

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Buffalo Crossings Healthcare & Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 3875 Wedgewood Lane 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45576</b></p> <p>Based on record review and interview, the facility failed to ensure resident representative was informed of a change in the resident's status for 1 of 3 residents reviewed for change in status, Resident #1.</p> <p>Findings include:</p> <p>Review of Resident #1's admission record revealed the resident was most recently admitted on [DATE] with diagnoses including periprosthetic fracture around internal prosthetic left hip joint, anxiety, depression, and left artificial hip joint.</p> <p>Review of Resident #1's care plan dated 6/3/2024 read, Focus: Surgical/Incision: Staples- I have surgical incision with staples. (D/C [discontinued] 6/10) . Interventions . Observe surgical staples for infection, drainage, increased swelling, warmth and surgical site reopening.</p> <p>Review of Resident #1's care plan dated 6/4/2024 read, Focus: I have impaired cognitive function or impaired thought processes r/t [related to] impaired decision making, Long term memory loss, Short term memory loss.</p> <p>Review of Resident #1's progress notes dated 6/17/2024 read, Redness, edema, pain, and heat noted to left hip. Physician ordered Cipro 250 mg [milligrams] BID [twice daily] x 7 days due to left hip cellulitis.</p> <p>During an interview on 7/22/2024 at 1:13 PM, the Infection Preventionist, Licensed Practical Nurse (LPN), stated, There is no documentation that the family was informed of the infection in the surgical site or that the resident was placed on antibiotics.</p> <p>During an interview on 7/22/2024 at 1:58 PM, Staff A, LPN, stated, Family was not notified about redness, edema, pain and heat. Infection was identified on 6/27/2024 of left hip and [Resident #1's name] was placed on antibiotics.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 106114	If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Buffalo Crossings Healthcare & Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE  3875 Wedgewood Lane 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)		
F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During an interview on 7/22/2024 at 2:18 PM, the Director of Nursing stated, There is no documentation related to informing the family of change in condition related to identified infection on 6/27/2024 of left hip. Any change of condition requires a change in condition report and physician and family are to be notified unless the residents are their own responsible party. We do not have a change in condition policy. It is a standard of care.		