled the grievance filed by resident #276's husband on 8/07/24. She read the follow-up section she wrote on the grievance form and said she and the Unit Manager (UM) spoke with the resident and her spouse about a care concern that day. She stated resident #276 did not want the nurse and CNA taking care of her. The ADON stated she removed the CNA and nurse from her assignment and offered resident #276 to move into another room or if she wanted to start a reportable. She indicated resident #276 verbalized no, she was going to be fine if the staff was removed from her assignment. When asked why she offered a reportable to resident #276, the ADON stated resident #276 told them the CNA and the nurse were rough when trying to obtain a urine sample. She recalled resident #276 said she felt hurried to get the specimen. She explained after talking to resident #276, she called the nurse who explained she had to collect the urine sample using a straight catheter because the resident could not urinate, but she asked for permission from the resident. The ADON stated she explained the reportable process to the resident which included contacting law enforcement, and the SSD stated based on this, resident #276 did not want a reportable done. The ADON pointed out to resident #276 the way she said the nurse or CNA was rough with her, they would have to investigate deeper. The ADON stated resident #276 told her the CNA grabbed her by her shoulder, to hurry her to pee. The ADON stated she spoke to the assigned CNA who indicated she was never in the room with the nurse during the urine sample collection. The ADON stated the grievance was discussed during their management meeting. The SSD stated the grievance was closed as resolved because the ADON investigated the concern, and the resident was satisfied with the removal of the staff. The ADON stated the resident and her husband, said no all the time, she mentioned reporting, so she did not report it to the Administrator (NHA). The ADON said she did not know they had to do a reportable until today when the Administrator informed her reporting was required. She stated she thought if the resident or family did not want to proceed, they did not have to do it. On 8/12/24 at 3:09 PM, the Administrator stated she met with resident #276 and her husband that day, before she was discharged home. The NHA indicated resident #276 told her she was treated roughly one-night last week while a nurse tried to collect a urine sample. The Administrator stated they initiated an investigation, contacted Law Enforcement and the Department of Children and Families (DCF). She stated both resident #276 and her husband said they did not want to report this incident, but she explained they had to do it. She stated they provided a description of the staff involved and the nurse was suspended pending investigation. She explained if the allegation was substantiated the staff was reported to Board of Nursing. She indicated the resident's safety was most important, but she was not affected as she was discharged today. The NHA read the grievance filed by resident #276's husband on 8/07/24 and stated she had understood it as a customer service issue. She explained if abuse was suspected staff would call her, but she did not receive a phone call last week while she was out of the facility. She stated the Director of Nursing (DON) told her she was not aware of this until today. She explained she had 2 hours to report allegations of abuse to the physician, the resident's representative, Law Enforcement, DCF and to submit an immediate report to the State Survey Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 3:39 PM, Registered Nurse (RN) Q in broken English stated resident #276 had a physician order for a urinalysis and culture and the collection needed to follow a sterile procedure. She indicated she explained the procedure and resident #276 agreed. She stated she asked resident #276 if she could go to the bathroom which she did. She mentioned she tried to collect the urine sample in the bathroom, but resident #276 was unable to urinate so she went back to bed. RN Q stated she told resident #276 to relax once back in bed and she waited a few minutes for resident #276 to calm down. She stated she told resident #276, procedure, catheterize urine and cultivo urinary, me catheterize, I can while showing her the equipment she was going to use. She indicated resident #276 responded yes more than once. RN Q stated she, Did not even touch her much, because the urine came out fast. I almost did not touch her. She recalled during morning report she was sitting at the nurse's station when resident #276's husband was upset after his wife stated she was handled roughly, and was catheterized without her consent. She indicated she tried to explain to him what had happened, but he would not listen. She recalled the ADON called her later that day with questions about this resident. On 8/15/24 at 2:03 PM, the East Wing UM recalled the morning of 8/07/24 resident #276's husband brought up a concern to her assigned nurse and the nurse took him to the nurse's station. The UM stated resident #276's husband mentioned the nurse last night, got a foley (catheter) in his wife and she did not need to do that. The UM stated the husband explained his wife was uncomfortable and asked why she was not taken to the bathroom. She indicated she went to resident #276's room with the ADON to speak with her and her husband. She explained she told them there was a physician order for a urine sample and resident #276 could not urinate so the nurse asked if she could collect a sample with a catheter and resident #276 approved. The UM said the husband clarified what his wife told him, she went to the bathroom, and she could not urinate, and the nurse just collected the sample using the catheter even though resident #276 would have been able to urinate. The UM indicated resident #276, could not really understand the nurse, I think it was miscommunication. She recalled resident #276 's husband requested RN Q not be assigned to his wife again. She stated the ADON and SSD were part of the interview, and one of them asked if they wanted the facility to do, a reportable. The UM said this was done, when there is an allegation of abuse or neglect, when the family thinks they were not taken care of, even if they do not want it, they offer that as an option. Review of the facility's Abuse, Neglect, Exploitation and Injuries of Unknown Origin Policy dated 3/01/17 revealed alleged violations involving abuse, Must be immediately reported to the facility administrator and other officials in accordance with state and federal law. The document indicated the facility would thoroughly investigate and document each alleged violation and ensure all alleged violations involving abuse were reported no later than 2 hours to the administrator and other officials (including the State Survey Agency) in accordance with State Law.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview and record review, the facility failed to provide written Notification of Transfer or Discharge forms to the residents or their representative for 2 of 2 residents reviewed for hospitalization s, of a total sample of 53 residents, (#121 and #123). Findings: 1. Resident #121 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, type 2 diabetes, angina, secondary malignant neoplasm of bone, malignant neoplasm of bladder, acute kidney failure and benign prostatic hyperplasia with lower urinary tract symptoms. Review of resident #121's medical record revealed he was scheduled to be discharged home on 6/08/24. Review of progress notes revealed resident #121 was admitted with an indwelling catheter on 6/02/24. The catheter was removed on 6/04/24. On 6/07/24, staff observed a urinal in resident #121's bathroom which contained bloody urine. Resident reported he started to see blood in his urine the day before but did not report it as he was not in pain. Nursing contacted resident #121's physician who ordered the resident be sent to the hospital immediately for evaluation and treatment. The facility provided a copy of the Notification of Transfer or Discharge form for the hospitalization . The form was not signed by resident #121 or his representative. The resident discharged home from the hospital and did not return to the facility. 2. Resident #123 was admitted to the facility on [DATE] with diagnoses including pancreatic cancer, spinal stenosis, chronic obstructive pulmonary disease, congestive heart failure, sleep apnea, and anxiety. Review of resident #123's medical record revealed she was hospitalized on [DATE]. A progress note dated 5/20/24 indicated the resident was noted to be very sleepy with non-reactive pupils and responded only to touch stimulus. The facility received an order for STAT (immediate) labs. Another progress note dated later on 5/20/24 noted the resident to have a blood pressure of 88/60, pulse 57 beats per minute and oxygen saturation level at 93%. The facility received a new order to transfer resident #123 immediately to the hospital for altered mental status and abnormal vital signs. The resident's representatives came in shortly after the transfer and removed her belongings from the facility. The facility provided a copy of the Notification of Transfer or Discharge form for the hospitalization . The form was not signed by resident #123 nor her representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 1:07 PM, the Social Services Director stated nursing completed the notice of Transfer or Discharge forms for residents who discharged to the hospital. The forms were then given to social services and they sent them to the Ombudsman's office. The Social Services Director clarified she only sent them to the Ombudsman office. She explained she was not responsible for sending the notification to residents or their representatives. On 8/15/24 at 2:50 PM, the Assistant Director of Nursing (ADON) acknowledged her signature was on each of the Notice of Transfer or Discharge forms. She explained nursing completed the forms, sent a copy in the hospital paperwork and gave the form to social services. The Director of Nursing was present and stated she did not know who provided a copy of the form to the resident or resident's representative. The facility was unable to provide proof the resident or resident's representative were notified in writing of the reason for transfer. On 8/15/24 at 2:10 PM, the Executive Director stated she thought social services sent a copy of the Notice of Transfer or Discharge form to the resident's representative if no one was here to sign the form. She explained she was not aware the forms were not being mailed out. The Executive Director clarified the expectation was the resident or resident's representative was provided a copy of the Notice of Transfer or Discharge form.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate for tracheostomy care for 1 of 1 resident, (#86), failed to accurately assess for insulin administration for 1 of 1 resident, (#15), and failed to ensure assessment accurately reflected oxygen (O2) therapy for 2 of 2 residents reviewed for O2 therapy, (#64, and #95), of a total sample of 53 residents. Findings: 1. Resident #86 was admitted to the facility on [DATE] with diagnoses that included nontraumatic brain bleed, respiratory failure, and partial paralysis. Review of the MDS Admission modification assessment with an assessment reference date (ARD) of 8/05/24 revealed resident #86 was, rarely or never understood. The assessment indicated the resident did not have tracheostomy care. A review of resident #86's medical record revealed a physician order dated 7/29/24 to obtain oxygen saturation every shift and, as needed, notify the physician. The order continued for staff to cap the tracheostomy, uncuffed as tolerated. Another order dated 8/01/24 read, tracheostomy-provide tracheostomy care every day and as needed. Change tracheostomy ties daily and as needed. On 8/15/24 at 1:35 PM, MDS Coordinator 1 reviewed resident #86's MDS assessment dated [DATE] and acknowledged she incorrectly coded section O for tracheostomy care. She acknowledged the MDS assessment should reflect the resident's status at the time of the assessment. The MDS Coordinator explained the assessment should include a chart review of the orders, all progress notes, and resident observation/interview during the assessment look-back period. 2. Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis, pulmonary embolism, and cardiomegaly. A review of the MDS Quarterly assessment with ARD 5/23/24 revealed resident #15 had a Brief Interview for Mental Status (BIMS) score of 0/15, which indicated the resident was severely cognitively impaired. The assessment showed the resident received insulin injections on three days during the last seven days or since admission or reentry if less than seven days. A review of resident #15's medical record revealed no physician orders or medication administration for insulin administration. On 8/15/24 at 1:35 PM, MDS Coordinator 1 reviewed resident #15's MDS and acknowledged she incorrectly coded section N. She again indicated the MDS assessment should reflect a picture of the resident at the time of the assessment. The MDS Coordinator stated the assessment should include a chart review of the orders, all progress notes, and resident observation/interview during the assessment look-back period. (continued on next page)

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Avante at St Cloud Inc	1301 Kansas Ave Saint Cloud, FL 34769

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policies and procedures Resident Assessment (RAI) dated 3/02/19 read, It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by the Department of Health and Human Services Center for Medicare and Medicaid Services. 49840 Cross Reference F695 3. Resident #64 was admitted to the facility on [DATE] with diagnoses that included dysphagia, obstructive sleep apnea, acute respiratory failure, shortness of breath, and encounter for palliative care. On 8/12/24 at 11:47 AM, resident #64 was observed in bed wearing a nasal cannula connected to an O2 concentrator set at 2 liters per minute (LPM). He stated that he used oxygen all the time and was received hospice care. The Quarterly MDS assessment dated [DATE], revealed resident #64 was cognitively intact, was dependent on staff for all activities of daily living (ADLs), had several respiratory diagnoses, and received hospice services. The assessment incorrectly reflected O2 therapy was not provided. A review of resident #64's medical record revealed no physician's order for O2. Review of resident #64's medical record revealed a hospital record dated 4/25/24 showed the resident had a diagnosis of O2 dependence, and used 2 LPM of O2 via nasal cannula. Resident #64 had a care plan for O2 therapy initiated on 6/09/23. Interventions included the use of O2 via nasal cannula at bedtime per resident request as ordered. On 8/15/24 at 11:03 AM, MDS coordinator #1 and MDS coordinator #2, both Licensed Practical Nurses (LPNs) stated they were both responsible for completing the MDS assessments. They confirmed resident #64 had been on O2 since he was admitted to the facility, nor was there an order in the medical record for O2 therapy. They explained it was therefore missed during the last Quarterly MDS assessment. 32131 4. Resident # 95 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD) with acute exacerbation, asthma, malignant neoplasm bronchus or lung, cough, and dependence on supplemental oxygen. A physician order dated 7/10/24 was for continuous O2 at 3 LPM via nasal cannula for shortness of breath. The resident's Admission MDS assessment with ARD of 7/16/24 revealed the resident's cognition was intact with a BIMS score of 15 out of 15. Section O for O2 therapy while a resident was not assessed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 1:33 PM, MDS Coordinator 1 stated MDS assessments were completed by doing a seven day look back of the resident's clinical records, observation of the resident, interview of the resident if the resident's cognition was intact, if not the family would be interviewed, interview of nurses, and Certified Nursing Assistants (CNAs). MDS Coordinator 1 reviewed the resident's Admission MDS assessment with ARD of 7/16/24 and confirmed O2 therapy was not assessed. She reviewed the resident's physician orders, which revealed an order dated 7/10/24 for O2 therapy at 3 LPM. The LPN MDS Coordinator confirmed the MDS assessment dated [DATE] was not accurate. On 8/15/24 at 1:35 PM, the Regional MDS Specialist stated the facility did not have a policy regarding accuracy of assessment. She said they followed the guidelines outlined in the RAI Manual. The Centers for Medicare & Medicaid Services Long term Care Facility Resident Assessment Instrument effective October 2019 on page 2-41 read The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA (Care Area Assessment) process provide the foundation upon which the care plan is formulated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview and record review, the facility failed to refer residents with a newly evident mental disorder for Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination for 1 of 4 residents reviewed for PASARR, of a total sample of 53 residents, (#97). Findings: Resident #97 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, diabetes mellitus, unspecified psychosis, and depression. A review of the Minimum Data Set Admission assessment with assessment reference date of 6/12/24 revealed resident #97 had a Brief Interview for Mental Status score of 13, which indicated she was cognitively intact. The document stated her active diagnoses included depression (other than bipolar) and psychotic disorder (other than schizophrenia). Review of resident #97 's electronic medical record revealed the diagnoses of unspecified psychosis with an onset date of 6/05/24 and major depressive disorder also with an onset date of 6/05/24 The record contained a Level I PASARR screening form dated 6/03/24 which did not indicate resident #97 had a mental illness (MI) or suspected MI. The record did not contain a Level II PASARR screening form. On 8/15/24 at 1:05 PM, the Director of Nursing (DON) stated that new admissions from the hospital should have a level I PASARR Screening completed by the hospital before admission to the facility. She explained when psychiatry services made a new diagnosis, the PASARR should be updated. The DON reviewed the Level I PASARR and current diagnoses for resident #97. The DON acknowledged the PASARR did not reflect the resident 's current MI diagnoses of unspecified psychosis and major depressive disorder. The DON stated she did not know why the diagnoses were not listed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice related to the collection of an urine specimen for 1 out of 5 residents reviewed for abuse, (#276), and for limited range of motion and contracture care, for 1 of 2 residents reviewed for limited range of motion and positioning, (#42), out of a total sample of 53 residents. Findings: Cross Reference F609 1. Review of resident #276's medical record revealed she was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, anemia and depression. Review of resident #276's medical record revealed Progress Notes dated 8/05/24 and 8/06/24 which showed she was alert and oriented to person, place and time. On 8/12/24 at 12:54 PM, resident #276 stated a nurse collected a urine sample using a catheter without her consent, through force, which hurt her. Resident #276 indicated she was taken to the bathroom, but she was unable to urinate at that time. She explained when she could not urinate, the nurse told her she would get the urine sample another way and collected the specimen using a catheter. Review of resident #276's physician orders revealed an order dated 8/05/24 which read, U/A C&S (urinalysis and culture and sensitive). The Treatment Administration Record (TAR) showed this was completed on 8/05/24. There was no evidence of a physician order to collect the U/A via urinary catheterization in the medical record. Urinary catheterization is the aseptic process of inserting a sterile hollow pliable tube into the urethra to facilitate urine drainage . Urinary catheters should be inserted only when medically [necessary] . Document attempts at and inadequacy of alternative methods for bladder elimination prior to insertion of the indwelling catheter . Urinary catheters should be placed only under the direction of a physician order, (Retrieved from https://www.ahrq.gov/ on 8/22/24). On 8/12/24 at 3:39 PM, Registered Nurse (RN) Q in broken English stated resident #276 had a physician order for a urinalysis and culture and it needed to be a sterile procedure. She explained she told the resident the procedure and resident #276 agreed. She stated she first asked resident #276 if she could go to the bathroom and she tried to collect the urine sample in the bathroom, but resident #276 was unable to urinate at that time. She explained the resident returned to her bed and she told her to relax. She waited a few minutes for resident #276, to calm down. She stated she told resident #276, Procedure, catheterize urine and cultivo urinary, me catheterize, I can, while showing her the equipment she was going to use. She indicated resident #276 responded yes more than once. RN Q stated she, Did not even touch her much, because the urine came out fast. I almost did not touch her. She recalled resident #276's husband approached her during morning report at the nurse's station. She stated he was upset and said his wife told him she was handled roughly, and was catheterized without her consent. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 2:03 PM, the East Wing Unit Manager (UM) recalled the morning of 8/07/24 resident #276's husband brought up a concern that last night his wife's nurse catheterized his wife without needing to. The UM recalled the husband told her his wife was uncomfortable and he asked why she was not taken to the bathroom for the sample. The UM indicated she went to resident #276's room with the Assistant Director of Nursing (ADON) to speak with them. She explained she told them there was a physician's order for the urine sample and since resident #276 could not urinate, the nurse asked if she could collect the sample with a catheter instead. The UM told her resident #276 had approved of the procedure. The UM indicated resident #276, Could not really understand the nurse, I think it was miscommunication. The UM stated when she reviewed the TAR she noticed there was no documentation of RN Q's collection of the U/A in resident #276's medical record. She confirmed there was no physician order for the alternate collection procedure, which was required for the urinary catheterization. She validated the Lab log showed urine was collected on 8/07/24 for resident #276's and her assigned nurse was RN Q. On 8/15/24 at 5:57 PM, the Director of Nursing (DON) stated she was unaware RN Q did not document she had collected the urine specimen without a new order. She confirmed RN Q did not have an order to collect the urine specimen using a straight catheter. She explained their process for collection of U/A which was collected by the night shift nurses. She confirmed there was no evidence the urine was collected on 8/05/24 as documented in the TAR. She validated there was no evidence the urine sample was sent to the laboratory before 8/07/24. She explained RN Q was required to obtain a new physician's order to collect the urine specimen using a straight catheter and repeated there was no order to recollect the urine sample and no order for straight catheter. She stated the assigned nurse on 8/05/24 should have never signed the U/A completed if not done. She stated RN Q should have verified the orders and notified the physician to obtain a new order. The DON validated RN Q performed the catheterization without a physician's order. Review of the facility's policy and procedures titled Laboratory, Radiology, and Other Diagnostic Services dated 3/02/19 revealed the facility would ensure laboratory, radiology, and other diagnostic services met the needs of the residents with prompt reporting to the ordering provider. Review of the facility's policy and procedures titled Physician Services dated 3/02/19 revealed the facility would provide Physician Services according to State and Federal regulations. The documented read, A physician . must provide orders for the resident's immediate care and needs. It also read, All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift. Review of the Facility Assessment reviewed by the Quality Assessment and Assurance Committee on 7/31/24 revealed nurses were competent in specialized care including catheterization insertion/care and received education/training/in-services Foley catheter and lab orders. 49840 2. Resident #42 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, muscle weakness, paraplegia, adjustment disorder with depressed mood and anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed resident #42 had a Brief Interview for Mental Status score of 15 out of 15, meaning he was cognitively intact. The assessment indicated he did not exhibit any rejection of care behaviors and was dependent on staff for toileting, personal hygiene, dressing, and mobility. Review of resident #42's physician's orders dated 3/23/23 revealed an order by Occupational Therapy (OT) for a right palm cone to be worn daily as tolerated and removed for meals, activities, and activities of daily living. On 8/12/24 at 11:59 AM, resident #42 was observed in his room sitting up in his wheelchair. His right hand was closed, and he stated he was unable to open the right hand without assistance. Resident stated he was not receiving OT, and did not have a palm cone. A blue palm cone was observed on his nightstand and the resident explained he no longer needed to wear it. Review of the OT evaluation and plan of treatment with a certification period from 3/23/23 to 4/21/23 revealed resident #42 was referred for OT by nursing due to a new onset of weakness, reduced functional endurance, and increased fisting posture in the right hand. The note indicated the new conditions placed the resident's right palm at risk for wounds. Further review of OT treatment notes dated 3/23/23 revealed a short-term goal that resident #42 would tolerate the right palm cone daily for 3 hours without signs or symptoms of adverse effects to reduce risk of skin breakdown in the palm of his hand. The document indicated resident #42 tolerated the palm cone for one hour as of 3/23/23. On 8/15/24 at 10:37 AM, the Director of Rehab (DOR) stated resident #42 was discharged from OT on 4/21/23 with an order for restorative nursing care and to continue with right palm cone to prevent skin break down. He explained the DON oversaw the restorative program, and she was responsible for communicating with the MDS coordinator to create the care plan. The DON would also be responsible for communicating with the west wing UM for the new order. Resident #42 was compliant with wearing the palm cone while receiving OT services, but the DOR said that sometimes resident #42 would refuse to wear it. He explained that it was important for the resident to wear the palm cone to prevent skin breakdown. On 8/15/24 at 10:50 AM, the west wing UM stated that resident #42 did not have a palm cone because his name was not on the list of residents with palm cones. She said that she received a list of residents with palm cones from the DON and it would be placed at the nurse's station. She looked in resident #42's medical record and confirmed there was an order for a palm cone dated 3/23/23. The DON stated that resident #42 refuses medical care sometimes. She was unsure why the DON had not added the resident to the palm cone list. The west wing UM stated that the DON was the person responsible for the restorative program and for communicating with the MDS coordinators. [NAME] wing UM explained that it was important for resident #42 to use the palm cone to prevent skin breakdown. Review of resident #42's medical record revealed that there were no care plans addressing restorative services or palm cone usage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 11:03 AM, MDS coordinator #1 and MDS coordinator #2, both Licensed Practical Nurses (LPNs) stated that they are both responsible for creating care plans. The stated that they were not aware resident #42 had an order for a palm guard and they did not find a care plan for it. MDS coordinator #1 explained that when a resident was recommended for a palm cone or restorative services, therapy would communicate with DON. The DON would then communicate with the MDS office so that a care plan could be created. If the resident was refusing care that would be added to the care plan along with interventions addressing the behavior. On 8/15/24 at 01:24 PM, an interview with the DON revealed that she was aware that resident #42 had an order for the palm cone to the right hand. She stated that she had a conversation with the resident on 8/15/24 and he did not want to wear the palm cone. She confirmed that that there was no documentation that showed resident declined the palm cone since 3/23/23. She confirmed that she oversaw the restorative program and was responsible for communicating with the MDS coordinators to create a plan of care for the palm cone.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview observation and record review, the facility failed to implement accident intervention for 1 of 5 residents reviewed for accidents, of a total sample of 53 residents, (#22) Findings: Resident #22 was admitted to the facility on [DATE] with diagnoses including multiple fractures of ribs, chronic obstructive pulmonary disease, and schizophrenia. The Minimum Data Set Admission assessment with assessment reference date 6/26/24 revealed resident #22 had a Brief Interview Memory score of 6/15, which indicated moderate cognitive impairment. The assessment indicated she required moderate assistance with bed mobility and personal hygiene and maximum assistance for transfers. A review of the Smoking assessment for resident #22 dated 7/02/24 read the resident must wear a smoking apron. On 8/12/24 at 2:14 PM, resident #22 was observed on the smoking patio dressed in a hospital gown, sitting in a wheelchair, smoking a cigarette. She was not wearing a smoking apron. On 8/13/24 at 11:37 AM, resident #22 was observed smoking with Certified Nursing Assistant (CNA) J's supervision. The resident was not wearing a smoking apron and flicked ashes from her cigarette to the ground. CNA J stated she was given the cigarettes and lighters for the residents but was not given an apron for any resident who required them. On 8/15/24 at 9:36 AM, resident #22 was observed dressed in two hospital gowns and assisted to light a cigarette by CNA G. The resident again was not wearing an apron. Resident #22's gown had three cigarette burns on the front. On 8/15/24 at 10:14 AM, the East Wing Unit Manager (UM) validated the cigarette burns on the hospital gown. The UM conducted a skin assessment and stated the resident had no injury. The UM confirmed resident #22 should use an apron when smoking. A review of resident #22's medical record revealed no care plan for potential injury related to smoking for staff to follow. On 8/15/24 at 10:20 AM, the Director of Nursing (DON) stated the resident was a safe smoker with an apron at the last assessment. A review of the facility's policy and procedure dated 1/11/19 read, If the IDT members determine that the resident is an unsafe smoker, the resident may be required to wear a protective smoking vest/apron and have a greater degree of staff supervision while smoking.

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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** 49840 Based on observation, interview and record review the facility failed to ensure a physician's order was obtained prior to the administration of oxygen (O2) therapy for 1 of 1 resident, (#64), and failed to ensure the flow rate for O2 therapy was administered as per physician's order for 1 of 1 resident, (#95) reviewed for O2 therapy, of a total sample of 53 residents. Findings: 1. Resident #64 was admitted to the facility on [DATE] with diagnoses that included dysphagia, obstructive sleep apnea, acute respiratory failure, shortness of breath, and encounter for palliative care. On 8/12/24 at 11:47 AM, resident #64 was observed in bed receiving O2 via nasal cannula at 2 liters per minute (LPM). He stated he used oxygen all the time and received hospice care. A review of resident #64's medical record revealed no physician's order for oxygen. The Quarterly Minimum Data Set (MDS) dated [DATE], revealed that resident #64 was cognitively intact, dependent on staff for all activities of daily living (ADLs), had several respiratory diagnoses, and received hospice services. Oxygen therapy was not documented as being provided. Review of resident #64's medical record revealed a hospital record dated 4/25/24 showed the resident had a diagnosis of oxygen dependence and used 2 LPM of O2 via nasal cannula. On 8/12/24 at 4:46 PM, Registered Nurse (RN G) confirmed resident #64 had been received O2 therapy since being admitted to the facility. She was unable to verify how many LPM of oxygen the resident was on because there were no physician's order for O2 in the medical record. RN G explained when a resident with O2 was admitted to the facility, it was the responsibility of the nurse to obtain an order for O2 therapy. She acknowledged having an order in the medical record would ensure the resident received the correct amount of oxygen. On 8/12/24 at 4:50 PM, the [NAME] wing Unit Manager (UM) stated nurses were responsible for checking the oxygen concentrators in the resident rooms to ensure they were set to the correct amount and matched the physicians' orders. She confirmed resident #64 had no physician's order for oxygen therapy in the medical record. The [NAME] wing UM explained the expectation was for all nurses to obtain physicians' orders and ensure they were entered into the medical record. On 8/15/24 at 1:15 PM, the Director of Nursing (DON) stated the expectation was for nurses to obtain the appropriate physician orders and enter them into the medical record as soon as possible. 32131 2. Resident # 95 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD) with acute exacerbation, asthma, malignant neoplasm bronchus or lung, cough, and dependence on supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 7/10/24 for O2 continuous at 3 liters per minute (LPM) via nasal cannula (N/C) for shortness of breath. A care plan for shortness of breath, cough, stable bilateral Pulmonary nodules, nebulizer treatment and requires continuous Oxygen was initiated on 7/10/24. There were no interventions that addressed the settings of the resident's O2 therapy. On 8/13/24 at 10:16 AM, and at 10:23 AM, resident #95 was sitting up in bed. She confirmed she used O2, and stated she should be on O2 at 2 LPM. Observation of the resident's flow rate showed her O2 therapy via N/C was infusing at 8 LPM. On 8/13/24 at 10:29 AM, Registered Nurse (RN) B stated O2 was considered medication. The resident's physician orders were reviewed with RN B, she stated the resident had a physician order for O2 at 3 LPM continuously. On 8/13/24 at 10:30 AM, an observation of the resident's O2 therapy was conducted in the resident's room with RN B, which showed the O2 via NC was infusing at 8 LPM. This was confirmed by RN B, who at that time adjusted the settings down to 3 LPM. RN B stated that during change of shift she received shift report regarding O2 therapy. She stated she did not check the resident's O2 setting this morning, and verbalized the O2 flow rate should be checked by nurses at the beginning and end of their shifts. On 8/13/24 at 10:36 AM, the [NAME] Wing RN/Unit Manager (UM) stated nurses adjust O2 settings and should ensure O2 was at the right setting. The RN/ UM reviewed the resident #95's physician orders and said the resident's order was for O2 at 3 LPM via N/C continually. On 8/13/24 at 10:44 AM, the Director of Nursing (DON) stated O2 therapy was administered per physician order. She stated her expectation for O2 therapy, was a physician order was in place, and nurses were expected to ensure the O2 therapy was being administered at the right flow rate. The DON said nurses should check O2 settings at the beginning of the shift and periodically throughout their shift to ensure O2 therapy was being infused as ordered by the physician. The facility's policy Oxygen issued date 9/02/2020 read, Oxygen is administered under orders of a physician . The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105670	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avante at St Cloud Inc	1301 Kansas Ave Saint Cloud, FL 34769

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** 43192 Based on interview and record review, the facility failed to accurately document administered medications in the Medication Administration Record (MAR) for 1 of 6 residents reviewed for choices, of a total sample of 53 residents, (#279). Findings: Review of resident #279's medical record revealed she was admitted to the facility on [DATE] with diagnoses including open wound on the left lower leg, pain, and cellulitis (bacterial skin infection). Review of resident #279's physician orders revealed an order dated 8/09/24 for Bactrim DS 800-160 milligrams every 12 hours for cellulitis for 10 days. Review of resident #279's Medication Administration Record (MAR) revealed code 9 was used for the 9:00 PM dose of Bactrim on 8/09, 8/10, 8/11, and 8/12/24 and on 8/13/24 for the 9:00 AM dose. The MAR showed the 9:00 AM dose of Bactrim was documented as given on 8/10, 8/11, and 8/12/24. The legend showed when code 9 was used it indicated Other / See Nurse Notes. Review of resident #279's medical record revealed a Progress Notes dated 8/10/24 which indicated on oral antibiotic Bactrim, awaiting medication to arrive. On 8/13/24 at 9:57 AM, resident #279 stated she was prescribed an antibiotic for an infection on her legs, but she had not received it for 3 days. On 8/15/24 at 4:38 PM, Registered Nurse (RN) O stated she entered code 9 for the 9:00 PM dose of Bactrim on 8/10, 8/11, and 8/12/24 because the antibiotic was not available. She stated she did not know she could access Bactrim from the automatic medication dispensing machine. RN O validated she did not give resident #279 the night dose of Bactrim for 3 days. On 8/15/24 at 6:15 PM, the Director of Nursing (DON) stated RN P did not give the 9:00 AM dose of Bactrim to resident #279 on 8/10 and 8/11/24 despite documentation showing he administered it. She mentioned he signed a written statement which indicated he documented the medication as administered accidentally instead of documenting not administered because it was not available. She explained she verified the automatic medication dispensing machine and confirmed Bactrim was not available those days therefore the medical record was inaccurate. Review of the Documentation policy and procedure dated 3/02/19 revealed guidelines for timeliness in documentation to ensure accuracy.