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	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Crossings Healthcare & Rehabilitation Cen	3875 Wedgewood Lane The Villages, FL 32162

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents' preference for shower was honored for 1 (Resident #19) of 3 residents reviewed for activities of daily living. Findings include: Review of Resident #19's admission record showed the resident was admitted on [DATE] with diagnoses including muscle weakness, unsteady on feet, chronic respiratory failure, chronic obstructive pulmonary disease, congestive heart failure, and gout. During an interview on 7/14/2025 at 10:23 AM, Resident #19 stated, I have not received anything I asked for. Tissues, shower, hair wash. I have been asking for it since 7 AM this morning [7/14/2025]. I have wounds on legs that need to be covered or changed. I don't want to wait for a dressing change to take a shower. They can just cover my legs if dressing gets wet, then change it. During an interview on 7/15/2025 at 11:54 AM, Resident #19 stated, I did not get my shower yesterday [7/14/2025]. I did get washed up. That is not a shower and my hair washed. My son is coming tomorrow, and I want to look nice. My friend is going to do my hair. Review of Resident #19's Minimum Data Set (MDS) assessment dated [DATE] showed the resident needed Partial/moderate assistance for shower/bathing under Section GG-Functional Status. During an interview on 7/15/2025 at 12:01 PM, Staff B, Certified Nursing Assistant (CNA), stated, [Resident #19's name] can shower herself. All [Resident #19's name] asked for is towels. I don't know if she can independently shower self. [Resident #19's name] needs to have the legs wrapped. I can wrap the legs. During an interview on 7/15/2025 at 12:08 PM, Staff A, Licensed Practical Nurse (LPN), stated, [Resident #19's name] is an assist of 1 for shower. Hair is usually done in the salon. During an interview on 7/15/2025 at 12:53 PM, the Director of Nursing (DON) stated, Therapy did report she was in the shower yesterday to the CNA. It is my understanding [Resident #19's name] refused to wash her hair. [Resident #19's name] does usually get her hair done in the salon. That is her preference. I do not see refusal of hair washing [while reviewing the records in Occupational Therapy notes]. Hair washing is part/component of a shower.

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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	106114	A. Building B. Wing	07/17/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan within 48 hours of a resident's admission for 1 (Resident #148) of 3 residents reviewed for skin conditions. Findings include: During an observation on 7/14/2025 at 11:44 AM, Resident #148 was sitting in a wheelchair in his room. There was a foam dressing on his right lower leg dated 7/11. Review of Resident #148's admission record showed the resident was admitted on [DATE] with diagnoses including lobar pneumonia, acute respiratory failure, hypocalcemia, hypo-osmolality and hyponatremia, hypocalcemia, [NAME] syndrome, hypothyroidism, depression, atopic dermatitis, hyperlipidemia, essential hypertension, atherosclerosis of aorta, obstructive sleep apnea, pulmonary hypertension, emphysema, and cirrhosis of liver. Review of Resident #148's physician order dated 7/10/2025 read, Cleanse skin tear to the back of L [Left] calf with NS [normal saline], cover with adaptic [sic] and foam dressing Q3 [every three] days until resolved, every day shift every 3 day(s) for wound care. Review of Resident #148's Skin Observation Note dated 7/10/2025 read, 4. Integrity. 1. Is skin impaired? Yes (if yes, complete the diagram below). 2. Skin impairment (specify location and describe): Site: 19) Right iliac crest, Description: bruising. 23) Coccyx, Description: non blanchable redness. 32) Left buttock, Description: small pressure area- no drainage. 4) Face, Description: discoloration-dry. 43) Right lower leg (rear), Description: skin tear obtained from hospital. Other (specify), Description: BUE [bilateral upper extremity] bruising. Review of Resident #148's New Admission/readmission Data Collection and observation dated 7/9/2025 read, 9. Skin. 1. Skin Description: No issues. Review of Resident #148's baseline care plan showed no focus or intervention for skin integrity. During an interview on 7/16/2025 at 9:56 AM, the Minimum Data Set Coordinator stated, [Resident #148's name] base line care plan do not include a focus of skin integrity. The nurse did not check it off in the comprehensive assessment upon admission. During an interview on 7/16/2025 at 12:19 PM, the Director of Nursing stated, [Resident #148's name] should have a focus of skin integrity in his baseline care plan. The nurse should have checked it off. He [Resident #148] had generalized bruising, and abrasions upon admission. Review of the facility policy and procedure titled Baseline Care Plan with the last review date of 5/23/2025 read, Intent: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of acre based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Procedure. The baseline care plan will: 1. Be developed within 48 hours of a resident's admission.

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	106114	A. Building B. Wing	07/17/2025

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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. Based on observation, interview, and record review, the facility failed to ensure physician- ordered parameters for administering hypertension medications were followed for 1 (Resident #40) of 5 residents reviewed for unnecessary medications and failed to ensure wound dressing was changed as per physician order for 1 (Resident #148) of 3 residents reviewed for skin conditions. Findings include: 1) Review of Resident #40’s admission record showed the resident’s diagnoses included essential (primary) hypertension, hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, unspecified atrial fibrillation, and hyperlipidemia. Review of Resident #40's physician order dated 6/11/2025 read, “Hydralazine HCl Oral Tablet 10 MG [milligrams] (Hydralazine HCl), Give 1 tablet by mouth every 8 hours as needed for HTN [hypertension], Give if SBP [Systolic Blood Pressure] > [greater than]160 mmHg [millimeters of mercury].” Review of Resident #40’s Weights and Vital Signs Summary from 6/1/2025 through 6/30/2025 showed on 6/12/2025 at 9:47 AM, a blood pressure (B/P) of 166/83 mmHg, on 6/13/2025 at 9:50 AM, a B/P of 195/98 mmHg, on 6/16/2025 at 10:10 AM, a B/P of 164/84 mmHg, on 6/19/2025 at 8:39 AM, a B/P of 180/80 mmHg, on 6/21/2025 at 11:29 AM, a B/P of 189/93 mmHg, on 6/25/2025 at 9:36 PM, a B/P of 170/81 mmHg, on 6/26/2025 at 8:02 AM, a B/P of 171/91 mmHg, on 6/28/2025 at 11:56 AM, a B/P of 170/79 mmHg, and on 6/30/2025 at 9:43 PM, a B/P of 162/83 mmHg. Review of Resident #40's Medication Administration Record (MAR) for June 2025 showed no Hydralazine HCl 10 mg was administered on the dates that Resident #40’s blood pressure was above 160 mmHg. Review of Resident #40’s Weights and Vital Signs Summary from 7/1/2025 through 7/15/2025 showed on 7/5/2025 at 10:43 AM, a B/P of 177/82 mmHg, on 7/6/2025 at 10:03 AM, a B/P of 175/89 mmHg, on 7/11/2025 at 11:51 AM, a B/P of 167/78 mmHg, on 7/12/2025 at 7:57 AM, a B/P of 172/80 mmHg, and on 7/15/2025 at 4:09 PM, a B/P of 179/88 mmHg. Review of Resident #40's MAR for July 2025 showed no Hydralazine HCl 10 mg was administered on the dates that Resident #40’s blood pressure was above 160 mmHg. During an interview on 7/15/2025 at 2:55 PM, Staff F, Licensed Practical Nurse (LPN), stated, I really didn't know that he [Resident #40] had a PRN [pro re nata meaning as needed] order. If I knew, I would have given it. We need to follow the orders for medicine. I should have given the medicine. I should have followed the doctor’s orders. During an interview on 7/16/2025 at 12:58 PM, the Director of Nursing (DON) stated, I would expect all nurses to administer the medications that are ordered. I see that they did not give any meds when the blood pressure was above the parameters. They should have administered the medication when the blood pressure was above 160. I do expect staff to follow the doctor’s orders as they are written or call and notify them when they can't. (continued on next page)

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	106114	A. Building B. Wing	07/17/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/2025 at 2:34 PM, the Advanced Practice Registered Nurse (APRN) stated, I absolutely expect the nurses to follow the physician orders for medication administration. The nurses, each time, should have administered the medication. I do have the expectation that the nurses give all medications as ordered and if they can't, to call and let me know. 2) During an observation on 7/14/2025 at 11:44 AM, Resident #148 was sitting in a wheelchair in his room. There was a foam dressing on his right lower leg dated 7/11. During an observation on 7/15/2025 at 8:44 AM, Resident #148 was sitting in his wheelchair eating breakfast. There was a dressing on his lower right leg dated 7/11 and it was peeling on lower right corner. During an observation on 7/16/2025 at 8:29 AM, Resident #148 was sitting in his wheelchair waiting for breakfast. There was a foam dressing on his right leg dated 7/11. During an interview on 7/16/2025 at 8:32 AM, Staff D, LPN, stated, [Resident #148's name] dressing is scheduled to be changed today. The dressing is to be done every 3 days.” During an observation on 7/16/2025 at 8:36 AM, Staff D, LPN, entered Resident #148’s room and confirmed the dressing on the resident’s right lower leg was dated 7/11/2025. Staff D verbalized to the resident that she would change the dressing since he still had an open area, the size of a dime. Review of Resident #148’s physician order dated 7/10/2025 read, “Cleanse skin tear to the back of L [Left] calf with NS [normal saline], cover with adaptic [sic] and foam dressing Q3 [every three] days until resolved, every day shift every 3 day(s) for wound care.” During an interview on 7/16/2025 at 8:45 AM, Staff D, LPN, stated, The order was written wrong. It should be the right leg not the left leg. I do not know who wrote the original order. During an interview on 7/16/2025 at 12:08 PM, the DON stated, “[Resident #148’s name] dressing should have been changed every three days. The dressing should not have been dated the date you observed.” Review of the facility policy and procedure titled “Clean Dressing Change” with the last review date of 5/23/2025 read, “Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician’s orders will specify type of dressing and frequency of changes.

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	106114	A. Building B. Wing	07/17/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review and interview, facility failed to ensure residents received restorative services for 1 (Resident#4) of 3 residents reviewed for range of motion. Findings include: During an interview on 7/14/2025 at 10:11 AM, Resident #4 stated, My main concern at this time is therapy services. I have not seen therapy, and I do not know what the plan is. Review of Resident #4's physician order dated 6/6/2025 read, Pt [patient]. D/C [discharge] from PT [Physical Therapy] services with RNP [Restorative Nursing Program] in place. Review of Resident #4's physician order dated 6/26/2025 read, Admit to RNP for AROM [Active Range of Motion]-omnicycle BUE [Bilateral Upper Extremities] and BLE [Bilateral Lower Extremities] prosthetic leg donned, transfers, donning/doffing prosthetic leg 3x [3 times] week for 60 days as per therapy recommendations. Review of Resident #4's PT Discharge Summary for service dates of 4/9/2025 through 6/6/2025 read, D/C Reason: Maximum Potential Achieved, referred to RNP. STG [Short Term Goal] #4.2-Met on 06/06/2025: Patient will increase LLE [Left Lower Extremity] residual limb strength to 4-/5 to improve limb stability using prosthetic limb during transfers and ambulation. Baseline: (4/9/2025) 2+/5. Discharge (6/6/2025) 4-/5. Discharge Recommendations: D/C to this LTC [Long Term Care] with RNP in place. Review of Resident #4's Range of Motion Task record for June 2025 showed restorative nursing program services were provided beginning on 6/27/2025. During an interview on 7/16/2025 at 10:40 AM, the Rehabilitation Director stated, Resident was discharged from therapy to RNP on 6/6/2025. Physical therapist will write a form and give it to the Assistant Director of Nursing who oversees RNP and also talk and educate the two aides that oversee restorative to make sure they are able to perform the exercise and meet the needs. During an interview on 7/16/2025 at 11:42 AM, the Assistant Director of Nursing (ADON) stated, Residents usually take 3-5 days to go on to the program after referral from therapy. I was out for an extended period of time and I am the one who usually puts in the orders for the restorative program. I came back on June 23rd [2025] and he [Resident #4] was put in on the 26th [June 26, 2025]. But there was a delay. During an interview on 7/16/2025 at 12:30 PM, the Director of Nursing stated, We do not have a regulated time frame to put a resident on case load. We would like to see the accommodations made as timely as possible. The resident should go on restorative services as soon as possible after being discharged from rehabilitation services. I cannot speak to such a lapse. Therapy would come to me if the ADON is not here and I would make sure orders were in place, but they did not communicate with me. During an interview on 7/17/2025 at 8:37 AM, the Rehabilitation Director stated, Usually when we discharge the resident, we put in the orders in the ADON's mailbox. I do not think there is another process. There was a delay in his restorative services.

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	106114	A. Building B. Wing	07/17/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received respiratory services consistent with professional standards of practice for 2 (Residents #19 and #147) of 4 residents reviewed for oxygen therapy. Findings include: 1) Review of Resident #19's admission record showed the resident was admitted on [DATE] with diagnoses including muscle weakness, unsteady on feet, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure, and gout. During an observation on 7/14/2025 at 10:29 AM, Resident #19's nebulizer mask was on top of the bedside table not bagged. During an observation on 7/15/2025 at 11:54 AM, Resident #19's nebulizer mask was on top of the bedside table not bagged (Photographic evidence obtained). Review of Resident #19's physician order dated 6/27/2025 read, Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/ml (milligram/milliliter) 3 ml inhale orally four times a day for COPD please schedule 0800 [8:00 AM], 1400 [2:00 PM], 2000 [8:00 PM], 0200 [2:00 AM] and 0200 if awake. Status: Active. 2) Review of Resident #147's admission record showed the resident was admitted on [DATE] with diagnoses including COPD, asthma, and iron deficiency anemia. During an observation on 7/14/2025 at 11:34 AM, Resident #147's nebulizer mask was on the bedside table, not bagged. During an observation on 7/15/2025 at 8:15 AM, Resident #147's nebulizer mask was on the bedside table, not bagged (Photographic evidence obtained). Review of Resident #147's physician order dated 7/9/2025 read, Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/ml 3 ml inhale orally three times a day for COPD. During an interview on 7/16/2025 at approximately 10:30 AM, the Director of Nursing (DON) confirmed that the nebulizer masks were not stored appropriately. The surveyor requested the DON for the facility's policy related to storage of mask and oxygen supplies. During an interview on 7/16/2025 at approximately 10:40 AM, the Administrator stated, We do not have a policy for oxygen supply nebulizer storage.

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	106114	A. Building B. Wing	07/17/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food items were dated, labeled and stored in a sealed container in nutrition rooms on 3 residential halls, Prairie, [NAME] and Meadows, of 4 residential halls.Findings include: During an observation on 7/14/2025 at 10:14 AM, there was one undated and unlabeled package of 12 waffles stored in the refrigerator in the nutrition room on the Prairie Hall. During an observation on 7/14/2025 at 10:17 AM, there was one undated and unlabeled Styrofoam cup of liquid stored on the counter in the nutrition room on the [NAME] Hall. During an observation on 7/14/2025 at 10:22 AM, there was one undated and unlabeled package of 12 waffles stored in the refrigerator in the nutrition room on the Meadows Hall. During an interview on 7/14/2025 at 10:14 AM, the Certified Dietary Manager confirmed the packages of waffles on the Prairie Hall and the Meadows hall should be dated and labeled when taken out of original containers and placed in nutrition rooms. She confirmed the Styrofoam cup of liquid on the counter in the [NAME] Hall nourishment room should be labeled and dated. Review of the facility policy and procedure titled Date Marking for Food Safety with the last review date of 5/23/2025, read Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food.

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	106114	A. Building B. Wing	07/17/2025

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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. Based on record review and interview, the facility failed to ensure resident records were complete and accurate for 1 (Resident #62) of 3 residents reviewed for medication administration, 2 (Residents #8 and #148) of 3 residents reviewed for skin conditions, and 1 (Resident #117) of 3 residents reviewed for nutrition. Findings include: 1) Review of Resident #62’s physician order dated 6/4/2025 read, “Antianxiety side effects: 0= No side effects observed 1= Drowsiness 2= Slurred Speech 3= Dizziness 4= Nausea 5= Aggressive/Impulsive Behavior, every shift for Monitoring document applicable code.” Review of Resident #62’s physician order dated 6/4/2025 read, “Please document appropriate number that best matches behavior observed: 1= No behaviors noted 2= Kicking/Hitting 3= Grabbing/Pushing 4= Sexually Inappropriate 5= Yelling/Screaming/Cursing 6= Refusing Care (ADL [Activities of Daily Living], Meds [medications] etc) 7= Wandering/Pacing 8= Exit Seeking 9= Crying 10= Wringing Hands 11= Withdrawn 12= Loss of appetite 13= Other (document in Progress Notes) every shift for psychoactive drug use if you code “Other” please make an entry in Progress Notes to describe in detail.” Review of Resident #62’s physician order dated 7/7/2025 read, “Lorazepam Oral Tablet 0.5 MG (Lorazepam), Give 1 tablet by mouth every 8 hours as needed for anxiety/restlessness for 14 Days. ” Review of Resident #62’s Medication Administration Record (MAR) for July 2025 for administration of Lorazepam 0.5 mg showed it was administered on 7/8/2025 at 8:09 AM, on 7/10/2025 at 6:17 PM, on 7/12/2025 at 8:22 AM and 8:33 PM, on 7/13/2025 at 8:06 AM and 8:25 PM, and on 7/14/2025 at 8:19 AM and 4:56 PM. Further review of the MAR showed 1 (No behaviors noted) was documented for all shifts for documentation of observed behavior, and 0 (no side effects) was documented for antianxiety medication side effects. Review of Resident #62’s nursing progress notes and medication administration notes from 7/1/2025 until 7/15/2025 showed no progress notes related to behaviors and need for PRN Lorazepam administration. During an interview on 7/15/2025 at 12:56 PM, Staff F, Licensed Practical Nurse (LPN), stated, He [Resident #62] has Lorazepam for the restlessness or agitation he has. I guess I really should document what his behaviors were when I gave them. I think that it would not be accurate documentation. I should have documented that. During an interview on 7/16/2025 at 12:41 PM, the Director of Nursing (DON) stated, I think that when any PRN antianxiety medication is given, the nurses should document the behaviors that the resident has that had them administer it. I do expect accurate documentation. (continued on next page)

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	106114	A. Building B. Wing	07/17/2025

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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	2) Review of Resident #8’s physician order dated 6/9/2025 read, “Cleanse left heel with NS [normal saline], pat dry, skin prep edges, apply medi-honey, cover with calcium alginate, cover with foam dressing, every day shift for wound care.” Review of Resident #8’s Treatment Administration Record (TAR) for June 2025 showed no entries documented on 6/12/2025 and 6/18/2025. Review of Resident #8’s physician order dated 6/19/2025 read, “Cleanse left heel with NS, pat dry, skin prep edges, cover with calcium alginate, cover with foam dressing every day shift for wound care. ” Review of Resident #8’s TAR for June 2025 showed no entry documented on 6/23/2025. Review of Resident #8’s progress notes showed no documentation for blank entries for 6/12/2025, 6/18/2024, and 6/23/2025. During an interview on 7/16/2025 at 12:12 PM, the DON stated, “I looked at the progress notes and could only find two refusals. I spoke to [Staff E, Registered Nurse (RN)’ name] and she stated she had completed the dressing changes and did not know why it was not signed off. I would believe it is a documentation inaccuracy. She [Staff E] verbalized she did the dressing change because that day she had come in to help with dressing changes. Nurses are expected to document accurately. It's important to document any episodes of refusals. Sometimes the resident refuses and the nurse plans to go back and might forget to document.” During an interview on 7/16/2025 at 2:53 PM, Staff D, LPN, stated, “I do not recall. I always do wound care and go back at the end of shift and make sure all entries are green. I am not sure what happened. ” 3) During an observation on 7/14/2025 at 11:44 AM, Resident #148 was sitting in a wheelchair in his room. There was a foam dressing on his right lower leg dated 7/11. During an observation on 7/15/2025 at 8:44 AM, Resident #148 was sitting in his wheelchair eating breakfast. There was a dressing on his lower right leg dated 7/11 and it was peeling on lower right corner. During an observation on 7/16/2025 at 8:29 AM, Resident #148 was sitting in his wheelchair waiting for breakfast. There was a foam dressing on his right leg dated 7/11. During an observation on 7/16/2025 at 8:36 AM, Staff D, LPN, entered Resident #148’s room and confirmed the dressing on the resident’s right lower leg was dated 7/11/2025. Review of Resident #148’s physician order dated 7/10/2025 read, “Cleanse skin tear to the back of L [Left] calf with NS [normal saline], cover with adaptic [sic] and foam dressing Q3 [every three] days until resolved, every day shift every 3 day(s) for wound care.” Review of Resident #148’s TAR for July 2025 showed the dressing was changed on 7/13/2025. (continued on next page)

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	07/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/2025 at 8:45 AM, Staff D, LPN, stated, [Resident #148’s name] has a small open area, the size of a dime. I do not recall why I checked off on 7/13/25 I did the dressing change. The order was written wrong. It should be the right leg not the left leg. I do not know who wrote the original order. During an interview on 7/16/2025 at 12:08 PM, the DON stated, “The nurse superimposed the legs. It was anatomically wrong.” During an interview on 7/17/2025 at 8:30 AM, the DON stated, “The nurse was just clicking away. It was a documentation error.” 4) Review of Resident 117’s physician order dated 6/20/2025 read, “Med Pass 2.0 two times a day for poor appetite.” The order did not indicate the amount to be administered to the resident. During an interview on 7/16/2025 at approximately 9:55 AM, Staff C, LPN, stated, “What I give is typically what is given. That is the protocol. I give the standard 120 ml [milliliter] unless it reads 237 mls. ” During an interview on 7/16/2025 at approximately 10:30 AM, the DON stated, “That is the standard for nutritional supplement. It should have an amount on the order. The amount should be clear and concise. ”