

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Club Healthcare and Rehabilitation Center at the V		STREET ADDRESS, CITY, STATE, ZIP CODE 16529 SE 86th Belle Meade Circle The Villages, FL 32162	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to ensure resident's physician was notified of a change in condition for 1 of 3 residents reviewed for significant weight loss, Resident #38.</p> <p>Findings include:</p> <p>Review of Resident #38's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including unspecified severe protein-calorie malnutrition, muscle wasting and atrophy, unspecified dementia, acute kidney failure and adult failure to thrive.</p> <p>Review of Resident #38's Weights and Vitals Summary showed the resident weighed 76.4 lbs. (pounds) on 12/30/2024, and 71.2 lbs. on 1/4/2025, which indicates -6.44% loss. The resident's weight on 1/11/2025 was 66.9 lbs., which indicates -12.09% loss compared to the weight on 12/30/2024, and the resident's weight on 1/25/2025 was 62.2 lbs., which indicates -18.59% loss compared to the weight on 12/30/2024.</p> <p>Review of Resident #38's dietary profile dated 1/2/2025 showed it read, New admit. Nutrition Evaluation and recommendations completed . Per her daughter she has not been eating or drinking for the last month per H and P [History and Physical] . Eating an estimated 26-75% at most meals, however PO [by mouth] intake is variable . Admit body weight is 76.4# [pounds], with BMI [Body Mass Index] of 13.9 indicating underweight and malnourished. Medications reviewed. Receiving Furosemide/Diuretic which may cause weight fluctuations . Labs 12/31 indicating low protein levels, high creatinine and high calcium levels . Continue to monitor PO intake, labs, weight changes and skin and adjust nutrition interventions prn [as needed]. Proceed with poc [plan of care].</p> <p>During an interview on 1/28/2025 at 12:57 PM, the Registered Dietitian (RD) stated, [Resident #38's name] was malnourished when she got to the facility. She has poor PO intake and daughter said she was not eating that much prior to coming here. [Resident #38's name] came in at 76.4 pounds. She should be on fortified foods. I was consulted and encouraged an appetite stimulant. The provider puts in the orders. She should be on an appetite stimulant. I have asked about it twice and still nothing is in there. It would be great to put her on one.</p> <p>During an interview on 1/28/2025 at 3:42 PM, the Director of Nursing (DON) stated, She [the RD] looks in the record and looks at our notes. The RD knows how to read the notes. She knows when a weight is available and knows how to request weights.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/29/2025 at 1:12 PM, the Advanced Practice Registered Nurse (APRN) #1 stated, I did see [Resident #38's name]. I oversee pain management. Not overall appetite and weights. I focus on pain management and physiatry [physical medicine and rehabilitation].</p> <p>During an interview on 1/29/2025 at 3:30 PM, the Medical Doctor #2 (MD #2) stated, The RD should have been monitoring the [Resident #38's name] weights. The RD never contacted me in regards to [Resident #38's name] weight loss. If I am not responding, I can get a text all the time.</p> <p>During an interview on 1/29/2024 at 3:49 PM, the APRN #2 stated, I recall the patient [Resident #38]. I do not have the record in front of me. I was not notified of any weight changes with the resident [Resident #38].</p> <p>During an interview on 1/30/2025 at 1:15 PM, the DON stated, I did not see a change in condition in the system for the weight changes of 1/4/2025 and 1/11/2025 for [Resident #38's name]. I didn't see one I cannot make it up. I would not be able to say if the provider or the family was notified of the significant weight change.</p> <p>Review of the facility policy and procedure titled Change in Condition with the last review date of 1/23/2025 showed it read, Policy: It will be the policy of this facility to notify the physician, family, resident, and/or responsible party/resident representative (as is applicable) of significant changes in condition and providing treatment(s) according to the resident's wishes and physician's orders. Procedure: 1. Observe resident during routine care and during monthly/quarterly/annual assessment periods to identify significant changes in physical or mental conditions, orientation, change in vital signs, weights, etc. 2 When a change is noted, gather pertinent data such as vital signs, weights and other clinical observations . 4. When significant changes in skin or weight are noted it is appropriate to contact the physician and responsible party/resident representative (if applicable) to notify them and receive orders such as consultations, root cause analysis or implementation of further monitoring . 7. Contact the primary physician to update him/her to the change in condition. In the event the primary physician cannot be notified, attempt to contact the facility's medical director.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 5 residents reviewed for nutrition, Resident #17.</p> <p>Findings include:</p> <p>Review of Resident #17's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including unspecified protein-calorie malnutrition, anemia, gastro-esophageal reflux disease without esophagitis, and acute kidney failure.</p> <p>Review of Resident #17's quarterly Minimum Data Set, dated dated [DATE] showed it read, Section K-Swallowing/Nutritional Status . K0310. Weight Gain: Gain of 5% or more in the last month or gain of 10% or more in last 6 months . 2. Yes, not on physician-prescribed weight-gain regiment. Section K did not indicate the resident was on therapeutic diet.</p> <p>Review of Resident #17's progress note dated 12/27/2024 showed it read, Weight Note. 12/18: 118.8# [pounds], 7/30/2024: 134.6#. Weight loss of 11.7% in 6 months.</p> <p>Review of Resident #17's physician order dated 12/2/2024 showed it read, Boost with meals for moderate protein energy malnutrition, albumin 2.6, Document percent consumed.</p> <p>Review of Resident #17's physician order dated 5/21/2024 showed it read, Regular diet, Regular texture, Thin consistency, Add Fortified Foods to all meals.</p> <p>Review of Resident #17's physician order dated 5/21/2024 showed it read, House Shake No Sugar Added two times a day varied PO [by mouth] intake Glucerna Shake by mouth.</p> <p>During an interview on 1/28/2025 at 12:47 PM, the Registered Dietitian stated, [Resident #17's Name] has been declining and losing weight for some time now. We have all nutritional interventions in place, but she does keep losing weight.</p> <p>During an interview on 1/29/2025 at 2:17 PM, the MDS Coordinator stated, I did have to make a modification for section K. It was coded for weight gain and she had weight loss.</p> <p>During an interview on 1/30/2025 at approximately 8:30 AM, the MDS Coordinator stated, [Resident #17's name] Section K in the MDS is not current. She should be coded for therapeutic diet since she has fortified foods ordered and supplements.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to reassess the effectiveness of the interventions, review and revise the resident's care plan when necessary for 1 of 3 residents reviewed for significant weight loss, Resident #38.</p> <p>Findings include:</p> <p>Review of Resident #38's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including unspecified severe protein-calorie malnutrition, muscle wasting and atrophy, unspecified dementia, acute kidney failure and adult failure to thrive.</p> <p>Review of Resident #38's Weights and Vitals Summary showed the resident weighed 76.4 lbs. (pounds) on 12/30/2024, and 71.2 lbs. on 1/4/2025, which indicates -6.44% loss. The resident's weight on 1/11/2025 was 66.9 lbs., which indicates -12.09% loss compared to the weight on 12/30/2024, and the resident's weight on 1/25/2025 was 62.2 lbs., which indicates -18.59% loss compared to the weight on 12/30/2024.</p> <p>Review of the Intradisciplinary Plan of Care review meeting summary dated 12/31/2024 showed it read, Nursing reviewed meds and diet due to resident's weight loss due to weight loss. Resident weight loss is from poor appetite @ [at] home.</p> <p>Review of Resident #38's care plan initiated on 1/2/2025 showed it read, Focus. [Resident #38's name] is at risk for an alteration in nutrition and/or hydration r/t [related to]: has a chewing problem, has a swallowing problem, receives therapeutic diet, receives mechanically altered diet, underweight BMI [Body Mass Index] of 13.9, UTI [urinary tract infection], HTN [hypertension], Bradycardia, HLD [hyperlipidemia], COPD [chronic obstructive pulmonary disease], Dementia, Adult FTT [failure to thrive], AKF [acute kidney failure] . Interventions/Tasks: Provide tray set up; assist as needed . Provide diet as ordered. Offer and provide alternate as needed . Honor food preferences . Encourage adequate intake at meals . Keep fresh water at bedside . Encourage adequate fluid intake . Educate resident of importance in adhering to prescribed diet and of consequences of deviation from diet as needed . Supplements as ordered . Registered dietician consult as needed . Allow adequate time to eat.</p> <p>Review of Resident #38's records showed no revised care plan.</p> <p>During an interview on 1/30/2025 at 10:17 AM, the Director of Nursing (DON) stated, After the 1/11/2025 significant weight loss, I do not see any interventions put in place for [Resident #38's name] other than what was already in place. Looking back, I would have addressed gastric tube with the family or palliative care.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/30/2025 at 12:26 PM, the Minimum Data Set (MDS) Coordinator stated, Typically the RD will revise the care plan and we will also review it. Typically, the care plan will be revised if a person has a significant weight change. We would revise the care plan and make sure she is taking all the supplements and any changes that can be made. We have a clinical meeting every morning and that's when we are notified of the significant weight loss. IDT [Intradisciplinary Team] meeting is where I am alerted what needs to go into the care plan and I would add it. We would review and revise and discuss weight loss as a team. On 1/4/2025, it should have triggered a care plan revision. I was not aware of her weight loss.</p> <p>During an interview on 1/30/2025 at 1:15 PM, the DON stated, [Resident #38's name]'s care plan should have been revised after significant weight loss.</p> <p>Review of the facility policy and procedure titled Comprehensive Assessments and Care Plans with the last review date of 1/23/2025 showed it read, Standard: It will be the standard of this facility to make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS . Guidelines . 6. The facility will maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessment to develop, review, and revise the residents' comprehensive care plan.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523</p> <p>Based on record review and interview, the facility failed to ensure residents received adequate nutrition for 1 of 3 residents reviewed for significant weight loss, Resident #38.</p> <p>Findings include:</p> <p>Review of Resident #38's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including unspecified severe protein-calorie malnutrition, muscle wasting and atrophy, unspecified dementia, acute kidney failure and adult failure to thrive.</p> <p>Review of Resident #38's Weights and Vitals Summary showed the resident weighed 76.4 lbs. (pounds) on 12/30/2024, and 71.2 lbs. on 1/4/2025, which indicates -6.44% loss. The resident's weight on 1/11/2025 was 66.9 lbs., which indicates -12.09% loss compared to the weight on 12/30/2024, and the resident's weight on 1/25/2025 was 62.2 lbs., which indicates -18.59% loss compared to the weight on 12/30/2024.</p> <p>Review of Resident #38's physician order dated 12/30/2024 showed it read, Regular diet, Mechanical soft texture, nectar thick consistency.</p> <p>Review of Resident #38's physician order dated 12/30/2024 showed it read, Obtain weight upon admission then weigh weekly x 4 [4 times] and then weight monthly.</p> <p>Review of Resident #38's physician order dated 12/30/2024 showed it read, Cholecalciferol Tablet 1000 unit, give 2 tablets by mouth one time a day form supplemental.</p> <p>Review of Resident #38's physician order dated 1/1/2025 showed it read, House Nutritional Supplement two times a day for nutritional supplement, risk of malnutrition, offer 240 ml [milliliters] and document amount consumed.</p> <p>Review of Resident #38's physician order dated 1/2/2025 showed it read, Regular diet, Mechanical soft texture, nectar thick consistency, add: Fortified foods to all meals for risk of malnutrition.</p> <p>Review of Resident #38's physician order dated 1/2/2025 showed it read, House Protein two times a day for risk of malnutrition, offer 30 ml and document amount consumed.</p> <p>Review of Resident #38's physician order dated 1/2/2025 showed it read, Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ [with] Minerals), Give 1 tablet by mouth one time a day for risk if malnutrition.</p> <p>Review of Resident #38's physician order dated 1/15/2025 showed it read, Regular diet, mechanical soft texture, thin consistency.</p> <p>Review of Resident #38's physician orders showed no appetite stimulant ordered.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #38's dietary profile dated 1/2/2025 showed it read, New admit. Nutrition Evaluation and recommendations completed . Per her daughter she has not been eating or drinking for the last month per H and P [History and Physical]. NKFA [no known food allergies]. Diet is Regular, Mechanical Soft texture with thin liquids. Eating an estimated 26-75% at most meals, however PO [by mouth] intake is variable. Can feed self needing help with set up . Admit body weight is 76.4# [pounds], with BMI [Body Mass Index] of 13.9 indicating underweight and malnourished. Medications reviewed. Receiving Furosemide/Diuretic which may cause weight fluctuations. Also receiving Vitamin D 3 as vitamin supplementation. Labs 12/31 indicating low protein levels, high creatinine and high calcium levels . Continue to monitor PO intake, labs, weight changes and skin and adjust nutrition interventions prn [as needed]. Proceed with poc [plan of care].</p> <p>During an interview on 1/28/2025 at 12:57 PM, the Registered Dietitian (RD) stated, [Resident #38's name] was malnourished when she got to the facility. She has poor PO intake and daughter said she was not eating that much prior to coming here. [Resident #38's name] came in at 76.4 pounds. She should be on fortified foods. I was consulted and encouraged an appetite stimulant. The provider puts in the orders. She should be on an appetite stimulant. I have asked about it twice and still nothing is in there. It would be great to put her on one.</p> <p>Review of Resident #38's medical visit note dated 1/6/2025 authored by Advanced Practice Registered Nurse #2 (APRN #2) showed it read, History of Presenting Problem: Patient starter [Sic.] stated that she has not been eating or drinking.</p> <p>During an interview on 1/28/2025 at 3:42 PM, the Director of Nursing (DON) stated, She [the RD] looks in the record and looks at our notes. The RD knows how to read the notes. She knows when a weight is available and knows how to request weights.</p> <p>During an interview on 1/29/2025 at 1:12 PM, the APRN #1 stated, I did see [Resident #38's name]. I oversee pain management. Not overall appetite and weights. I focus on pain management and physiatry [physical medicine and rehabilitation].</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/29/2025 at 3:30 PM, the Medical Doctor #2 (MD #2) stated, The patient had weight loss prior to coming in. She [Resident #38] had severe protein calorie malnutrition. I consulted the dietitian and started on protein shakes. The nursing staff said she [Resident #38] was finishing her meals, and the registered dietitian should have been monitoring, but sometimes patients will not respond to treatment. The patient might not respond with protein shakes and fortified meal. The RD never contacted me in regards to [Resident #38's name] weight loss. Maybe she contacted my nurse practitioner. Keep in mind she lost weight and that does not stop when you leave the hospital you can continue to lose weight until recovery because of weakness, sickness, inflammation and being bedridden. I believe that dietitian has been following, and they would tell me if she would need an appetite stimulant, but I was never notified to start her on an appetite stimulant. She came with weight loss. I rounded at the beginning and was never told. I don't know if my NP [Nurse Practitioner] was notified. She left a week ago. If the facility is saying they notified me, they should be able to prove that. If I am not responding, I can get a text all the time. When she continued to lose weight, the next thing would have been talk to the RD, go with an appetite stimulant and finally g-tube, or do nothing depending on the family. Weight loss is not uncommon to be seen in patients with dementia. They need to be encouraged to eat and be assisted with hand feeding. Common sense questions would be fortified meals, supplement does the resident like the shake, there are different variables. Supervise by staff if despite supervision and try the appetite stimulant. If resident was being weighed weekly, the facility should communicate to the nurse practitioner weekly in regards to the weights letting her know the weight changes. That would be the reason for weekly weights.</p> <p>During an interview on 1/29/2024 at 3:49 PM, the APRN #2 stated, I recall the patient [Resident #38]. I do not have the record in front of me. I no longer work for the facility. I was not notified of any weight changes with the resident [Resident #38]. Of course, I would have implemented the intervention. I would check thyroid levels to make sure it is not the reason of weight loss, but I do not recall the facility communicating the weight loss.</p> <p>During an interview on 1/30/2025 at 9:45 AM, the Dietary Manager stated, [Resident #38's name] is on fortified foods. I communicate with the RD. I am notified when residents have a significant weight loss weekly. I communicate with the RD, and she informs me. I started working here on 1/6/2025. I was not aware of her [Resident #38] significant weight loss. I would expect interventions to be put in place. I would try food first, supplement and appetite stimulant.</p> <p>During an interview on 1/30/2025 at 10:17AM with the DON stated, After the 1/11/2025 significant weight loss, I do not see any interventions put in place for [Resident # 38 name] other than what was already in place. Looking back, I would have addressed a gastric tube with the family or palliative care.</p> <p>During an interview 1/30/2025 at 11:50 AM, the Speech Language Pathologist stated, I changed her diet order after evaluating the patient [Resident #38]. We monitor, for a period of time, the residents in the facility and do trials to see if we can place residents on thin liquids. The resident [Resident #38] was not having any issues during the trials. I changed the diet from thicken liquids to thin liquids because she [Resident #38] was tolerating it well, the diet change or evaluation completed was not because of weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Weights and Weight Loss with the last review date of 1/23/2025 showed it read, Policy: It will be the practice of this facility to implement the following systems regarding weight documentation. Procedure . 3. The RD/DTR [Dietetic Technician, Registered] is to review all admission weight for possible interventions. 4. Consistent weight loss noted during the admission weight process will be brought to the attention of the physician and/or RD and responsible party. 5. Significant weight loss shall be addressed by the physician and/or RD through discussion with the resident and/or resident representative for known preferences and desires and development and implementation of interventions to attempt to address the weight loss . 8. Weekly and Daily weights may be obtained per RD or physician orders in order to monitor clinical status of a resident requiring closer monitoring and intervention.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not five percent or greater for 2 out of 31 observations of medication administration. The facility had a medication error rate of 6.45%.</p> <p>Findings include:</p> <p>1) During an observation on 1/28/2025 at 8:25 AM, Staff E, Licensed Practical Nurse (LPN), began pouring Resident #159's medications into individual cups. Staff E removed Guaifenesin ER (Extended Release) tablet from her medication cart and placed the medication in a medication cup. Staff E finished placing all medications into individual cups and then proceeded to crush each medication. Staff E donned personal protective equipment and entered Resident #159's room. Staff E was about to begin to administer the medication via Resident #159's gastric tube. The surveyor asked Staff E to stop the medication administration process and notified Staff E that she had crushed an extended-release medication to administer enterally.</p> <p>During an interview on 1/28/2025 at 8:30 AM, Staff E, LPN, stated, I know she has an extended-release medication. I have not had any problem with them. But I know they should not administer. I know that they cannot be administered via g tube [gastric tube].</p> <p>Review of Resident #159's physician order dated 1/13/2025 showed it read, Guaifenesin ER Tablet Extended Release 12 Hour 600 MG [milligram], Give 1 tablet via G-Tube every 12 hours for cough.</p> <p>Review of Resident #159's physician order dated 1/14/2025 showed it read, Nothing by mouth diet, Nothing by mouth texture, Nothing by mouth consistency.</p> <p>2) During an observation on 1/29/2025 at 9:55 AM, Staff D, Registered Nurse (RN), began pouring medications in individual medication cups for Resident #161. Staff D crushed one Aspirin low dose delayed-release tablet, one Lisinopril tablet and poured one Cholestyramine oral packet of powder into a cup. Staff D entered Resident #161 room. Staff D entered Resident #161's room, and then entered Resident #161's bathroom and poured water into two plastic cups. Staff D donned gloves. Staff D premixed each medication cup with water and dissolved each medication. Staff D checked Resident #161's gastric tube for placement. Staff D proceeded to flush Resident #161's gastric tube. Staff D was going to begin administering the medications. The surveyor asked Staff D to stop the medication administration process and step outside to review the medications.</p> <p>During an interview on 1/29/2024 at approximately 10:20 AM, Staff D, RN, stated, I know I should not crush and administer a delayed-release medication via g-tube.</p> <p>Review of Resident #161's physician order dated 11/12/2024 showed it read, Aspirin Low Dose Oral Tablet Delayed Release 81 MG (Aspirin), Give 1 tablet via G-Tube one time a day for heart health.</p> <p>During an interview on 1/29/2025 at 11:23 AM, the Director of Nursing stated, The nursing staff should not crush and administer delayed-release or extended-release medication via the g-tube. They should call the provider and get alternative medication.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Medication Errors with the last review date of 1/23/2025 showed it read, Policy: It will be the policy of this facility that the staff and practitioner shall try to prevent medication errors and adverse medication consequences and shall strive to identify and manage them appropriately when they occur.</p> <p>Review of the facility policy and procedure titled Medication Administration via Enteral Feeding Tube with the last review date of 1/23/2025 showed it read, Policy: Medication shall be prepared and administered according to the following established guidelines . Precautions: Common Medications not to crush: Some medications and dosage form should not be crushed. If there are any questions regarding the crushing of medications, call the pharmacy.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure the drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles (Photographic evidence obtained).</p> <p>Findings include:</p> <p>During an observation on 1/26/2025 at 10:06 AM, Resident #160 was lying in bed. There was one bottle of Tylenol tablets on top of the resident's drawer.</p> <p>During an interview on 1/26/2025 at 10:06 AM, Resident #160 stated, I had a headache and my daughter brought the Tylenol for me. I took the medication, and it has been there ever since.</p> <p>During an observation on 1/26/2025 at 10:18 AM, Resident #1 was lying in bed. There was one tube of 1% Silver Sulfadiazine Cream on top of the bedside table next to the resident's bed.</p> <p>During an interview on 1/26/2025 at 10:18 AM, Resident #1 stated, The nurses will apply the cream to my wound when I ask them too.</p> <p>During an observation on 1/26/2025 at 10:41 AM, Resident #32 was lying in bed. There was one tube of Goodsense extra strength itch relief cream on top of the resident's bedside table.</p> <p>During an interview on 1/26/2025 at 10:41 AM, Resident #32 stated, The itch cream is for my neck to stop it from itching.</p> <p>During an interview on 1/29/2025 at 11:17 AM, the Director of Nursing (DON) stated, If a resident can self-administer, they will have a self-administration assessment, physician order and care. The resident should not have meds [medications] at bedside. The family is in and out. We will take the medication out if deem unsafe. The nightstand locks so the resident is given a key.</p> <p>Review of the facility policy and procedure titled Medication/Biological Storage with the last review date of 1/23/2025 showed it read, Policy: It will be the policy of this facility to store medications, drugs and biologicals in a safe, secure and orderly manner. Procedure . 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications, drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unlocked if out of a nurse's view.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>40559</p> <p>Based on observation, record review and interview, the facility failed to ensure resident records were complete and accurate for 6 of 8 residents reviewed for nutrition (Residents #1, #12, #21, #38, #41, and #256), 2 of 6 residents reviewed for wound care (Residents #158 and #42), and 2 of 5 residents reviewed for blood pressure medication (Residents #17 and #32).</p> <p>Findings include:</p> <p>1) Review of Resident #12's physician order dated 1/16/2025 showed it read, House Protein two times a day for risk of malnutrition, wound healing, Offer 30 ml [milliliters] and document amount consumed.</p> <p>Review of Resident #12's medication administration record for January 2025 showed no entry documented for the amount of House Protein consumed from 1/17/2025 through 1/27/2025.</p> <p>Review of Resident #21's physician order dated 12/16/2024 showed it read, House Protein two times a day for risk of malnutrition, wound healing, Offer 30 ml and document amount consumed.</p> <p>Review of Resident #21's medication administration record for January 2025 showed no entries documented for the amount of House Protein consumed from 1/1/2025 through 1/27/2025.</p> <p>Review of Resident #41's physician order dated 11/15/2024 showed it read, House Protein two times a day for risk of malnutrition, Offer 30 ml and document amount consumed.</p> <p>Review of Resident #41's medication administration record for January 2025 showed no entries documented for the amount of House Protein consumed from 1/1/2025 through 1/27/2025.</p> <p>Review of Resident #256's physician order dated 1/21/2025 showed it read, House Protein three times a day for risk of malnutrition, wound healing, Offer 30 ml and document amount consumed.</p> <p>Review of Resident #256's medication administration record for January 2025 showed no entries documented for the amount of House Protein consumed from 1/22/2025 through 1/27/2025.</p> <p>46523</p> <p>Review of Resident #1's physician order dated 12/25/2024 showed it read, House Nutritional Supplement two times a day for Nutritional Supplement, risk of malnutrition, Offer 240 ml and document amount consumed.</p> <p>Review of Resident #1's physician order dated 12/25/2024 showed it read, House Protein two times a day for risk of malnutrition, Offer 30 ml and document amount consumed.</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 - Some</p>	<p>Review of Resident #1's medication administration record for January 2025 showed no entries documented for the amount of House Protein consumed or the amount of House Nutritional Supplement consumed from 1/1/2025 through 1/27/2025.</p> <p>Review of Resident #38's physician order dated 1/1/2025 showed it read, House Nutritional Supplement two times a day for Nutritional supplement, risk of malnutrition, Offer 240 ml and document amount consumed.</p> <p>Review of Resident #38's physician order dated 1/2/2025 showed it read, House Protein two times a day for risk of malnutrition, offer 30 ml and document amount consumed.</p> <p>Review of Resident #38's medication administration record for January 2025 showed no entries documented for the amount of House Nutritional Supplement consumed or the amount of House Protein consumed from 1/1/2025 through 1/27/2025.</p> <p>During an interview on 1/30/2025 at 9:31 AM, the Director of Nursing (DON) confirmed Residents #1, #12, #21, #41, #256, and #41's medication administration records for January 2025 did not contain documentation of the amount of House Protein or House Supplement consumed and the physician orders did include document amount consumed.</p> <p>2) Review of Resident #42's physician order dated 12/14/2025 showed it read, Cleanse sacrum with NS [normal saline], pat dry, cover with calcium alginate, and border foam, skin prep surrounding tissue, every day shift . Order Status: Discontinued.</p> <p>Review of Resident #42's physician order dated 1/28/2025 showed it read, Late order entry: for 1/17/2025, 1/19/2025, 1/25/2025, 1/26/2025, 1/28/2025. The order is as such, cleanse sacrum, pat dry. Cover wound bed with calcium alginate, add border foam dressing. Skin prep surrounding tissue every 7-3 shift and PRN soiling or dislodgement.</p> <p>Review of Resident #42's treatment administration record for January 2025 showed two orders for sacrum wound care, one with a start date of 12/15/2024 and a discontinue date of 1/2/2025, and another with the start date of 1/3/2025 and discontinue date of 1/15/2024. There was no entries documented on 1/3/2025, 1/7/2025, 1/9/2025, and 1/10/2025.</p> <p>Review of Resident #42's physician orders showed no active orders for sacral wound care after 1/15/2025.</p> <p>Review of Resident #42's Wound Assessment Report dated 1/20/2025 showed it read, Location: sacrococcygeal . Wound status: Stable . Treatment: Dressing Change Frequency: Daily and PRN. Clean wound with: Cleanse with normal saline. Primary Treatment: Calcium alginate, skin prep surrounding tissue or peri wound, Collagen. Other Dressings: Bordered foam, Recommended air mattress.</p> <p>Review of Resident #42's Wound Assessment Report dated 1/27/2025 showed it read, Location: sacrococcygeal . Wound status: Improving without complications . Treatment: Dressing Change Frequency: Daily, and PRN. Clean wound with: Cleanse with normal saline. Primary Treatment: Calcium alginate, skin prep surrounding tissue or peri wound, Collagen. Other Dressings: Bordered foam.</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 - Some</p>	<p>During an interview on 1/28/2025 at 3:50 PM, the DON stated, I spoke to the nurse. It [the physician order] was deleted by error, but wound care was provided as ordered.</p> <p>During an interview on 1/29/2025 at 9:23AM, Staff A, Licensed Practical Nurse (LPN), stated, We discontinued the Santyl order, and I don't know what happened that I didn't put in the new order. I did all wound care for the resident.</p> <p>Review of the facility policy and procedure titled Wound Care with the last review date of 1/23/2025 showed it read, Procedure . 10. Document in the clinical record when treatments are performed.</p> <p>3) During an observation on 1/26/2025 at 10:10 AM, Resident #158 was lying in bed. There was a single lumen midline on her left arm with a transparent dressing dated 1/22.</p> <p>During an observation on 1/28/2025 at 11:11 AM, Resident #158 was lying in bed with a midline on her left arm with a transparent dressing dated 1/22.</p> <p>Review of Resident #158's physician order dated 1/23/2025 showed it read, Change needleless connector every day shift every 7 day(s).</p> <p>Review of Resident #158's physician order dated 1/23/2025 showed it read, Change transparent dressing. Measure external catheter length every day shift every 7 day(s), Observe site for signs and symptoms of infection, infiltration and or/ extravasation.</p> <p>Review of Resident #158's medication administration record for January 2025 showed the needleless connector was changed on 1/24/2025.</p> <p>Review of Resident #158's medication administration record for January 2025 showed the transparent dressing was changed on 1/24/2025.</p> <p>During an interview on 1/28/2025 at 1:30 PM, the DON stated, I spoke to the nurse and she stated she had documented incorrectly in the system.</p> <p>During an interview on 1/28/2025 at 2:05 PM, Staff A, LPN, stated, It was a mistake. It was clicked off by accident.</p> <p>Review of the facility policy and procedure titled PICC [Peripherally Inserted Central Catheter]/Midline IV [Intravenous] Line with the last review date of 1/23/2025 showed it read, Dressing Changes . 2. Dressing changes will be documented in the clinical record.</p> <p>4) Review of Resident #32's physician order dated 11/10/2024 showed it read, Hydralazine HCl Oral Tablet 25 MG [milligram] (Hydralazine HCl), Give 1 tablet by mouth three times a day for htn [hypertension], hold for SPB<110 or DBP <60 [systolic blood pressure less than 110 and diastolic blood pressure less than 60].</p> <p>Review of Resident #32's medication administration record for January 2025 showed the resident received Hydralazine HCl on 1/3/2025 at 6:00 AM for a systolic blood pressure of 92, on 1/18/2025 for a systolic blood pressure of 107, and on 1/27/2025 for a systolic blood pressure of 101.</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 - Some</p>	<p>During an interview on 1/28/2025 at 3:40 PM, the DON stated, I spoke to the physician and order was correct. He wants to keep both the systolic and diastolic blood pressures separate. The medication was given out of parameters, and it should have been held.</p> <p>Review of Resident #17's physician order dated 1/22/2025 showed it read, Metoprolol Succinate ER [Extended Release] Tablet Extended Release 24 hour 25 MG, Give 1 tablet by mouth one time a day for HTN, Hold if SBP <115 or HR <60 [heart rate less than 60].</p> <p>Review of Resident #17's medication administration record for January 2025 showed the resident received Metoprolol Succinate ER 25 mg tablet on 1/22/2025, 1/23/2025, and 1/24/2025 at 9:00 AM when systolic blood pressure was 111.</p> <p>Review of Resident #17's physician order dated 11/25/2024 showed it read, Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG, Give 1 table by mouth one time a day for HTN, Hold if SBP <110 or HR <60. The order was discontinued on 1/21/2025.</p> <p>Review of Resident #17's medication administration record for January 2025 showed the resident received Metoprolol Succinate ER 25 mg tablet on 1/4/2025 at 9:00 AM with the HR of 53, on 1/6/2025 at 9:00 AM with the SBP of 100 and HR of 57, on 1/12/2025 at 9:00 AM with the HR of 57, on 1/13/2025 and 1/14/2025 at 9:00 AM with the SBP of 94 and HR of 59.</p> <p>During an interview on 1/29/2025 at 7:51 AM, the Medical Director stated, The staff notify me about the vital signs and ask if blood pressure medication should be given. We are starting to change the parameters because the one we had in place were pretty high. When vitals are out of parameters, they notify me. There can always be improvements on documentation. One should expect if the staff is asking us what parameters are and we say it is okay for the medication to be given, they should be documenting in the system.</p> <p>Review of the facility policy and procedure titled Charting and Documentation with the last review date of 1/23/2025 showed it read, Policy: It is the policy of this facility that services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical record as is needed.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>40559</p> <p>Based on record review and interview, the facility failed to submit accurate direct care staffing information to CMS for the fourth quarter of 2024.</p> <p>Findings include:</p> <p>Review of the Payroll Based Journal (PBJ) for the fourth quarter of 2024 (July 1 - September 30) showed low weekend registered nurse (RN) staffing for Saturday and Sunday on September 7-8, 2024.</p> <p>During an interview on 1/28/2025 at 2:00 PM, the Administrator stated, The PBJ staffing trigger of low weekend staffing for nurses was because an RN who was covering for the RN Supervisor on the weekend of September 7th and 8th, while the weekend supervisor was on vacation was coded for another sister facility and not here at this facility. Upon request, the Administrator did not provide a policy and procedure on PBJ submission.</p> <p>During an interview on 1/29/2025 at 8:16 AM, Staff D, RN, stated, I worked at the Club back in September, the first weekend to cover for the weekend supervisor. My hours worked were coded for the facility I normally work in and not for the Club.</p>

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<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>46523</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff used appropriate personal protective equipment (PPE) while providing direct contact care for 2 of 10 residents reviewed for enhanced-barrier precautions (EBP), Residents #1 and #161, and 1 of 4 residents reviewed for transmission-based precautions, Resident #158, to prevent the possible spread of infection and communicable diseases.</p> <p>Findings include:</p> <p>During an observation on 1/26/2025 at 12:23 PM, Staff C, Activities Assistant, donned gloves and grabbed a pillow from Resident #1's chair in the residents' room. Staff C assisted Resident #1 to turn to his right side. Staff C placed the pillow on the resident's back, tucking the pillow in the left side of the resident's back to assist with repositioning and offloading the resident. Resident #1's room door had an enhanced barrier precaution sign and a plastic bin outside of Resident #1's room with personal protective equipment.</p> <p>Review of Resident #1's physician order dated 1/24/2025 showed it read, Requires enhanced barrier precautions R/T [related to] wound care every shift for prophylaxis.</p> <p>During an observation on 1/26/2025 at 2:05 PM, Staff B, Licensed Practical Nurse (LPN), was flushing Resident #158's midline with normal saline. Staff B was wearing gloves and a surgical mask. Staff B did not have a gown. Resident #158's door had a contact-precaution sign posted and there was a plastic bin with personal protective equipment outside of the room.</p> <p>Review of Resident #158's physician order dated 1/24/2025 showed it read, Contact isolation-MRSA [Methicillin-Resistant-Staphylococcus Aureus] in wound every shift for precaution until 3/01/2025 23:59 [11:59 PM].</p> <p>During an interview on 1/28/2025 at 2:29 PM, the Infection Preventionist stated, The staff are supposed to wear gloves and gown when entering an enhanced barrier room during high contact activity; when the staff is touching the resident for more than a couple of seconds. If the staff was tucking the pillow and assisting with repositioning, the staff should have had gloves and gown on. If a staff is flushing an IV [Intravenous Catheter], I believe they should also wear a gown and gloves.</p> <p>During an observation on 1/29/2025 at 9:55 AM, Staff D, Registered Nurse (RN), began pouring medications in individual medication cups for Resident #161. After preparing the medications, Staff D entered Resident #161's room. Resident #161 room door had an enhanced barrier sign posted with a plastic bin containing personal protective equipment. Staff D entered Resident #161's room without donning a gown or gloves. Staff D entered Resident #161's bathroom and poured water into two plastic cups. Staff D donned gloves. Staff D did not wear a gown. Staff D premixed each medication cup with water and dissolved each medication. Staff D checked Resident #161 gastric tube for placement. Staff D proceeded to flush Resident #161 gastric tube.</p> <p>Review of Resident #161's physician order dated 1/13/2025 showed it read, Requires enhanced barrier precautions R/T GTUBE [gastric tube] every shift for precaution.</p> <p>(continued on next page)</p>		

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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>During an interview on 1/29/2024 at approximately 10:20 AM, Staff D, RN, stated, I am covering today from another facility. I know I should have put on gloves and a gown before coming into contact with the gastric tube.</p> <p>During an interview on 1/29/2025 at 11:19 AM, the Director of Nursing (DON) stated, Enhanced barrier is to protect residents that have portals for infection. Staff must don gloves and gown when providing care, putting hands on and have contact with patient.</p> <p>During an interview on 1/29/2025 at 1:25 PM, Staff C, Activities Assistant stated, I do remember that [Resident #1's name] said he was on his bottom for a while and I asked if he wanted to be repositioned and I offered to take pressure off his bottom. I put the pillow underneath, and he said he felt better. You are supposed to gown up and stuff, but I was not sure if he was an enhanced barrier precautions. There is usually a sign on the door, but I don't recall there being a sign on the door. If they have open wounds or infection, we should follow enhanced barrier precautions. I was unaware [Resident #1's name] had wounds. If I knew he had wounds, I would have put on a gown.</p> <p>During an interview on 1/30/2025 at 8:22 AM, the DON stated, Staff should gown and wear gloves when going into a contact precaution room. No exceptions. It is not like the enhanced barrier precautions.</p> <p>Review of the facility policy and procedure titled Enhanced Barrier Precautions with the last review date of 1/23/2025 showed it read, Policy: It will be the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Definitions: Enhanced barrier precautions refers to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms . Procedure . 4. For residents for whom EBP are indicated, EBP is employed when performing the following High-contact care activities- a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, e. Changing linens, f. Changing briefs or assisting with toileting, g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, h. Wound care: any skin opening requiring a dressing.</p> <p>Review of the facility policy and procedure titled Transmission Based Precautions with the last review date of 1/23/2025 showed it read, Contact Precautions. Contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment . Guidelines for Contact Precautions . Gowns. 1. [NAME] gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident care environment.</p>		