

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Villages Healthcare and Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>52507</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure proper hydration for 1 of 3 residents, Resident # 363.</p> <p>Findings include</p> <p>During an observation on 05/05/25 at 11:14 AM Resident #363 was sitting in a wheelchair at his bedside table that had a breakfast tray on it. The resident ate approximately 75% of a bowl of cheerios with milk.</p> <p>Review of Resident #363's physician order dated 4/2/25 read, Sodium Chloride Intravenous Solution 0.45 % (Sodium Chloride) Use 50 ml/hr [milliliters an hour] intravenously [IV] one time a day every Tuesday, Thursday, Sunday for AKI (Acute Kidney Injury), dehydration. 50 ml/hr for a total of 500 milliliters only three days a week.</p> <p>During an interview on 05/06/25 at 12:13 PM, Staff C, LPN (Licensed Practical Nurse) stated A nurse with the last name [Staff D's last name] was on last night, the patient [Resident #363] was not hooked up to any IV fluids when I saw him and gave him meds this morning at around 09:30 AM. Sometimes the night nurses start the IV fluids earlier than ordered so that it will finish by the time the patient is ready to get out of bed in the morning.</p> <p>During an interview on 05/06/25 at 01:26 PM, Staff C, LPN stated the resident often refuses meals, He is not a big drinker or eater. That's why we have to give him supplements and IV fluids.</p> <p>During an observation on 05/06/2025 at 1:26 PM, Staff C administered 120 ml (milliliter) of MedPass 2.0 supplement, (a fortified nutritional shake designed to provide extra calories and protein) to Resident #363.</p> <p>During an observation on 05/06/25 at 1:37 PM Resident #363 was sitting in a wheelchair in his room eating a pudding cup. Resident #363 was not observed to have IV fluids being administered.</p> <p>During an interview on 05/06/25 at 1:37 PM, Resident #363 stated he told the staff he did not want a tray or any food for lunch, and that he does not feel like eating. The resident was unable to recall whether he received IV fluids this morning or last night.</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/06/25 at 02:43 PM Staff B, Unit Manager stated that 1/2 normal saline bag was not administered to the patient [Resident #363] last night by [Staff D's name].</p> <p>Review of Resident #363's care plan read, (Resident #363's name) is at risk for complications r/t [related to] receiving IV therapy. Currently has midline to left upper arm. Is receiving IV fluids for the treatment of: Decrease fluid [Resident #363's name] is at risk for an alteration in nutrition and/or hydration r/t; AKF [Acute Kidney Failure], has had significant weight loss, has variable PO [oral] intakes, receives diuretics. Date Initiated: 02/15/2025.</p> <p>Review of the MAR (electronic medication administration record) read, Sodium Chloride Intravenous Solution 0.45% (Sodium Chloride) Use 50 ml/hr intravenously one time a day every Tuesday, Thursday, Sunday for AKI, dehydration 50 ml/hr for a total of 500 ml only three days a week, Start Date 04/03/2025. The administration time was documented at 0600 [6:00 AM].</p> <p>Review of the MAR dated 05/06/2025 documented Sodium Chloride Intravenous Solution was administered, per the documented initials, by Staff D.</p> <p>Review of the policy and procedure titled, P&P Medication Administration issued 4/1/2022 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. Procedure: 3. Medications should be administered in a timely manner and in accordance with the physician's orders.</p> <p>Review of the policy and procedure titled, P&P Nutrition and Hydration Assistance, issued 4/1/2022 read, Policy: It will be the policy that this facility will provide the level of assistance required to the residents while maintaining their highest practical level of function and personal preferences.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>39371</p> <p>Based on observation, record review, and interview, the facility failed to administer enteral nutrition for 1 of 3 residents, Resident #92, and fluids as ordered for hydration and water flushes as order by the physician.</p> <p>Findings include:</p> <p>During an observation of Resident #92 on 5/5/25 at 10:12 AM the feeding pump was set at 45 milliliter/hour (ml/hr) administering Glucerna 1.5 and 30 ml/hr H2O (water) flush.</p> <p>During an observation of Resident #92 on 5/5/25 at 2:35 PM the feeding pump was set at 45 ml/hr administering Glucerna 1.5 and 30 ml/hr H2O flush. (Photographic evidence obtained)</p> <p>During an observation of Resident #92 on 5/6/25 at 8:36 AM the feeding pump was set at 45 ml/hr administering Glucerna 1.5 and 30 ml/hr H2O flush.</p> <p>During an observation of Resident #92 on 5/6/25 at 12:06 PM the feeding pump was set at 45 ml/hr administering Glucerna 1.5 and 30 ml/hr H2O flush.</p> <p>Review of Resident #92's physician order dated 3/25/25 read, Glucerna 1.5 at 60 ml/hr via pump 24 hrs [24 hours/continuous] and H2O at 55 ml/hr via pump 24 hrs.</p> <p>Review of Resident #92's Nutrition Risk Evaluation dated 3/25/25 read, Resident at nutritional risk related to medical conditions. History of metabolic encephalopathy, diabetes. Has feeding tube. Receiving Glucerna 1.5 at 60 ml/hr daily to achieve adult requirements of 20 kcal/kg [kilocalories per kilogram] and protein needs of 1.0-1.2 g/kg [gram/kilogram] daily. Current weight 247 lbs. [pounds] and 70 inches for a Body Mass Index (BMI): 35.4 (obesity). Nursing staff provides care as ordered by Physician team.</p> <p>Review of Resident #92's dietary progress note dated 4/22/25 by the Dietitian read, RD [Registered Dietitian] monthly TF [tube feed] review weight at 239 lbs., no significant weight changes, BMI 34.3 indicative of obesity. Using adjusted obesity weight of 184 lbs. to calculate estimated nutritional needs. On TF of Glucerna 1.5 at 60ml/hr x 24 hrs with 55 ml/hr of H2O x 24 hrs. Resident is at risk for malnutrition due to NPO [nothing by mouth] on enteral feedings due to dysphagia, obesity, DM [diabetes mellitus], CVA [cerebral vascular accident]. TF provides 100% estimated nutritional needs. Recommend to continue with current nutritional plan of care.</p> <p>During review of Resident #92's weights on 2/24/25, the resident weighed 247 lbs. On 4/10/25, the resident weighed 239 pounds which is a -3.24 % weight loss.</p> <p>During an interview on 5/06/25 at 1:21 PM Staff A, Licensed Practical Nurse (LPN) verified the feeding pump setting, the pump is running at 45 ml/hr with 30 ml/hr flush. Staff A, LPN went to her computer and stated [Resident #92's name] should be on 60 ml/hr with 55 ml/hr of water, the order date is 3/25/25. I have to go by doctor orders. I don't know who changed that setting.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/06/25 at 1:51 PM Staff B, Unit Manager/LPN stated [Staff A's name], did not ask me anything regarding [Resident #92's name] and I am not aware of any changes from the dietitian/nutritionist. You are supposed to check the setting is correct and if you are not sure get clarification from the doctor or Unit Manager.</p> <p>During an observation on 5/6/25 at 2:52 PM with the Director of Nursing (DON) of Resident #92's room showed the feeding pump was set at 60 ml/hr, however the water flush continued to be set at 30 ml/hr.</p> <p>During an interview on 5/6/25 at 2:53 PM the DON stated, The expectation is for the nurse to follow the doctors' orders. When the staff fix the setting it should have been done correctly according to the doctors orders.</p> <p>Review of the policy and procedure titled, P & P Enteral Tube Feeding issued: 1/1/2022 read, Policy: It will be the policy of this facility to provide nourishment to the resident who is unable to obtain adequate nourishment orally via use of enteral tube feeding. Procedure: 1. Verify/obtain physician's order for enteral feeding. Be certain that the order for the enteral feeding tube specifies such as rate, amount, times of administration and any specific orders related to stopping/holding tube feeding.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>52507</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents received respiratory care consistent with professional standards of practice for 2 of 4 residents, Resident #36 and #363, reviewed for oxygen therapy.</p> <p>Findings Include:</p> <p>1) During an observation on 05/05/25 at 09:55 AM, Resident #36 was observed lying in bed wearing nasal cannula (NC) with oxygen being administered at 3 liters/minute (l/min). There was no date on the oxygen tubing.</p> <p>Review of the electronic medication administration record (MAR) read, Change, date oxygen tubing and bag weekly every Thursday midnight shift every night shift every 7 day(s) Wash concentrator air filters with soap and water weekly on Thursday midnight shift, be sure oxygen in use sign is on the door. Start Date 05/03/2025.</p> <p>2) During an observation on 05/05/25 at 11:26 AM Resident #363 was observed lying in bed, holding the oxygen nasal cannula tubing in his hands. The oxygen concentrator was administering oxygen at 4 liters/minute, and the oxygen tubing was not dated.</p> <p>During an observation on 05/06/25 at 02:14 PM Resident #363 was sitting in a wheelchair wearing a nasal cannula with oxygen being administered at 4 liters/min. There is no date on the oxygen tubing.</p> <p>Review the physician's order for Resident #363 read, Change, date oxygen tubing and bag weekly every Thursday midnight shift.</p> <p>During an interview on 05/08/25 at 09:50 AM, the Director of Nursing stated that the nurses are expected to change, label and date the oxygen tubing every seven days on Thursdays.</p> <p>Review of the policy and procedure titled P&P Oxygen Administration issued on 4/1/2022 read, Policy: It is the policy of this facility to provide guidelines for safe oxygen administration. Procedure: 7. Weekly oxygen tubing changes can be documented in the medical record as a reminder to the staff, but is only required to have tubing dated appropriately demonstrating that the tubing was changed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47275</p> <p>Based on observations, interviews, and record review, the facility failed to maintain the kitchen equipment in a clean and sanitary manner for 3 of 4 nourishment rooms.</p> <p>Findings Include:</p> <p>During an observation on 5/5/25 beginning at 9:28 AM with the Assistant Dietary Manager showed at 9:54 AM in the 500 Hall nourishment room, there were brown and red splattered substances on the interior base of the freezer. There was an orange sticky substance splattered on the inside walls of the microwave. At 10:03 in the 200 Hall nourishment room, there was a brown splattered substance on the back wall of the refrigerator, there was food build up on the microwave oven plate and opaque splatters on the exterior front glass of the microwave oven, at 10:15 AM in the 100 Hall nourishment room, there was a brown splattered substance on the lower refrigerator drawers, and a brown built up sticky substance on the interior base of the freezer.</p> <p>During an interview on 5/5/25 at 10:20 AM the Assistant Dietary Manager stated, The nutrition rooms should be cleaned daily. I usually do rounds in the morning to make sure the cooks have cleaned them, but I haven't gotten to them this morning.</p> <p>Review of the policy and procedure titled P&P Kitchen Sanitation, with an issue date of 4/1/22 and a revision date of 10/1/23 read, Procedure: 1. Kitchens: kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. 2. Utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>52507</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain complete and accurately documented medical records for 2 of 5 residents, Residents #365 and #363, reviewed for medication administration and unnecessary medications.</p> <p>Findings include:</p> <p>Review of Resident #365's physician order read, Metoprolol 25 mg [milligrams] PO [oral] BID [twice daily], 0.5 tablet [1/2 tablet]. Hold for SBP [systolic blood pressure] less than 110, HR [heart rate] below 60 BPM [beats per minute].</p> <p>Review of Resident #365's Medication Administration Record (MAR) for May 2025 did not provide for documentation of the resident's heart rate or blood pressure as ordered prior to administering metoprolol to Resident #365 on 5/1/2025 at 8:00 AM, 5/2/2025 at 8:00 AM, 5/2/2025 at 9:00 PM, 5/3/2025 at 8:00 AM, 5/4/2025 at 8:00 AM, 5/4/2025 at 9:00 PM, 5/6/2025 at 8:00 AM, and 5/7/2025 at 8:00 AM.</p> <p>During an interview on 05/06/25 at 01:28 PM Staff C, Licensed Practical Nurse (LPN) stated The CNA [Certified Nursing Assistant] gives me the vital signs and I check them before giving medications. Sometimes I will wait and put all the blood pressures in last, so I will put 'NA' [not applicable] in the meantime as a place holder.</p> <p>During an interview on 05/07/25 at 12:06 PM Staff B, Unit Manager stated, I expect the nurses to document the blood pressure and heart rate prior to giving cardiac medications, such as metoprolol. Nurses should not document 'NA' in place of vital signs on the MAR.</p> <p>During an interview on 05/07/25 at 12:10 PM the Director of Nursing (DON), stated, The nurses should document the vital signs on the MAR.</p> <p>Review of physician order for Resident #363 dated 4/2/25 read, Sodium Chloride Intravenous Solution 0.45 % [Sodium Chloride] Use 50 ml/hr [milliliters/hour] intravenously one time a day every Tuesday, Thursday, Sunday for AKI [acute kidney injury], dehydration. 50 ml/hr for a total of 500 ml only three days a week.</p> <p>During an observation on 05/06/25 at 01:37 PM Resident #363 was observed at lunch time eating a pudding cup in his room. IV (intravenous) fluids were not observed being administered.</p> <p>Review of MAR (electronic medication administration record) read, Sodium Chloride Intravenous Solution 0.45% (Sodium Chloride) Use 50 ml/hr intravenously one time a day every Tuesday, Thursday, Sunday for AKI, dehydration 50 ml/hr for a total of 500 ml only three days a week, Start Date 04/03/2025. The administration time was documented at 0600 [6:00 AM].</p> <p>Review of the MAR dated 05/06/2025 documented Sodium Chloride Intravenous Solution was administered, per the documented initials, by Staff D.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/06/25 at 12:13 PM Staff C, LPN stated, A nurse with the last name [Staff D's last name] was on last night. The patient [Resident #363] was not hooked up to any IV fluids when I saw him and gave him meds this morning at around 0930 [9:30 AM]. Sometimes the night nurses start the IV fluids earlier than ordered so that it will finish by the time the patient is ready to get out of bed in the morning.</p> <p>During an interview on 05/06/25 at 02:43 PM Staff B, Unit Manager stated, The 0.45% normal saline bag was not hung last night by Registered Nurse, Staff D.</p> <p>Review of the policy and procedure titled P&P Medication Administration issue date, 4/1/2022 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. Procedure: 3. Medications should be administered in a timely manner and in accordance with the physician's orders.</p> <p>Review of Policy and Procedure titled, P&P Charting and Documentation issued, 4/1/2022 reads, 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. Procedure: 1. Observations, medications administered, services performed, etc., should be documented in the resident's clinical records.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39371</p> <p>Based on observations, interviews, and record reviews, the facility failed to prevent the possible spread of infection by failing to adhere to posted infection control signage and standards of practice, failing to maintain hand hygiene during medication administration, failing to maintain hand hygiene during wound care, and failing to handle and store tube feeding products per the manufacturer's recommendations. (Photographic evidence obtained)</p> <p>Findings include:</p> <p>1) During an observation on 5/6/25 at 10:02 AM the door to Resident #61's room had a sign posted for Enhanced Barrier Precautions that read, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Devise care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Upon entering Resident #61's room a blue disposable gown was observed hanging inside the room.</p> <p>Review of Resident #61's, medical record documented the resident was admitted on [DATE] with a diagnosis of Clostridium Difficile (C-Diff - a bacterium that can cause severe diarrhea and inflammation of the colon) and placed on contact precautions at that time. Resident #61 completed antibiotic treatment for C-Diff and was no longer symptomatic. Resident #61 went to a higher level of care for an unrelated surgical procedure on 4/11/25 to the left hand. Resident #61 returned to facility with a surgical wound to the left wrist.</p> <p>Review of Resident #61's physician order dated 3/13/25 read: Contact Precautions for C. Difficile bacterium in stool. The order dated 3/13/25 was discontinued on 5/7/25. An order dated 5/7/25 read, Resident requires Enhanced Barrier precautions due to wound.</p> <p>During an observation on 5/6/25 at 12:17 PM of Resident #61's room, a Certified Nursing Assistance (CNA) entered the room; then entered the resident's bathroom to provide care. The CNA was wearing gloves; no other personal protective equipment was donned.</p> <p>During an observation on 5/6/25 at 12:40 PM of Resident #61's room, a disposable blue gown was hanging inside on the back of the door.</p> <p>During an interview on 5/6/25 at 2:01 PM Staff C, Licensed Practical Nurse (LPN) stated I do not know why the gown is hanging in [Resident #65's name] room, it was there when I got here this morning.</p> <p>During an interview on 5/6/25 at 2:52 PM the Director of Nursing (DON) stated, That gown should not be there, it is disposable, that is strange.</p> <p>During an interview on 5/7/25 at 8:36 AM Resident #61 stated, The staff does not wear gowns when they are with me, they haven't in a long time.</p> <p>(continued on next page)</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>2) During an observation on 5/7/25 beginning at approximately 9:17 AM of medication administration Resident #166 was observed to request a pain pill from Staff F, LPN. The pain medication was not available in the medication cart for the resident. Staff F, LPN contacted the pharmacy via phone to receive an authorization code to retrieve the requested pain medication from the Pyxis machine (an automated medication dispensing cabinet for the dispensing of medications). At approximately 9:42 AM Staff F, LPN started toward the 200 unit via a secured corridor, the secured corridor required a pass key to enter. While walking through the corridor the laundry and kitchen rooms were passed. Upon exiting the secured corridor Staff F, LPN requested the assistance of another nurse to retrieve the pain medication from the Pyxis machine. Staff F, LPN entered the code on the Pyxis screen with her bare index finger. The other nurse did the same sequence, and the pain medication was retrieved. Staff F, LPN went through the 200 unit via the secured corridor. Upon exiting the secured corridor Staff F, LPN went directly to the Resident #166's room, did not perform hand hygiene and administered the pain medication to Resident #166.</p> <p>During an interview on 5/7/25 at approximately 9:56 AM Staff F, LPN stated, I should have sanitized my hands before giving the resident their pain medication.</p> <p>During an interview on 5/7/25 at 11:35 AM the Director of Nursing stated, That should not have happened [not performing hand hygiene prior to the medication administration.]</p> <p>Review of the policy and procedure titled, P & P Medication Administration issued on 4/1/2022 read, Policy: It will be the policy of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. 11. Established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) must be followed during the administration of medications.</p> <p>3) During an observation on 05/07/25 at 10:35 AM Staff E, CNA (Certified Nursing Assistant) was providing assistance for Resident #56 in the bathroom. Staff E was not wearing personal protective equipment of a gown when assisting the resident in the bathroom.</p> <p>During an observation on 05/07/25 at 10:36 AM there was an Enhanced Barrier Precautions (EBP) Sign posted on Resident #56's door.</p> <p>During an interview on 05/07/25 at 10:38 AM Staff E, CNA stated, I didn't have to wear a gown when taking [Resident 56's name] to the bathroom. Not that I know of. They didn't tell me nothing about that.</p> <p>Review of the physician order dated 3/19/25 for Resident #56 read, Requires enhanced barrier precautions R/T [related to] G-tube [gastric tube].</p> <p>During an interview on 05/07/25 at 11:35 AM the Director of Nursing (DON) stated, The expectation is for staff to wear gloves and a gown when toileting residents that are on enhanced barrier precautions. We go over enhanced barrier precautions and the need for gowning every week during our town hall meetings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Villages Healthcare and Rehabilitation Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy and procedure titled, P & P Enhanced Barrier Precautions issued on 4/1/2024 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. 4. For residents for whom EBP (Enhanced Barrier Precautions) are indicated, EBP is employed when performing the following High-contact resident 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>4) During an observation on 05/05/25 at 10:17 AM, Resident #366 was lying in bed with his eyes closed. A Jevity 1.5 tube feeding bottle was on the table below the television. The Jevity 1.5 bottle was approximately one third full and the bottle was not dated.</p> <p>During an observation on 05/07/25 at 08:18 AM of Resident #366's room it showed there was a bottle of Jevity 1.5 tube feeding on the table in the room. The Jevity 1.5 tube feed bottle was approximately one half full, was not dated, and there was no cap on the bottle.</p> <p>During an interview on 05/07/25 at 08:20 AM Staff B, Unit Manager stated, The tube feeding bottles should be dated and timed.</p> <p>Review of the physician order for Resident #366 dated 4/10/25, read, Jevity 1.5 Bolus Feed 237 ml (milliliters) every 4 hours, 137 ml free water flush with each bolus feed.</p> <p>Review of the [NAME] Nutrition recommendations for Jevity 1.5 for bolus feeding read, Storage and Handling: After Opening: Once opened, the formula should be covered, refrigerated, and used within 48 hours.</p> <p>Review of the policy and procedure titled, P&P Enteral Tube Feeding issued on 1/1/2022 read, Policy: It will be the policy of this facility to provide nourishment to the resident who is unable to obtain adequate nourishment orally via use of the enteral tube feeding. Procedure: 9. For residents receiving enteral tube feeding with the use of a pump or via gravity infusion - Replace infusion sets every 24 hours for open tube systems or 48 hours for closed tube feed systems or per manufacturer's guidelines.</p> <p>5) During an observation on 05/08/2025 beginning at 8:30 AM of the Wound Care Nurse and the Assistant Director of Nursing (ADON) performing wound care for Resident #316 a wound dressing was not observed on the wound. Resident #316 stated it was just removed since she knew she was going to have the wound dressing changed. The ADON cleansed the wound bed with sterile water and gauze. The ADON did not remove her gloves, perform hand hygiene, don a clean pair of gloves, and applied physician ordered ointment to the wound and covered the wound with the clean wound dressing.</p> <p>During an interview on 05/08/2025 at 8:42 AM the ADON stated, I should have changed my gloves and sanitized my hands after I cleaned the wound.</p> <p>51447</p>		