STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106099	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villages Healthcare and Rehabilitation Center, The	900 Highway 466 Lady Lake, FL 32159

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to ensure care was provided in a manner that maintains each residents' dignity for 1 of 7 residents, Resident #2, reviewed for personal clothing.Findings included: During an observation on 12/11/2025 at 11:25 AM, Resident #2 was lying on his back in bed on an air mattress. The call device was within reach. There was a foley catheter bag clipped to the right side of the bed. There was a wheelchair at the foot of the bed with a pair of pants and a shirt placed over the back of the wheelchair. The resident was wearing a hospital-style gown and had a white blanket over his legs. During an interview on 12/11/2025 at 11:25 AM, Resident #2 stated that he prefers to wear his personal clothing but was not given an option to get dressed this morning, stating, I think they don't want to get me dressed because of this catheter tube. During an observation on 12/11/2025 at 2:10 PM, Resident #2 was dressed in a hospital-style gown, lying on his back in bed. Review of Resident #2 care plan dated 09/15/2025 read, Focus: Baseline care plan: Resident needs assist with ADLs [activities of daily living]. Date initiated: 09/15/2025. Interventions: Assist/provide ADL care and support as needed. During an interview on 12/12/2025 at 10:08 AM, the Director of Nursing stated that it is her expectation that all residents are provided assistance as needed to get up out of bed each morning, ADL [activities of daily living] care is provided, and residents are dressed in their own personal clothing, unless the resident prefers otherwise. Review of policy and procedure titled, ADL Care and Assistance issued 04/01/2022 read, Policy: It will be the policy of this facility to provide the resident with Activities of Daily Living (ADL) care and assistance while attempting to maintain the highest practicable level of function for the resident. 3. Staff should be mindful to provide ADL care with dignity, privacy, and respect to the resident, unless otherwise indicated by the resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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** Based on interview and record review, the facility failed to ensure residents received post operative care per the physician's orders for 1 of 3 residents, Resident #1, reviewed for wound care. Findings include: Resident #1 was admitted to the facility on [DATE], with medical diagnoses that included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing and Unspecified severe protein-calorie malnutrition. Review of Resident #1's physician's orders dated 5/12/2025 read, Day 5 post op [after surgery] clean right hip with hibiclens. Day 10 post op remove aquacel dressing [a dressing to absorb wound fluids]. Clean right hip surgical site with hibiclens [antiseptic skin cleanser] and 4 by 4s [a square medical bandage] remove staples and apply steri strips [sterile adhesive strips] for 2 wks [weeks].Review of Resident #1's TAR (Treatment Administration Record) for May 2025 did not contain documentation the physician's orders were followed for day 5 post op clean right hip with hibiclens, day 10 post op remove aquacel dressing clean right hip surgical site with hibiclens and 4 by 4s or to remove staples and apply steri strips in 2 wks.During an interview on 12/12/2025 at 10:08 AM, the Director of Nursing stated, The expectation is that all physician orders are to be followed or the physician should be notified. Resident #1's staples should have been removed on May 16th [2025]. Review of the policy and procedure titled, Wound Care, with an issue date of 4/01/2022 read, Policy: It will be the policy of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. Procedure: 6. Wound care procedures and treatments should be performed according to physician orders. 12. Contact the physician for additional order changes as is appropriate or to notify of skin condition changes or refusals of care.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the recurrence of pressure ulcers for 1 of 3 residents, Resident #2, reviewed for pressure ulcers.Findings include: During an observation on 12/11/2025 at 11:25 AM, Resident #2 was lying on his back in bed on an air mattress. The call device was within reach There was a foley catheter bag clipped to the right side of the bed. There was a wheelchair at the foot of the bed. During an interview on 12/11/2025 at 11:25 AM, Resident #2 stated, They haven't turned me since last night. I am getting a sore on my butt, and it hurts. During an observation on 12/11/2025 at 2:10 PM, Resident #2 was dressed in a hospital-style gown, lying on his back in bed, in the same position that the surveyor observed him in at 11:25 AM. During an observation on 12/11/2025 at 2:18 PM, the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) were observed wearing gowns and gloves, and repositioning Resident #2 in bed. Resident #2's lower back was bright red and there was a small open area on the left side of the sacrum. During an interview on 12/12/2025 at 5:19 PM, the Assistant Director of Nursing stated, Residents with wounds should be turned and repositioned every hour and as needed. Residents without wounds should be turned and repositioned every two hours and as needed. Review of Resident #2's care plan dated 09/15/2025 read, Focus: [Resident #2's name] is noted to have skin impairment as follows: pressure ulcer: to sacrum. Date initiated: 09/16/2025. Interventions: Monitor and treat for pain as indicated/ordered. Administer medications for wound healing as ordered; observe for effectiveness and for Se's [side effects]. Provide diet as ordered. Observe intake. Offer/provide alternatives as needed. Provide nutritional supplements as ordered to promote wound healing. Registered Dietician consult as needed. Pressure reducing mattress to bed. Turn and reposition to promote wound healing. Keep sheets clean, dry, and as wrinkle free as possible. Use proper positioning, transferring, and turning techniques to minimize friction. Perform wound treatments as ordered. Wound care physician services to follow. Observe wound for sx/sx [signs/symptoms] of infection and for significant decline; update physician if noted. Review of Resident #2's care plan dated 09/15/2025 read, Focus: [Resident #2's name] has a potential for skin impairment/pressure ulcer r/t [related to]: impaired mobility, incontinence of bowel, incontinence of bladder, hx [history] of pressure ulcers, fragile skin. Turn and reposition to promote offloading of pressure. Use proper positioning, transferring, and turning techniques to minimize friction, pressure reducing mattress to bed. Encourage and assist resident to float heels while in bed. Apply/remove foam boots to [NAME] [lower extremity] as ordered. Perform incontinence care prn [as needed] after each episode of incontinence. Perform skin treatments as ordered. Observe skin for sx/sx of skin breakdown/pressure ulcer if noted. Allow resident to make decisions re: daily cares; educate of unsafe choices as needed. Review of Resident #2's Healing Partners skin and wound note dated 12/08/2025 read, Reason for visit: new skin and wound consult on current resident. [Resident #2's name]. Wound care consulted today after nursing staff noted an open area on the sacrum. Patient was previously treated for a stage II pressure injury to the buttock. The patient was admitted to the facility on [DATE] following treatment at the hospital due to complaints of a recent fall that led to fracture of the right femur. Patient is at high risk for pressure ulcer formation related to decreased mobility, comorbidities, incontinence of stool. The resident is incontinent of bowel. Wound Assessment: Location: Sacrum: Primary Etiology: Pressure Ulcer/Injury. Stage/Severity: Stage 2. Assessment/plan: The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Review of the policy and procedure titled, Wound Care issued 04/01/2022 read, Policy: It will be the policy of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds, and the treatment of skin impairment. 8. Preventative measures, such as barrier creams, can be employed to help maintain skin integrity as well as utilization of pressure relieving surfaces, floating heels, protective boots, and use of positioning devices. Use of barrier creams may vary according to product and may be used following incontinent care for additional prevention, provided there is no clinical contraindication.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize, evaluate, and address the needs of residents, including but not limited to, residents at risk or already experiencing impaired nutrition, for 3 of 5 residents, Residents #1, #2, and #7, reviewed for nutrition and weight loss.Findings Include: 1) Review of Resident #1's medical record documented an admission date of 5/09/2025, with medical diagnoses that included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing and unspecified severe protein-calorie malnutrition Review of Resident #1's MDS (Minimum Data Set) assessment dated [DATE] documented under Section C - BIMS [Brief Interview for Mental Status] Score 09 = moderate cognitive impairment. Section K – Feeding tube; Proportion of total calories the resident received through parenteral or tube feeding – 51% or more. Review of Resident #1's Care Plan documented, Focus – The resident's nutrition is provided by non-oral methods. [Resident #1's name] Is at risk for complications associated with enteral feedings due to dx [diagnosis] of: dysphasia [impairment in the in producing, understanding, reading, or writing language] and esophageal cancer, has severe protein calorie nutrition receives enteral feedings to supplement PO [by mouth] intake to ensure nutritional and hydration needs are met. Goal - Resident will remain free from significant weight loss (5%/30 days, 10%/180 days) and maintain adequate hydration through the next review date. Interventions – Weights as ordered and as needed. Notify Physician of significant weight changes as needed. Routine Dietitian assessment. Review of Resident #1's Weight Summary documented dated 5/26/2025 130.0 pounds. There were no additional weights recorded in the record. Review of Resident #1's Nutritional Risk Evaluation dated 5/16/2025 read, Current Weight – [nothing documented]; Ideal Body Weight 128 – 156 lbs [pounds]; BMI [Body Mass Index] [nothing was documented]. Summary: 83 y.o [year old] male admitted NPO [nothing by mouth] on enteral feedings [receives nutrition through a gastrointestinal tube that is inserted in the stomach]. Will monitor PO intakes, TF [tube feed] tolerance and recommend to adjusted TF/supplement as needed. Review of Resident #1's physician's orders dated 05/09/2025 read, Nothing by mouth diet: Nothing by mouth texture, Nothing by mouth consistency. During an interview on 12/11/2025 at 4:45 PM the Director of Nursing (DON) stated, New admits get weighed, and the dietitian sees all new patients initially. She will follow residents with wounds and weight loss. We have an RD [Registered Dietitian] here 5 days a week. She sees all new patients within the first couple of days. We also have the Dietary Manager who sees the residents for their food preferences. For weights, we try to get them with the admission assessment or as soon as possible. Weights are obtained on an as needed basis or physician order. We don't have a set frequency when we get them. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 3:24 PM the RD stated, [Resident #1's name], I see there was no weight on admission. I did not bring it to anyone's attention. I go see them when they are admitted . I use an ideal weight range – when I saw him, I could tell that he was in the range. There again, anybody who was on a tube feeding, I need to see them monthly. When I go through the halls at feeding time, I see them, I talk to the nurses. From what I saw he was doing fine. Weights is a tool that I use. I don't feel that the weight is imperative. I believe the facility's policy is to weigh residents on admission, every week for 4 weeks, and then monthly, that is the standard. During an interview on 12/12/2025 at 4:04 PM the DON stated, Between nursing, the RD and the CDM [Certified Dietary Manager], we go over any issues in the morning meeting, and we go over orders. If something comes up, we let [the RD's name] know right then and there. If there's a low albumin, we'll let her know and put in an order. She [the RD] will follow up. If someone has a change in weight, if they are not liking what they are being offered or if they have a new wound, we let her know. It is up to me, the ADON, the UM [Unit Manager] or the nursing staff to obtain weights and notify the RD of concerns. Weights are obtained upon admission, monthly and PRN, just depending on if the doctor said more often. If it's not being done [obtaining weights] [name of the RD] gives us a list. We [the ADON and DON] go over the list with the nurses and assign someone to obtain the weights. A request was made for Resident #1's weights. None were provided. 2) Review of Resident #2's medical record documented the resident was admitted on [DATE] with a diagnosis of unspecified protein-calorie malnutrition. Review of Resident #2's weight documented the resident weighed 147 pounds on 09/16/2025. No weights were documented for October 2025 or November 2025. Dated 12/11/2025 the resident was documented as weighing 124.8 pounds, a 15% weight loss over three months. Review of Resident #2's Dietary Narrative Note dated 09/22/2025 read, 75 y/o [year old] male seen for new admission. On PO [oral] diet of NAS [no added sodium]/CCHO [consistent carbohydrate diet]/reg [regular]/thins with fair PO intakes. Per staff report patient is able to eat independently with set up help. No chewing or swallowing difficulties. BMI 19.9 in an acceptable range. Per documentation stage 2 pressure ulcer to R [right] buttocks. Recent labs noted with low PAB [prealbumin] level, low H&H [hemoglobin and hematocrit]. Meds include; Amlodipine, Carvedilol, Metformin, Terazosin, HTCZ [hydrochlorothiazide], Lisinopril, FeSO4 [iron sulfate], MV [multivitamin] w/ minerals, Vit [vitamin] B12, Atorvastatin, Hydralazine, Resident is at risk for altered nutrition d/t [due to] receives a therapeutic diet, has suboptimal PO intakes, DM2 [diabetes mellitus), CKD [chronic kidney disease], receives diuretics. Recommend to add 120ml [milliliter] house nutritional supplement for at risk for malnutrition and to meet increased calorie/protein needs. Will monitor and f/u [follow up] prn [as needed]. Review of Resident #2's physician order dated 09/22/2025 read, House Nutritional Supplement three times a day for at risk for malnutrition offer 120 ml [milliliters] TID [three times per day] and document percent consumed. Review of Resident #2's Medication Administration Records (MAR) for October 2025 and November 2025 revealed that there was no documentation of the daily percentage of the house supplement that was consumed by Resident #2. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2025 at 11:25 AM Resident #2 stated, I have lost weight. I don't like the food that is served. Sometimes they bring me different food if I ask. I don't know how much weight I have lost. During an interview on 12/12/2025 on 3:24 PM, the Registered Dietician stated, When someone has a low BMI I look at them. I look at the residents when I go by. Communication here is really great, so the nurses or doctors will send me messages. For me, weights are a tool that I use, but it is not the most important tool that I use. I make sure skin is ok. I don't feel that weight is imperative. I do a weight range to estimate the ideal. I emailed [Director of Nursing's name] for the monthly weights today and let her know which ones weren't done. He [Resident #2] was on that list. She checked all of the weights. I go through the monthly weights. I just started here back in May. In November I sent her a list of residents with no November weights. When I went back, she told me they were done, and nothing triggered. If I don't do one little thing when I put in the order for supplements, the nurses don't have the option to document the percentages of the supplements consumed and I don't check the amount consumed unless there is weight loss. Review of Resident #2's admission MDS dated [DATE] under section C documented Resident #2's BIMS score as 15 = normal cognitive function with little to no impairment. Review of Resident #2's care plan dated 09/15/2025 read, Focus: [Resident #2's name] is at risk for an alteration in nutrition and/or hydration r/t [related to]: receives a therapeutic diet, has suboptimal PO [oral] intakes, DM2, CKD, receives diuretics. Date initiated: 09/22/2025. Interventions: 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. Observe for s/sx [signs/symptoms] of dehydration, update for physician if noted. Supplements as ordered. Registered Dietician consult as needed. Administer medications as ordered; observe for effectiveness and for SE's [side effects]. Labs as ordered; report findings to physician. Provide cues/encouragement during meals. Allow adequate time to eat. Weights as ordered and as needed. Notify physician of significant weight changes if noted. 3) Review of Resident #7's medical diagnoses documented a diagnosis of unspecified protein-calorie malnutrition. Review of Resident #7's weight record documented dated 10/16/2025 130.9 pounds , 132.0 pounds on 10/17/2025, and 132.0 pounds on 10/21/2025. There were no weights documented for November 2025 or December 2025. Review of Resident #7's Dietary narrative note dated 10/23/2025 read, 89 y/o female seen for new admission. On PO diet of NAS/reg/thins with variable PO intakes. Per staff report resident is able to eat independently with set up help. No chewing or swallowing difficulties noted. BMI 22 within a healthy range. Resident c/o [complains of] diarrhea, no food intolerances/allergies, a probiotic has been started. Resident also agreeable to add 120 ml house supplement q [every] day. Per documentation LLE [left lower extremity] wound, no pressure areas noted. Recent labs noted with PAB 11. Meds include; isosorbide, metoprolol, famotidine, sertraline, mirabegron, melatonin, lactobacillus, vit B12, Cholecalciferol. Resident is at risk for altered nutrition d/t receives a therapeutic diet, has variable PO intakes, cancer dx [diagnosis]. Recommend to add 120 ml house nutritional supplement q day for at risk for malnutrition. Will monitor and f/u prn. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's physician order dated 10/23/2025 read, House nutritional supplement one time a day for at risk for malnutrition offer 120 ml q day and document percent consumed. Review of Resident #7's MAR for October 2025, November 2025, and December 2025 did not document the daily percentage of the house supplement that was consumed by Resident #7. Review of Resident #7's care plan dated 10/16/2025 read, Focus: [Resident #7's name] is at risk for an alteration in nutrition and/or hydration r/t receives a therapeutic diet, has variable PO intakes, cancer dx [diagnosis]. Date initiated: 10/23/2025. Interventions: 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. Observe for sx/sx of dehydration; update physician if noted. Supplements as ordered. Registered Dietician consult as needed. Administer medications as ordered. Labs as ordered; report findings to physician. Allow adequate time to eat. Weights as ordered and as needed. Notify physician of significant weight changes if needed. During an interview on 12/12/2025 at 4:03 PM, the Director of Nursing stated, Between nursing and the Dietician and the CDM [Clinical Dietary Manager], we go over orders in the clinical morning meetings, and if something comes up, like a low pre albumin, I would let [Registered Dietician's name] know about the issue and to follow up on it. If someone has a changing weight, or they are not liking what they are being offered for food, or has a new wound, we will communicate that to [Registered Dietician's name], either myself, the nurses and staff, or ADON [Assistant Director of Nursing]. Residents should be weighed upon admission, monthly, and PRN, depending on if the doctor says to do it more often. [Registered Dietician's name] usually communicates with us via email or gives us a list of weights that are still needed, then the nursing staff go around and get the weights. A request was made for the weights for Residents #1, #2, and #7 and the percentage of the supplements consumed by Residents #2 and #7 for November and December, none were provided. During an interview on 12/12/2025 at 4:16 PM, the Director of Nursing stated, nurses should put the weights into [name of the electronic system], there was obviously a communication breakdown. A request was again made for the weights for Residents #1, #2, and #7, none were provided. Review of the policy and procedure titled Weights and Weight Loss, with an issue date of 4/01/2022 read, Policy: It will be the practice of this facility to implement the following systems regarding weight documentation. Procedure: New admits and readmissions will be weighed upon admission, monthly and/or as ordered by the physician. Staff will be responsible for obtaining weights for these admits and will have this information available for morning stand-up meeting. Weights will be recorded. 3. The RD/DTR [Dietetic Technician] is to review all admission weight for possible intervention. 7. Monthly weights will be completed by the nursing department, unless otherwise indicated or ordered. 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to prevent the possible spread of infection via indwelling urinary catheters for 1 of 3 residents, Resident #2, reviewed for urinary catheters. Findings Include: During an observation on 12/11/2025 at 2:10 PM, Resident #2 was dressed in a hospital-style gown, lying on his back in bed. The Resident's urinary catheter collection bag was lying on the floor. Review of Resident #2's care plan dated 09/15/2025 read, Focus: Baseline Care Plan: Resident has a urinary catheter. Date initiated: 09/15/2025. Interventions: Resident has a urinary catheter in place and needs the following care: keep the bag below bladder level, cover the bag for dignity, give catheter care as ordered, report immediately if the catheter comes out, the resident seems to be in pain, the urine becomes dark or cloudy, or there is no urine to empty on your shift. During an interview on 12/11/2025 at 2:13 PM, the Director of Nursing stated, The foley bag should be hanging on the bed frame, off of the floor. Review of the policy and procedure titled, Indwelling Catheters issued: 04/01/2022 read, Policy: It will be the policy of this facility to provide appropriate documentation for use and care for indwelling catheters of the resident's that have the indication for use beyond 14 days. 8. Staff will provide daily catheter care or as ordered by the physician and/or needed. Catheter care should be provided in a manner that promotes infection control and maintenance of the insertion site. 10. Staff should ensure proper placement of the catheter tubing as to ensure that it is not kinked, pulling excessively, and allows for gravity drainage. If a resident does not wish to utilize proper placement of the catheter tubing and/or bag, his/her wishes should be maintained, and addressed in the plan of care.