STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106114	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Crossings Healthcare & Rehabilitation Cen	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48865 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 (Resident #106) of 1 resident reviewed for hospitalization and 1 (Resident #80) of 5 reviewed for hospice services. Findings include: 1. Review of the Discharge-Return Not Anticipated Minimum Data Set assessment dated [DATE] documented Resident #106 was discharged to a Short-Term General Hospital (acute hospital, IPPS (Inpatient Prospective Payment System)). Review of the progress note dated 1/18/2024 for Resident #106 read, Resident discharged to ALF (Assisted Living Facility) at 1215 [12:15 PM]. Questions answered and confirmed understanding. Education provided. During an interview on 4/16/2024 at 9:10 AM, the Minimum Data Set (MDS) Coordinator stated, For [Resident #106 Name] the Minimum Data Set Section A should have read ALF (Assisted Living Facility) instead of hospital. For [Resident #80's name] MDS Section O, hospice question should have said Yes instead of No. I do not have a policy for minimum data set. I use the Resident Assessment Instrument. 46523 2. Review of the physician's order for Resident #80 dated 4/29/2023 read, admitted to Cornerstone Hospice 4/28/23 Dx [Diagnosis]: End Stage Heart Disease. Review of Resident #80's Quarterly MDS dated [DATE] documented the resident did not receive hospice services. Review of Resident #80's care plan, date initiated 4/27/2023, last review date 2/23/2024, read, I have a terminal prognosis relating to my diagnosis of left ventricular failure. 4/27/2023-received terminal certificate and placed in medical record.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on record review and interview, the facility failed to ensure that resident records were complete and accurate for 2 of 5 residents sampled for medication administration record review. (Resident #92 and #262) Findings include: 1. Review of the admission record for Resident #92 documented the resident was admitted with a diagnosis of Hypertension, Acute on Chronic Systolic Heart Failure, Atrial Fibrillation, Ischemic Cardiomyopathy, an Automatic implantable Cardiac Defibrillator, and Atherosclerosis of Coronary Artery Bypass Graft. Review of the Medication Administration Record (MAR) for Resident #92 for 4/13/2024 and 4/14/2024, the MAR documents that the scheduled 9 AM medication administration for Amiodarone HCL Tablet 200 mg (milligrams), Ascorbic Acid 500mg, Aspirin 81mg tablet, Multiple Vitamin Tablet, Potassium Chloride 20meq tablet, Zinc Capsule 220mg, Acidophilus Capsule 100mg, Eliquis 2.5mg tablet, Gabapentin 100mg capsule, and Protein Oral Liquid 30ml, and Metoprolol 50mg tablet was refused (Chart Code 2 equals Drug Refusal) by Resident #92. Review of the MAR for Resident #92 for 4/13/2024 and 4/14/2024, the MAR documents that the scheduled 9 PM medication administration for Acidophilus Capsule 100mg, Eliquis 2.5 mg tablet, Gabapentin 100mg capsule, and Protein Oral Liquid 30ml (milliliters) was refused (Chart Code 2 equals Drug Refusal) by Resident #92. Review of the medical record for 4/13/2024 and 4/14/2024 showed no documentation in the medical record that the provider was notified that Resident #92 refused medication administration for the 9AM administration time. During an interview on 4/14/2024 at 3:09 PM, Staff B, Registered Nurse (RN) stated, I didn't call the doctor yet. I still have charting to complete and I do it at the end of the shift. If he (Resident #92's name) had a priority medication like an antihypertensive [medication to lower the blood pressure], I would make it a priority and call the doctor. I'm not going to make it a priority to call the doctor for these meds this morning because I was five patients behind, but I will call them and let them know before I leave. The protocol is to document that we contacted the doctor and made them aware that the medications were refused. Review of the MAR on 4/15/2024 at 10:17 AM for Resident #92, shows that the scheduled 9 AM medications were given including Amiodarone HCL Tablet 200mg, Ascorbic Acid 500mg, Aspirin 81mg tablet, Multiple Vitamin Tablet, Potassium Chloride 20meq tablet, Zinc Capsule 220mg, Acidophilus Capsule 100mg, Eliquis 2.5mg tablet, Gabapentin 100mg capsule, and Protein Oral Liquid 30ml as ordered. During an interview on 4/15/2024 at 10:26 AM Resident Representative stated, The nurse brought in some pills in a medicine cup and liquid in another medicine cup this morning. He (Resident #92) refused to take the medication, closed his eyes and mouth, and refused. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 10:30 AM Staff D, Licensed Practical Nurse (LPN) stated, I did document that I gave the medications (pointing to the 9AM medications on the computer) but I didn't give them. He (Resident #92) refused them (the morning medications), and I wasted them. I should not have documented that the medications were administered before attempted to give them. I was going to try again later. During an interview on 4/15/2024 at 11:56 AM, the Director of Nursing (DON) stated, the nurse should document the medication as given after they have watched the resident take the medication. The nurse should not document that the medication was given beforehand. The DON stated that the nurses should call the doctor if a resident refuses the medication and the documentation of that call and response should be documented in the resident's chart. Review of the Orders-Administration note in the medical record dated 4/15/2024 at 12:39 PM, by Staff D, LPN reads, Note Text: Pt's meds were poured and ready to be given. This nurse was interrupted D/T (due to) an emergent situation. Pills were destroyed. One time order given to re-administer meds late by [NAME], ARNP from Premier Medical Group. Pills re-poured and administered as ordered . During an interview on 4/16/2024 at 08:49 AM, the Advanced Practice Registered Nurse (APRN) #1 stated that the staff are expected to call when the resident refuses medication and document the call and response in the resident's medical record. Staff are really good about monitoring his vital signs, including his blood pressure and report any variations to me immediately. During an interview on 4/17/2024 at 12:45 PM, Staff D, LPN stated, He (Resident #92) usually takes his medications, so I signed it off before I gave it to him. I can always go back and strikethrough and put a number 9 (Chart Code: 9 - Other/See Progress Note). During an interview on 4/17/2024 at 1:54 PM, the DON stated, The nurses didn't document that they contacted the doctor on Saturday (4/13/2024) and Sunday (4/14/2024) but the nurses mentioned it to the APRN (APRN #1) when she was here visiting a resident on Sunday. The nurses didn't document it. Review of the initial care plan dated 2/16/2024 reads, I have uncooperative behaviors with eval (evaluation)/Care and/or being resistive with completing oral hygiene, medications, and bathing. Interventions: Alert family, significant other, responsible party with continued uncooperative behavior/refusal of care. Communicate with MD (medical doctor) for continued refusal of care. During an interview on 4/17/2024 at 2:00 PM, the DON stated, We don't have any specific policy on documentation. Review of the policy titled, Medication Administration, last reviewed, reads, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 17. Sign MAR (Medication Administration Record) after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 19. Report and document any adverse side effects or refusals. 48708 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #262's admission record documented the resident was admitted to the facility on [DATE] with diagnoses including unspecified fracture of left femur, orthostatic hypotension, bradycardia, hyperlipidemia, hypothyroidism, unspecified atrial fibrillation, hypertension, atherosclerotic heart disease and syncope and collapses. Review of Resident #262's physician's order dated 4/6/24 read, Midodrine HCl (Hydrochloride) Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension due to BB (Beta Blocker) for AFIB (Atrial Fibrillation) RVR (Rapid Ventricular Rate). Hold for BPS (Blood Pressure Systolic) greater than 145. Review of the MAR for April 2024 for Resident #262 for Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension due to BB for AFIB RVR. Hold for BPS greater than 145 documented no blood pressures from 4/5/24 through 4/15/24 where the medication was documented as given or held at the 0630 [6:30 AM] and 1630 [4:30 PM] administration times. Review of the MAR for 4/8/24 for Resident #262 for Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension due to BB for AFIB RVR. Hold for BPS greater than 145 documented Midodrine was received at 0630 [6:30 AM] on 4/8/24. Review of the Weights and Vitals Summary for Resident #262 documented blood pressures on 4/8/24 at 8:06 AM with blood pressure documented as 147/63. Review of the MAR for 4/12/24 for Resident #262 for Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension due to BB for AFIB RVR. Hold for BPS greater than 145 documented Midodrine was received at 0630 [6:30 AM] and 'held' at 1630 [4:30 PM]. Review of the Weights and Vitals Summary for Resident #262 dated 4/12/24 at 8:07 AM documented a blood pressure of 165/68 and at 2123 [9:23 PM] documented a blood pressure of 101/60. There was no blood pressure at documented at 4:30 PM. Review of the MAR for 4/15/24 for Resident #262 for Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth two times a day for Hypotension due to BB for AFIB RVR. Hold for BPS greater than 145 documented Midodrine was 'held' at 0630 [6:30 AM]. Review of the Weights and Vitals Summary for Resident #262 dated 4/15/24 documented a blood pressure at 7:27 AM of 128/77. During an interview on 4/17/24 at 1:30 PM the DON stated that nurses had taken blood pressures and medications were administered within parameters and not documented. My expectation is they would document the vitals at the time they are taken. She also stated [Staff E's Name, LPN] had reported taking blood pressures and administered the medication within parameters but could not provide documentation.

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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. 49289 Based on observation, interview and record review, the facility failed to prevent the possible spread of infection by not performing hand hygiene during medication administration in 2 out of 6 observations for medication administration and clean blood pressure cuff monitors between residents in 2 out of 6 observations. Finding include: During an observation of medication administration for Resident #92 on 4/14/2024 at 9:20 AM Staff B, Registered Nurse (RN) was observed entering the resident's room to check the resident's blood pressure with an automatic wrist cuff without performing hand hygiene. Staff B, RN returned the automatic blood pressure monitoring wrist cuff to the medication cart without cleaning the equipment after use. During an observation of medication administration for Resident #92 on 4/14/2024 at 9:32 AM, Staff B, RN started preparing the medications for Resident #92 without performing hand hygiene. Staff B, RN locked the medication cart, entered the resident's room without performing hand hygiene before medication administration. Staff B, RN exited the resident's room without performing hand hygiene, returned to the cart, went to the medication room, then went to the nursing station and used the telephone without performing hand hygiene. During an interview on 4/14/2024 at 9:52 AM Staff B, RN stated, I did not perform hand hygiene before entering the resident's room or when exiting the resident's room. I should perform hand hygiene before and after patient care and before going to another patient. During an interview on 4/14/2024 at 10:55 AM the Director of Nursing (DON) stated, The nurses should be washing their hands before entering a resident's room and before leaving the room, before continuing with another resident. The DON stated that nursing staff should clean equipment used for multiple residents, between each resident according to the manufacturer's instructions on the cleaning and disinfecting products for each type of equipment. During an observation of medication administration for Resident #20, on 4/16/2024 at 08:35 AM, Staff C, Licensed Practical Nurse (LPN) after checking Resident #20's blood pressure, the LPN returned the manual blood pressure cuff and stethoscope to the medication cart without cleaning the equipment after use before initiating medication administration to another resident, Resident #46. During an interview on 4/16/2024 at 08:35 AM, Staff C, LPN stated, We are supposed to clean the blood pressure cuff and stethoscope after use on each resident. I should have cleaned the cuff and stethoscope before I took care of the next resident. During an interview on 04/17/24 at 10:10 AM, the Director of Nursing (DON) stated that blood pressure equipment (including the manual cuff, automatic cuff, and stethoscope) needs to be cleaned before and after each use with residents, per the policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled, Medication Administration, last reviewed 5/10/2023, reads, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 4. Wash hands prior to administering medication per facility protocol and product. 15. Observe resident consumption of medication. 16. Wash hands using facility protocol and product. Review of the policy titled, Hand Hygiene, last reviewed 5/10/2023, reads, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations of the facility. Definitions: 'Hand hygiene' is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 3. Alcohol-based hand rub with 60-95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. 6. Additional considerations. A. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the policy titled, Cleaning and Disinfection of Resident-Care Equipment, last reviewed 5/10/2023, reads, Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. 1. Resident-care equipment is categorized based on degree of risk for infection involved in the use of the equipment. c. Non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning followed by low/intermediate-level disinfection (i.e., use of EPA-registered disinfectants) following manufacturer's instructions. 3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include: b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. d. Multiple-resident use equipment shall be cleaned and disinfected after each use.