

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Clermont Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E Minnehaha Ave Clermont, FL 34711	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to ensure insulin was administered as ordered by physician for 4 of 8 residents reviewed for unnecessary medications (Residents #1, #183, #72, and #102), and failed to ensure hypotensive medication was administered as per the parameters ordered by physician for 1 of 8 residents reviewed (Resident #27).</p> <p>Findings include:</p> <p>1) Review of Resident #1's physician order dated 2/24/2025 read, Insulin Glargine-yfgn Subcutaneous Solution 100 UNIT/ML [milliliters] (Insulin Glargine-yfgn), Inject 30 unit subcutaneously two times a day for DM [Diabetes Mellitus] Give in morning and HS [Hour of Sleep].</p> <p>Review of Resident #1's Medication Administration Record (MAR) for May 2025 for administration of Insulin Glargine-yfgn showed code 11 (insulin not required) was documented on 5/3/2025 at 8:00 AM, 5/13/2025 at 8:00 AM, 5/17/2025 at 8:00 AM, 5/23/2025 at 8:00 AM, and 5/30/2025 at 8:00 AM, and code 5 (hold/see nurses notes) was documented on 5/9/2025 at 8:00 AM and 5/27/2025 at 8:00 AM.</p> <p>Review of Resident #1's nursing progress notes for May 2025 showed no documentation related to holding insulin.</p> <p>Review of Resident #1's MAR for June 2025 for administration of Insulin Glargine-yfgn showed code 5 was documented on 6/1/2025 at 8:00 AM and 6/6/2025 at 8:00 AM, and code 11 was documented on 6/10/2025 at 8:00 AM, on 6/13/2025 at 8:00 PM, 6/14/2025 at 8:00 AM, 6/24/2025 at 8:00 AM, and 6/28/2025 at 8:00 AM.</p> <p>Review of Resident #1's nursing progress notes for June 2025 showed no documentation related to holding insulin.</p> <p>Review of Resident #1's MAR for July 2025 for administration of Insulin Glargine-yfgn showed code 11 was documented on 7/1/2025 at 8:00 PM, 7/8/2025 at 8:00 AM and 8:00 PM, 7/12/2025 at 8:00 AM, 7/22/2025 at 8:00 AM, and 7/26/2025 at 8:00 AM.</p> <p>Review of Resident #1's nursing progress notes for July 2025 showed no documentation related to holding insulin.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/6/2025 at 3:09 PM, Staff I, Licensed Practical Nurse (LPN), stated, The code 11 means insulin not required. I did not administer the insulin. It was not needed. It (the insulin) was outside the parameters to be given. I don't know if that has any parameters without looking. I did not administer the insulin. I didn't need to give it. I would not need to call the doctor and tell them it (insulin) was not given.</p> <p>During an interview on 8/6/2025 at 5:10 PM, Staff H, LPN, stated, "I did not give the insulin. It was outside the parameters. It [the chart code] means I did not administer it because it's not required. If that's what I documented, that's what happened. I wouldn't need to call (a doctor) if there are parameters.</p> <p>During an interview on 8/6/2025 at 12:29 PM, the Director of Nursing (DON) stated, All staff should follow the orders for medication administration. They need to follow the doctor's orders. The long-acting insulin does not have any order to hold the medication.</p> <p>2) Review of Resident #183's physician order dated 2/24/2025 read, Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, Inject 32 unit subcutaneously every morning and at bedtime for DM.</p> <p>Review of Resident #183's MAR for May 2025 for administration of Insulin Glargine showed code 11 was documented on 5/3/2025 at 8:00 AM, 5/13/2025 at 8:00 AM, 5/17/2025 at 8:00 AM, 5/18/2025 at 8:00 AM, 5/23/2025 at 8:00 AM and 5/28/2025 at 8:00 AM.</p> <p>Review of Resident #183's MAR for June 2025 for administration of Insulin Glargine showed code 11 was documented on 6/10/2025 at 8:00 AM, 6/14/2025 at 8:00 AM, 6/24/2025 at 8:00 AM and 6/28/2025 at 8:00 AM.</p> <p>Review of Resident #183's MAR for July 2025 for administration of Insulin Glargine showed code 5 was documented on 7/2/2025 at 8:00 PM and 7/3/2025 at 8:00 AM, and code 11 was documented on 7/8/2025 at 8:00 AM, 7/12/2025 at 8:00 AM, 7/22/2025 at 8:00 AM and 7/26/2025 at 8:00 AM.</p> <p>Review of Resident #183's nursing progress notes showed no documentation related to insulin administration.</p> <p>During an interview on 8/6/2025 at 3:09 PM, Staff F, LPN, stated, The code 11 means insulin not required. I did not administer the insulin to that resident [Resident #183]. It was not needed. I did not know that I should give it.</p> <p>During an interview on 8/7/2025 at 7:15 AM, Staff G, LPN, stated, I did not administer that insulin to him [Resident #183]. It was outside the parameters. Long-acting insulin doesn't have parameters. I didn't give the insulin.</p> <p>3) Review of Resident #102's physician order dated 5/7/2025 read, "Insulin Glargine-yfng Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine-yfng), Inject 24 unit subcutaneously at bedtime for DM."</p> <p>Review of Resident #102's MAR for June 2025 for administration of Insulin Glargine-yfng at 8:00 PM showed code 9 (other/see progress notes) was documented on 6/7/2025, 6/14/2025, 6/21/2025, 6/22/2025, 6/28/2025, 6/29/2025, and 6/30/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #102's progress note dated 6/7/2025 read, "BS [Blood Sugar]=143. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/14/2025 read, "BS=143. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/21/2025 read, "BS=139. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/22/2025 read, "BS=137. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/28/2025 read, "BS=158. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/29/2025 read, "BS=111. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 6/30/2025 read, "BS=167. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's MAR for July 2025 for administration of Insulin Glargine-yfgn at 8:00 PM showed code 9 was documented on 7/4/2025, 7/9/2025, 7/11/2025, 7/13/2025, 7/18/2025, 7/19/2025, and 7/20/2025.</p> <p>Review of Resident #102's progress note dated 7/4/2025 read, "BS=134. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 7/11/2025 read, "BS=112. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 7/18/2025 read, "BS=160. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's progress note dated 7/20/2025 read, "BS=81. The progress note did not have any other information related to insulin administration.</p> <p>Review of Resident #102's medical record did not have a progress note for 7/13/2025 and 7/19/2025 regarding administration of Insulin Glargine-yfgn.</p> <p>During an interview on 8/6/2025 at 10:39 AM, the DON stated, "Normally you are not supposed to hold long-acting insulin."</p> <p>During an interview on 8/6/2025 at 3:25 PM, Staff B, LPN, stated, "It depends on the blood sugar number. If insulin is low, I know long-acting insulin is for maintenance, but I hold it using my nursing judgement."</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/7/2025 at 8:24 AM, Medical Doctor #1 stated, Long-acting insulin should not be held, but if the blood sugar is low, it can be at times. The nurses will usually call me and let me know when they do. [Resident #102's name] tends to have low blood sugar levels.</p> <p>4) Review of Resident #27's physician order dated 8/9/2024 read, "Blood pressure every shift for PRN [as needed] midodrine usage, give if systolic BP [Blood Pressure] is less than 110 every shift for PRN midodrine usage."</p> <p>Review of Resident #27's physician order dated 7/15/2024 read, "Midodrine HCl Oral Tablet 2.5 MG [milligram] (Midodrine HCl), Give 1 tablet by mouth every 8 hours as needed for hypotension, Give if SBP [Systolic Blood Pressure] less than 110."</p> <p>Review of Resident #27's MAR for June 2025 for blood pressure monitoring and Midodrine administration showed SBP documented as 93 on 6/2/2025 during day shift, 109 on 6/2/2025 during night shift, 102 on 6/7/2025 during night shift, 108 on 6/8/2025 during night shift, 102 on 6/10/2025 during day shift, 109 on 6/11/2025 during night shift, 96 on 6/12/2025 during day shift, and 100 on 6/16/2025 during night shift. Midodrine 2.5 MG was not administered as ordered</p> <p>Review of Resident #27's MAR for July 2025 for blood pressure monitoring and Midodrine administration showed SBP documented as 106 on 7/4/2025 during day shift, 102 on 7/7/2025 during night shift, 93 on 7/8/2025 during day shift, 101 on 7/10/2025 during day shift, 108 on 7/10/2025 during evening shift, 106 on 7/11/2025 during day shift, 107 on 7/11/2025 during night shift, 109 on 7/12/2024 during day shift, 106 on 7/14/2025 during night shift, 97 on 7/16/2025 during night shift, 107 on 7/25/2025 during day shift, and 95 on 7/28/2025 during day shift. Midodrine 2.5 MG was not administered as ordered.</p> <p>Review of Resident #27's MAR for August 2025 for blood pressure monitoring and Midodrine administration showed SBP documented as 90 on 8/1/2025 during night shift and 105 during 8/2/2025 at night shift. Midodrine 2.5 MG was not administered as ordered.</p> <p>Review of Resident #27's physician order dated 5/20/2024 read, "Carvedilol Oral Tablet 3.125 MG (Carvedilol), Give 1 tablet by mouth every 12 hours for tachycardia."</p> <p>Review of Resident #27's MAR for June 2025 for administration of Carvedilol 3.125 MG at 8:00 AM showed code 5 was documented on 6/2/2025, 6/3/2025, 6/5/2025, 6/6/2025, 6/9/2025, 6/10/2025, 6/12/2025, 6/23/2025, 6/24/2025, 6/26/2025, and 6/29/2025.</p> <p>Review of Resident #27's MAR for July 2025 for administration of Carvedilol 3.125 MG at 8:00 AM showed code 5 was documented on 7/3/2025, 7/4/2025, 7/7/2025, 7/8/2025, 7/10/2025, 7/11/2025, 7/14/2025, 7/15/2025, 7/17/2025, 7/18/2025, 7/21/2025, 7/24/2025, 7/25/2025, 7/27/2025, 7/28/2025, and 7/29/2025.</p> <p>Review of Resident #27's MAR for August 2025 for administration of Carvedilol 3.125 MG at 8:00 AM showed code 5 was documented on 8/1/2025, and 8/5/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/5/2025 at 1:16 PM, Staff C, LPN, stated, "When her [Resident #27's] blood pressure is low, that is when I got to give her the midodrine to get it up. When the blood pressure is too low, we hold the Carvedilol. For the Midodrine, she gets it when the bottom blood pressure is lower than 60. Midodrine we really look more at the diastolic blood pressure. The facility did an in-service and told us what we were supposed to do regarding the blood pressure medication and what parameters to use to hold it. They instructed us during the in-service to only hold and recheck before I leave. Also, report to the next shift."</p> <p>During an interview on 8/6/2025 at 1:45 PM, the DON stated, "I spoke to the nurse. It was the same nurse throughout. She was confused about the perfect blood pressure and what we spoke about in the in-service. I would expect staff to follow the providers' parameters."</p> <p>During an interview on 8/7/2025 at 10:09 AM, the Medical Doctor #3 stated, Nursing staff should follow the parameters and physician orders provided. [Resident #27's name] has not had any medical concerns.</p> <p>5) Review of Resident #72's a physician order dated 6/18/2025 read, Insulin Glargine Subcutaneous Solution 100 Unit/ML (Insulin Glargine), Inject 20 unit subcutaneously at bedtime for DM.</p> <p>Review of Resident #72's MAR for June 2025 for administration of Insulin Glargine showed code 11 was documented on 6/26/2025 and on 6/27/2025 at 8:00 PM.</p> <p>Review of Resident #72's MAR for July 2025 for administration of Insulin Glargine showed code 11 was documented on 7/3/2025, 7/11/2025, 7/15/2025, and 7/17/2025 at 8:00 PM.</p> <p>During an interview on 8/6/2025 at 10:30 AM, the Director of Nursing stated, Long-acting insulins should not be held unless the doctor gives an order to hold it. If the resident refuses and is adamant that they don't want it, the nurse should educate the resident. If they have been educated and continue to refuse, the nurse should notify the doctor of the refusal and document a note.</p> <p>During an interview on 8/7/2025 at 10:17 AM, the Medical Doctor #4 stated, Long-acting insulin should not be held. If long-acting insulin is held, the blood sugar can go high. I expect the nurses to give the long-acting insulin and not hold it. I looked at [Resident #72's name] blood sugars, and they have all been below 179, so I do not believe he has experienced any harm or consequences due to the insulin being held.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper positioning while tube feeding for 1 of 2 residents reviewed for tube feeding (Resident #40). Findings include: During an observation on 8/4/2025 at 9:19 AM, Resident #40 was lying in bed with the mattress flat and tube feeding pump running at 50 milliliters per hour. Resident #40 had her head on a pillow and the rest of her body was flat on the mattress. Review of Resident #40's physician order dated 7/30/2025 read, Enteral feed order every shift PEG [Percutaneous Endoscopic Gastrostomy] tube Feed: Glucerna 1.5 Cal [calorie] Continuous via tube to infuse at a rate of 50 ml/hr [milliliter/hour]. Total volume of 1100 ml infused in 22 Hours. Hang feed at 1900 [7:00 PM]. May turn off for care/services. Verify infusing Q [every] shift. Clear pump when total volume has infused. Review of Resident #40's physician order dated 6/11/2025 read, Elevate head of bed while feeding and medication is being administered every shift every shift for prevention. During an interview on 8/4/2025 at 9:25 AM, Staff A, Registered Nurse (RN), stated that Resident #40's head of bed should be at least up at a 30-degree angle while tube feeding. Review of Resident #40's care plan dated 6/3/2025 read, Focus: Tube feeding: The resident is receiving enteral nutrition. Interventions. Elevate HOB [head of bed] during administration of feeding or medication administration. During an interview on 8/5/2025 at 1:15 PM, when the policy and procedure on tube feeding was requested, the Director of Nursing stated they did not have a policy, just a standard for enteral feeding.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>Based on record review and interview, the facility failed to ensure the physician documented the rationale for disagreement with the pharmacist's recommendation for 1 of 5 residents reviewed for unnecessary medications (Resident #58). Findings include: Review of Resident #58's pharmacy review titled Note to Attending Physician/Prescriber dated 6/12/2025 read, 1. Can PRN [as needed] Geri-Tussin DM [Dextromethorphan] be discontinued due to non-use? No. 2. Can PRN Loperamide be discontinued due to non-use? No. 3. Can PRN Meclizine be discontinued due to non-use? No. 4. Can PRN Midodrine be discontinued due to non-use? No. 5. Can PRN Tramadol be discontinued due to non-use? No. Physician/Prescriber response: Disagree. Provide Rationale [Blank]. The document was signed by the Medical Doctor #4. During an interview on 8/7/2025 at 8:34 AM, the Director of Nursing (DON) stated, I receive monthly pharmacy reviews and sometimes in between. For short stay residents, we send over a pharmacy review request, the pharmacist looks the medications over and sees if anything needs to be discontinued and we run that by the primary care doctor. We have monthly GDR [Gradual Dose Reductions] meetings. During an interview on 8/7/2025 at 9:14 AM, the Medical Doctor #4 stated, They usually bring all of the papers from the pharmacy at once, and sometimes I don't have time to assess all of the pharmacy notes. Usually, I write on the pharmacy paper whether I want to make a change or why I disagree. I don't always have time to write a disagreement because there just isn't time, but I try to do it.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate for antidiabetic medication administration for 1 of 8 residents reviewed for medication management (Resident #34). Findings include: Review of Resident #34's physician order dated 8/14/2024 read, Monitor BS [Blood Sugar] every 12 hours for PRN [as needed] glipizide two times a day for PRN glipizide, Administer is [Sic.] BS is greater than 180. Review of Resident #34's physician order dated 2/8/2025 read, Glipizide Oral Tablet 10 MG [milligram] (Glipizide), Give 1 tablet by mouth every 12 hours as needed for DM [Diabetes Mellitus], Give if blood sugar is greater than 180. Review of Resident #34's Medication Administration Record (MAR) for June 2025 for monitoring blood sugar showed blood sugar was documented as 223 at 8:00 AM, and 224 at 8:00 PM on 6/2/2025; 336 at 8:00 AM, and 247 at 8:00 PM on 6/3/2025; 310 at 8:00 AM on 6/7/2025; 203 at 8:00 AM on 6/8/2025; 260 at 8:00 PM on 6/9/2025; 238 at 8:00 AM, and 232 at 8:00 PM on 6/10/2025; 316 at 8:00 AM on 6/11/2025; 266 at 8:00 AM, and 223 at 8:00 PM on 6/13/2025; 194 at 8:00 AM on 6/15/2025; 192 at 8:00 AM on 6/17/2025; 238 at 8:00 AM on 6/18/2025; 220 at 8:00 AM on 6/20/2025; 185 at 8:00 AM on 6/23/2025; 291 at 8:00 AM, and 388 at 8:00 PM on 6/24/2025; and 225 at 8:00 AM on 6/30/2025. Review of Resident #34's MAR for June 2025 for administration of Glipizide Oral Tablet 10 MG showed no entries documented on 6/2/2025, 6/3/2025, 6/7/2025 (for administration of medication at 8:00 AM), 6/8/2025, 6/9/2025, 6/10/2025, 6/11/2025, 6/13/2025, 6/15/2025, 6/17/2025, 6/18/2025, 6/20/2025, 6/23/2025, 6/24/2025, and on 6/30/2025. Review of Resident #34's Medication Administration Record (MAR) for July 2025 for monitoring blood sugar showed blood sugar was documented as 194 at 8:00 PM on 7/3/2025; 189 at 8:00 AM, and 286 at 8:00 PM on 7/6/2025; 274 at 8:00 AM on 7/7/2025; 206 at 8:00 PM on 7/8/2025; 253 at 8:00 PM on 7/9/2025; 184 at 8:00 PM on 7/10/2025; 208 at 8:00 PM on 7/15/2025; 228 at 8:00 AM on 7/16/2025; 216 at 8:00 AM on 7/19/2025; 186 at 8:00 AM on 7/20/2025; 201 at 8:00 PM on 7/21/2025; 214 at 8:00 PM on 7/22/2025; 225 at 8:00 AM on 7/23/2025; 200 at 8:00 PM on 7/24/2025; 265 at 8:00 PM on 7/27/2025; 210 at 8:00 AM on 7/28/2025; and 183 at 8:00 AM on 7/30/2025. Review of Resident #34's MAR for July 2025 for administration of Glipizide Oral Tablet 10 MG showed no entries documented on 7/3/2025, 7/6/2025, 7/7/2025, 7/8/2025, 7/9/2025, 7/10/2025, 7/15/2025, 7/16/2025 (for administration of medication at 8:00 AM), 7/19/2025, 7/20/2025, 7/21/2025, 7/22/2025, 7/23/2025, 7/24/2025, 7/27/2025 (for administration of medication at 8:00 PM), 7/28/2025, and 7/30/2025. During an interview on 8/6/2025 at 10:39 AM, the Director of Nursing stated, Nursing documentation is expected to be accurate and should ask questions if they need an order to be clarified. During an interview on 8/6/2025 at 12:47 PM, Staff D, Registered Nurse (RN), stated, I always give her the Glipizide if it is more than 180. If she refuses, then I will call the daughters and tell them also. Maybe I am documenting it in the wrong area. During an interview on 8/7/2025 at 9:10 AM, the Medical Doctor #3 stated, [Resident #34's name] is very non-complainant with her antidiabetic medication. She will often refuse and will absolutely not want insulin injections. The Glipizide orders have parameters as a request from the daughters. She is a very brittle diabetic and will bottom out easily, but she is very non-complainant. I do think the nurse give her the Glipizide as per the parameters when she allows them to. During an interview on 8/7/2025 at 9:14 AM, the Director of Nursing stated, In talking to nursing staff, I think there is some confusion as to where they think they are documenting they are giving the Glipizide since the PRN order has the medication and parameters listed and then you have the PRN medication also. I spoke to [Staff D, RN's name] and that was what she was explaining to me. During an interview on 8/7/2025 at 10:09 AM, Staff J, Licensed Practical Nurse (LPN), stated, Usually [Resident #34's name] will refuse her medication. If she does want to take the medication, I follow the parameters. I don't recall right now what happened those days. The doctor is aware she refuses frequently. Review of the facility policy and procedure titled Medication Administration with the last review date of 1/3/2025 read, Procedures. Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. 5. When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and if applicable, injection site.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Clermont Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E Minnehaha Ave Clermont, FL 34711	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105512	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident (Resident #192) was placed on contact precautions and failed to ensure staff used appropriate Personal Protective Equipment (PPE) and performed hand hygiene while providing care to the residents on contact precautions to prevent the possible spread of infection and communicable diseases. Findings include: During an interview on 8/5/2025 at 11:50 AM, Resident #192 stated, I have an infection. It's MRSA [Methicillin Resistant Staphylococcus aureus]. They [staff members] don't wear any gowns or anything when they help me. During an observation on 8/4/2025 at 11:50 AM, there was no contact isolation signage on the Resident #192's room door. Review of Resident 192's nursing progress note dated 8/1/2025 read, Resident admitted to the facility via wheelchair. Female patient [AGE] years old with diagnosis of COPD [Chronic Obstructive Pulmonary Disease], asthma, respiratory failure, aortic stenosis. Resident on oxygen 2L [liters] via nasal cannula. Resident on fluids restriction 1500ml [milliliters]. Resident on IV [intravenous] antibiotic every 24 for MRSA, follow contact precaution for MRSA, her skin is intact, no complain [Sic.] of pain, will continue to monitor. Review of Resident #192's physician order dated 8/4/2025 read, Enhanced barrier precaution for IV therapy. Review of Resident #192's physician order dated 8/5/2025 read, Enhanced/contact barrier precaution for IV therapy. During an observation on 8/5/2025 at 7:40 AM, Staff K, Certified Nursing Assistant (CNA), entered Resident #192's room to deliver a meal. Staff K did not perform hand hygiene, did not don personal protective equipment. Staff K moved the overbed table, placed the meal tray and assisted the resident to sit up. Staff K exited the room. During an interview on 8/5/2025 at 9:05 AM, Staff K, CNA, stated, She is not on isolation for anything, so I don't need to use a gown. Review of Resident #192's care plan initiated on 8/1/2025 and revised on 8/4/2025 read, Focus: Infection: The resident has an infection MRSA, Blood infection and is receiving IV ABT [Antibiotics] via RUA [Right Upper Arm] PICC [Peripherally Inserted Central Catheter]. Interventions. Contact Precautions. During an observation on 8/6/2025 at 7:08 AM, Staff I, Registered Nurse (RN), did not don PPE or perform hand hygiene. Staff I entered Resident #192's room. Staff I took vital signs. Staff I exited the room, returned to the medication cart, unlocked the medication cart, prepared medications, locked the medication cart, and entered Resident #192's room without donning PPE. Staff I administered oral medications and exited the room. Staff I obtained a dressing kit from the medication cart, and donned gloves without performing hand hygiene. Staff I did not don a gown. Staff I removed supplies from the dressing kit and donned sterile gloves over non-sterile gloves. Staff I placed a mask on the resident, but did not put a mask on. Staff I removed the old dressing and did not don sterile gloves. Staff I had the same gloves. Staff I cleaned the insertion site, placed a new transparent dressing on the site, doffed gloves without performing hand hygiene, and exited the room. Staff I went to the medication room, obtained a normal saline flush, entered Resident #192's room without donning PPE, removed the end cap on the needleless connector and flushed the line. Staff I exited the room and returned to the medication cart and began preparing medications for another resident without performing hand hygiene. During an interview on 8/6/2025 at 7:38 AM, Staff I, RN, stated, She [Resident #192] is on IV antibiotics for an MRSA infection. I should have gowned and gloved when I did the vitals and gave the meds [medications]. She [Resident #192] is on contact precautions. Review of the facility policy and procedure titled Barrier Precautions with the last review date of 1/3/2025 read, Policy: Standard Precautions are the minimum infection prevention steps to include. 2. Use of appropriate protective equipment (i.e., gloves) before patient contact. Contact precautions are used when the employee expects to be in direct or indirect contact with a patient and/or his or her environment including a person's room, or objects in contact with the person, that has an infection with an organism transmitted fecal- orally, such as Clostridium difficile, or wound and skin infections, or multi-drug resistant bacteria such as methicillin- resistant Staphylococcus aureus (MRSA). PPE required before entering a contact precaution designated room is always gloves and a gown.</p>		