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	05/07/2026

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

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who require nephrostomy services receive such care consistent with professional standards of practice for 1 (Resident #2) of 3 residents reviewed for indwelling catheter care.Findings include: During an observation on 5/06/2026 at 2:30 PM, Resident #2 was sitting up in bed. There was a gauze pad with a transparent occlusive dressing covering her nephrostomy catheter insertion site on her right lower back. The dressing had a half-dollar sized area of bloody drainage and was dated 4/30/2026. (photographic evidence) During an interview on 5/06/2026 at 2:30 PM, Resident #2 stated that the last time she went to the hospital it had been because there was blood in her nephrostomy drainage bag and then the tube was pulled out. At the hospital they reinserted a nephrostomy tube. The dressing [over her nephrostomy catheter] had not been changed since she returned from the hospital. Review of Resident #2's admission Record documented an admission date of 4/14/2026 with medical diagnoses that included fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing; other artificial openings of urinary tract status; and local infection of the skin and subcutaneous tissue. Review of Resident #2's most recent MDS (Minimum Data Set) Admission/5-day Medicare Assessment, dated 4/20/2026, documented her BIMS (Brief Inventory of Mental Status) Score as 15 out of 15, which indicated she was cognitively intact. The assessment documented an indwelling catheter and an ostomy (nephrostomy - a thin, flexible tube [catheter] is inserted through the skin of the back directly into the kidney to drain urine into an external bag). Review of Resident #2's Physician Orders dated 4/15/2026, read, empty nephrostomy bag q shift.Review of Resident #2's Physician Orders dated 4/27/2026, read, cleanse with n/s [normal saline], pat area dry, apply bandage to nephrostomy site daily - every night shift and as needed. It was discontinued on 4/28/2026.Review of Resident #2's Physician Orders dated 4/28/2026, read, Consult f/u [follow up] with nephrology d/t [due to] nephrostomy.Review of Resident #2's Physician Orders dated 4/28/2026 read, cleanse with n/s, pat area dry, apply bandage to nephrostomy site daily - every night shift and as needed.Review of Resident #2's Physician Orders dated 4/30/2026 read, Send to ED [emergency department] for eval and treatment for hematuria - one time only for 1 day.Review of Resident #2's Physician Orders from 4/14/2026 through 4/27/2026 documented no orders for nephrostomy site care.Review of Resident #2's MAR/TAR (Medication Administration Record/Treatment Administration Record) from 4/14/2026 through 4/27/2026 documented no nephrostomy dressing changes. Review of Resident #2's MAR/TAR (Medication Administration Record/Treatment Administration Record) from 5/01/2026 through 5/05/2026 revealed documentation of daily nephrostomy dressing changes. Review of Resident #2's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 4/10/2026 documented in Section P - Patient Health Status that Resident #2 had an ostomy, a right nephrostomy. Review of Resident #2's Nursing admission assessment dated [DATE], in the Genitourinary section, documented that she did not have a catheter. There was no documentation in the admission Assessment regarding the presence of her nephrostomy. During an interview on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/06/2026 at 5:17 PM, Physician #1 stated that the expectation was that the nurses would do skin and wound care and call the doctor to check on orders. It was the nurses' responsibility to provide care to the patients. The nurses did not do their due diligence. During an interview on 5/06/2026 at 5:22 PM, APRN (Advanced Practice Registered Nurse) #1 stated that typically there were protocols for catheter care. The expectation was for the nurses to follow the orders for nephrostomy care. There was a risk for infection when a nephrostomy dressing wasn't changed as ordered. Bacteria thrived in a moist, wet environment. During an interview on 5/06/2026 at 5:32 PM, Staff A, LPN (Licensed Practical Nurse) stated that she couldn't recall an order for a [nephrostomy] dressing change [for Resident #2]. She confirmed that she did not complete a dressing change on 5/03/2026. She believed she had to have checked it off accidentally. During an interview on 5/06/2026 at 5:37 PM, Staff B, LPN confirmed that he did not do a dressing change for [Resident #2's Name] on 5/05/2026. He might have inadvertently checked it [the nephrostomy dressing change] off. During an interview on 5/06/2026 at 6:15 PM, the DON (Director of Nursing) stated that the expectation was for the admitting nurse to contact [Resident #2's Name] physician for nephrostomy care orders and when orders were in place the expectation was for the nurses to follow those orders. During an interview on 5/07/2026 at 1:30 PM, Staff D, LPN stated that she remembered [Resident #2's Name]. She had checked off all the sections in the admission Assessment that applied to [Resident #2's Name]. She thought she had put the nephrostomy in the skin section. She confirmed that the nephrostomy should be documented in the admission Assessment. The expectation was that they should be doing dressing changes. She had notified the doctor and got the order to empty the [nephrostomy] bag. She should have gotten an order for nephrostomy dressing changes. Review of the policy and procedure titled, Indwelling Catheters, with the last review date of 1/29/2026 read, Policy: It will be the policy of this facility to provide appropriate documentation for use and care for indwelling catheters of the residents that have the indication for use beyond 14 days. Procedure: 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. Review of the policy and procedure titled, Wound Care, with the last review date of 1/29/2026 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: 1. Pressure injury risk/skin integrity assessment/evaluation will be completed upon admission. 4. The admission evaluation may identify pre-existing signs prior to admission to the facility. 6. Wound care procedures and treatments should be performed according to physician orders. 7. Wound care treatment should maintain proper technique, as is indicated by the type of wound and physician orders. 10. Document in the clinical record when treatments are performed.