STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105556	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village on the Green	500 Village Place Longwood, FL 32779

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on observation, interview, and record review, the facility failed to ensure an intravenous (IV) dressing was changed as ordered for 1 of 1 residents reviewed for IV therapy, of a total sample of 27 residents, (#45). Findings: Resident #45 was admitted to the facility on [DATE] with diagnoses including infection following a procedure, superficial incisional surgical site. A care plan for IV Medication use was initiated on 3/10/25. The care plan indicated resident #45 received IV antibiotics status post exploratory surgery and drained abscess to surgical site mid lower back. Interventions included to observe IV site for possible signs/symptoms of infection or infiltrate and peripherally inserted central catheter (PICC) line care and flush as ordered. A PICC line is a long, thin tube inserted into a vein usually in your arm and passed through larger veins near your heart to give access to the larger veins for some types of medication or nutrition. A PICC line requires careful care and monitoring for complications, including infection and blood clots, (retrieved on 4/01/25 from www.mayoclinic.org). Review of resident #45's electronic medical record (EMR) revealed a physician order dated 3/14/25 which instructed licensed nurses to change injection caps weekly with PICC line dressing change every day shift every Friday for PICC line dressing. The order was cancelled 3/14/25 and another order entered to start on 3/22/25. The new order instructed licensed nurses to change injection caps weekly with PICC line dressing change every day shift, every Friday for PICC line dressing. Review of resident #45's EMR revealed a progress note dated 3/12/25 entered by Licensed Practical Nurse A which read, PICC line dressing changed. Review of the Treatment Administration Record (TAR) for March 2025 revealed documentation the IV dressing was changed on 3/14/25 by Registered Nurse B. On 3/17/25 at 10:38 AM, resident #45 was observed in bed. An IV medication bag was hanging from the IV pole. The IV site was covered with a transparent bandage with a white gauze pad underneath. The IV dressing was dated for 3/12/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 3:10 PM, resident #87 was observed in a wheelchair next to the bed. Transparent IV dressing with a gauze pad underneath remained in place, dated 3/12/25. On 3/18/25 at 3:20 PM, the Director of Nursing (DON) observed the transparent IV dressing applied to resident #87's right arm. She acknowledged the date on the dressing was 3/12/25. She verified there was a gauze dressing under the clear dressing which should have been changed within 24 hours. The DON stated the dressing should have been changed since 3/12/25. The DON was made aware of documentation for dressing change on 3/12/25 and of another nurse documenting dressing change on 3/14/25. She acknowledged the dressing obviously had been changed on 3/12/25. The facility's policy and procedure for Central Venous Catheter Care and Dressing Changes indicated the IV dressing should be changed at least every two days for sterile gauze dressing including gauze under a transparent semi-permeable membrane dressing.

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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 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** 50875 Based on observation, interview, and record review, the facility failed to maintain oxygen flow rates as ordered by the physician for 1 of 1 residents reviewed for respiratory care, of a total sample of 27 residents, (#657). Findings: Review of the medical record revealed resident #657 was admitted to the facility on [DATE] from the hospital. His diagnoses included sepsis, pneumonia, acute respiratory failure with hypoxia, congestive heart failure, type 2 diabetes mellitus, and hypertension. Resident #657's Order Summary Report showed an active physician's order for oxygen at 2 liters per minute (LPM) via nasal cannula. The medical record also revealed a care plan intervention initiated on 3/17/25 that indicated the resident's oxygen settings should be administered via nasal cannula per physician orders. On 3/17/25 at 12:28 PM, resident #657 was observed in bed, being administered humidified oxygen through a nasal cannula connected to an oxygen concentrator. The concentrator's flow rate was set at 3 LPM. On 3/18/25 at 9:29 AM, resident #657 was in bed with the nasal cannula connected to an oxygen concentrator with his daughter at bedside. The concentrator's flow rate of oxygen was observed at 3 LPM and both resident #657 and his daughter stated they had not adjusted the flow rate on the oxygen concentrator. On 3/19/25 at 9:26 AM, the assigned nurse who was the Assistant Director of Nursing (ADON) verified the amount of oxygen shown on the concentrator with a flashlight from her phone, took photographic evidence and then stated it was set at 3 LPM of oxygen. She immediately went to her computer to verify the physician's order and confirmed the order was for 2 LPM of oxygen and not 3 LPM. The ADON explained she would notify the doctor. At that time the Director of Nursing (DON) passed by and stated she would verify the amount on the concentrator, just to be sure. The Facility's Policy for Oxygen Administration revised October 2010 showed that staff were to review the physician's orders for oxygen administration in preparation for administration.