Agency fo	or Health Care Adminis	tration					0: 04/06/202 1 APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		1 ' '	CONSTRUCTION	(X3) DATE S COMPL	
		30901		B. WING		02/1	0/2022
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
ODWOTA!	D0/FD 11F41 711 44/D DF	MADE ITATION OF	136 NORTH	EAST 12TH A	VENUE		
CRYSIAL	RIVER HEALTH AND RE	HABILITATION CEN	CRYSTAL F	RIVER, FL 344	129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FU SCIDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETE DATE
N 000	INITIAL COMMENTS			N 000			
	An unannounced re-li conducted at Crystal I Rehabilitation Center through	River Health and on Deficient practice	e				
N 054 SS=D	59A-4.107(5), FAC Fo	ollow Physician Orders		N 054			
		nust be followed as followed, the reason m sident's medical record					
	Based on observation review, the facility fails orders were followed residents reviewed for	s not met as evidenced i, interview, and record ed to ensure physician as prescribed for 1 of 3 r administration sample of 54 residents			In preparation, submission, and implementation of this plan of correct does not constitute an admission of agreement with the conclusions set for on the survey report. Our plan of correction is prepared and executed	orth	
	Findings:				continuously improve the quality of ca and comply with all applicable state a		
	resident was admitted	8's records revealed the I on with	9		federal regulatory requirements.		
	airflow and makes it o	that bloc lifficult to breathe), left on one side of the bod	sided		N054 The facility will continue to follow phy orders as prescribed.	sician	
	and major	(high ,	),		CRITERIA 1: Resident #8 flow was set to t	he	

AHCA Form 3020-0001

Resident #8 was receiving . . . at 4 liters per minute via , , concentrator, with the LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Resident #8 was receiving \_\_ at 4 liters per

minute via . . . . concentrator, with the . . . . .

at 7:55 AM,

humidification bottle on the floor.

During an observation on

TITLE (X6) DATE Electronically Signed /22

physician ordered two liters and a new

Nurse.

CRITERIA 2:

humidification bottle obtained and placed

in concentrator holder by Licensed

Remaining 19 residents on ,, were

Development Coordinator and D.O.N to

audited by Licensed Nurse, Staff

STATE FORM 8SFG11 If continuation sheet 1 of 10

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 054 Continued From page 1 N 054 humidification bottle on the floor. ensure . . . . flow rates were per physician's orders and humidification During an observation on at 1:52 PM, bottles were in concentrator holder and Resident #8 was receiving \_\_\_ at 4 liters per not on floor. No other ... was noted to minute via . , . . concentrator, with the . , . . be erroneous on ...... humidification bottle on the floor. CRITERIA 3: Review of the physician order dated for Licensed Nurses re-educated on . . Resident #8 revealed . , , at 2 liters per administration by Staff Development minute as needed for Coordinator, completed During an interview on at 2:12 PM. Staff CRITERIA 4: G. Licensed Practical Nurse (LPN), stated, "The D.O.N/designee to audit three residents ... is not supposed to be on 4 liters. She has with ,, administration twice weekly x doctor's orders for 2 liters. I'm not sure why she is 3 months or until substantial compliance is on 4 liters. The humidification bottle should not be achieved and results brought to monthly on the floor and needs to be changed right away." QA meeting and any additional interventions added, as necessary. During an interview on at 2:45 PM, the Director of Nursing (DON) stated, " should be administered according to the doctor's orders. I can't believe that the humidification hottle was on the floor. It needs to be in the holder. I expect that the nurses are assessing every shift and making sure that it is being

SS=F

Class III

N 094 59A-4.112(5), FAC Drug Labeling

administered according to the doctor's orders."

(5) Prescription drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles. Chapter 499, F.S. and Rules 64B16-28.108 and 64B16-28.502, F.A.C., as required by the Department of Health.

This Statute or Rule is not met as evidenced by:

N 094

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COME ETC PREFEX PREFIX DATE TAG REGULATORY OR LISC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 094 Continued From page 2 N no4 Based on observation, interview, and record N094 review, the facility failed to ensure the DRUGS AND BIOLOGICALS WILL BE LABELED IN ACCORDANCE WITH medications used in the facility were labeled in accordance with currently accepted professional CURRENTLY ACCEPTED PROFESSIONAL PRINCIPLES. principles in 5 of 6 medication carts reviewed. Findings: The facility will continue to label drugs and biologicals in accordance with currently On ...... at 9:25 AM, the surveyor observed accepted professional principles. Medication Cart #1 with Staff A. Licensed Practical Nurse (LPN), and found one opened CRITERIA 1: with no opened or expiration The one open dates, one opened Lispro ... , with no Lispro . , one bottle of ..... , one bottle of Ofloxacin opened or expiration dates, one opened bottle of

with no opened or expiration dates. and one opened bottle of Ofloxacin with no opened or expiration dates. During an interview on .... at 9:25 AM, Staff A, LPN, stated, "All ... and ... should

be labeled when they are opened. I'm not sure

why they aren't. This is not my cart."

at 9:30 AM, the surveyor observed Medication Cart #2 with Staff B. Registered Nurse (RN), and found one opened with no opened or expiration dates, one opened with no opened or expiration with no opened or expiration dates, two opened bottles of \_\_\_\_\_ tears with no resident identifiers and no opened or expiration dates, and one opened bottle of . . . . , . . . . . . . with no opened or expiration dates.

During an interview on at 9:35 AM, Staff B, RN, stated, "All . . . . . and . . should have the date opened and when they expire." On at 9:40 AM, the surveyor observed

from cart #1, and one ... one , , one bottle .... tears, one bottle Refresh tear, one bottle of , , , one bottle of ....., one bottle of , , , , , two bottles of tears, and one bottle of , from cart #2, and one .... , , , one .. .

. . . tears, one bottle of Brimondine. one bottle of , one bottle of ..... , ...., from cart #4, and one bottle of Latanprost , , one bottle of Lumigan . , . . . , . , one bottle of Refresh , and one bottle of ., . . . from cart #5 were discarded and newly opened medication labeled and dated on ...... by Licensed Nurses.

Aspart one bottle of .......

one bottle of , , one bottle

of . , . . . , . . , . from cart #3, and

two , one bottle of

Remaining medication cart #6 audit

CRITERIA 2:

case

8SFG11 If continuation sheet 3 of 10

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COME ETC PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 094 | Continued From page 3 N no4 Medication Cart #3 with Staff C, LPN, and found completed ... by Licensed Nurse, no one opened with no opened undated, unlabeled or expired medications or expiration dates, one opened observed. with no opened or expiration dates, one CRITERIA 3: opened Aspart ... with no opened or expiration dates, one opened bottle of Re-education of Licensed Nurses with no opened or expiration dates, and regarding medication storage and labeling one opened bottle of , , with no completed by Staff Development Coordinator on ...... opened or expiration dates. CRITERIA 4: C, LPN, stated, "All and , should D.O.N/designee to audit medication carts be labeled when they are opened." to ensure expired medication and/or biologicals are not present or unlabeled On at 9:50 AM, the surveyor observed weekly x 3 months or until substantial Medication Cart #4 with Staff D, LPN, and found compliance is achieved and results one opened ... ... with no opened or brought to QA monthly and any additional expiration dates, one opened interventions added, as necessary. with no opened or expiration dates, and one opened bottle of 0.2% , with no opened or expiration dates. During an interview on ...... at 9:55 AM, Staff D, LPN, stated, "All , and need to be labeled when they are opened and when they

expire."

one opened bottle of

at 10:05 AM, the surveyor observed Medication Cart #5 with Staff E, LPN, and found

.... with no opened or expiration dates, one opened bottle of Lumigan 0.01% , with no opened or expiration dates, one opened bottle of Refresh , with no opened or expiration dates, and one opened bottle of with no resident identifier and an opened date of ...........

During an interview on ...... at 10:10 AM, Staff E. LPN, stated, "We should not have any

0.005%

STATE FORM caso 8SEG11 If continuation sheet 4 of 10

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B MING 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 (X433F) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 094 Continued From page 4 N no4 expired meds on the cart." Review of the facility policy number 5.3 titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" with the last revision date of reads. "Procedure: .... 4. Facility should ensure that medications and biologicals: 4.1 Have an expiration date on the label: 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines ... 5. Once any medication or biological package is opened. Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened, 5.1 Facility staff may record the date based on date opened on the medication container " Class III N 915 400.147(7), FS Adverse Incident N 915 SS=F (7) The nursing home facility shall initiate an investigation within 1 business day after the risk

manager or his or her designee has received a report pursuant to paragraph (1)(d). The facility must complete the investigation and submit a report to the agency within 15 calendar days after the adverse incident occurred. The agency shall develop a form for the report which must include the name of the risk manager, information regarding the identity of the affected resident, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to any other

STATE FORM caso 8SFG11 If continuation sheet 5 of 10

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B MING 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG DEFICIENCY) N 915 Continued From page 5 N 915 resident. The report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each report and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456,073 shall apply. This Statute or Rule is not met as evidenced by: N915 Based on record review and interview, the facility failed to submit a report of adverse incidents to The facility will continue to report adverse the Agency for Health Care Administration for 3 of incidents. 3 residents reviewed for facility response to ..... allegations, Residents #10, #59, and #69. CRITERIA 1: Findings: Grievance reports for residents #10, #69, and #59 were investigated and reported to required agencies such as DCF, AHCA

Review of the facility grievances report dated revealed Resident #10 had voiced an allegation of . . . . . . that a Certified Nursing Assistant had called him a name

Review of the facility grievances report dated revealed Resident #69 had voiced an allegation that he was told to urinate in his brief, and he was not getting water.

Review of the facility grievances report dated revealed Resident #59's daughter had voiced an allegation that Resident #59 had been locked in the shower and was screaming.

at 9:27 AM, the

During an interview on

allegations. CRITERIA 3:

CRITERIA 4:

CRITERIA 2:

and law enforcement on

by Director of Nursing on

further grievances were noted as

Re-education provided to staff on reporting requirements of allegations by Staff Development Coordinator. Completed by

Remaining grievance reports for last 6 months reviewed to ensure that

allegations were not missed for reporting

cnso 8SFG11 If continuation sheet 6 of 10

PRINTED: 04/06/2022 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 30901 02/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CEN CRYSTAL RIVER, FL 34429 (X433ID) SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 915 Continued From page 6 N 915 Social Worker verified that the facility had not NHA/designee to audit grievance logs reported the allegations of weekly to ensure allegations are not Resident #10, Resident #69, and Resident #59. missed for reporting x 3 months or until substantial compliance is achieved and results brought to monthly QA meeting Administrator acknowledged the requirement for and any additional interventions added as the incidents involving Resident #10. Resident necessary. #69, and Resident #59 to have been reported. During an interview on at 11:42 AM, the Social Worker stated Resident #10 had voiced the allegation on , Resident #69 had voiced the allegation on ....., and Resident #59's daughter had voiced the allegation on ........ Administrator stated he knew that the incidents involving Resident #10. Resident #59, and Resident #69 had occurred and he had signed off on them. He stated, "After I reviewed these, we really should have reported them. I'm aware we have an ... .... to report. These seemed so subtle, we just didn't realize. But we really should

have identified them after the second occurrence and come up with a plan." Review of the facility policy titled " . Neglect. Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source.

. . . " reviewed on . . . . , read, "Purpose: This Policy (the "Policy") is concerned with all incidents and accidents involving resident/quest(s). The facility will investigate and document all incidents and accidents involving resident/guest(s). Certain incidents and accidents involving residents/guests must also be reported to the appropriate agencies. All of our resident/guest(s) have the right to be free from , and misappropriation

. nealect.

STATE FORM caso 8SFG11 If continuation sheet 7 of 10

02/10/2022

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

NAME OF PROVIDER OR SUPPLIER

B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE

30901

CRYSTAL RIVER HEALTH AND REHABILITATION CEN  136 NORTHEAST 12TH AVENUE  CRYSTAL RIVER, FL 34429						
		CRYSTAL RI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE	
N 915	Continued From page 7		N 915			
	of resident/guest property. This includes but is limited to freedom from corporal punishment, involuntary and physical or chemic not required to treat the resident/guest(s) medical symptoms. This policy addresses the acts and occurrences the constitute neglect, and misappropriation of resident/guest property as suspicious injuries of unknown source; this includes but is not limited to: freedom from corporal punishment, involuntary and physical or chemical not required to treat the resident/guest(s) medical symptoms any type, by anyone, when such acts and occurrences transpire, it must be reported to agencies and officials outside of the facility; the proper reporting procedures to be used in suc instances; training of employees regarding su acts and occurrences and reporting procedures acts and occurrences and reporting procedures. The palso addresses the proper investigation and documentation of incidents and accidents involving resident/guest(s) that are not causer involving resident/guest(s) that are not causer involving resident/guest(s) that are not causer in the property propose of this Policy, the following terms shall have the following meanings: A. The definition encompanses a broad scope of behavis in the willful infliction of injury, unreasonable confirement, intimidation, or	s not all at at at and of of ab				
	200 0004				1	

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 30901 B. WING \_\_\_ 02/10/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CRYSTAL	RIVER HEALTH AND REHABILITATION CEN		IEAST 12TH A RIVER, FL 344		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 915	Continued From page 8  . Willful means the individual have acted deliberately (not inadverently or accidentally), not that the individual must have acted deliberately (not inadverently or accidentally), not that the individual must ha intended to inflict injury or harm. A	ove  confine  confine	N 915		

Agency f	or Health Care Adminis	stration	BER: A BUILDING: COMPLETED  B. WING 02/10/2022  STREET ADDRESS, CITY, STATE, ZIP CODE  136 NORTHEAST 12TH AVENUE  CRYSTAL RIVER, FL. 34429  J. PROFUGERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE ONL)  LAG CROSS-REFERENCED TO THE APPROPRIATE DATE  N 915			
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			
		30901	B. WING		02/1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CEN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
N 915	Continued From page	9	N 915			
	instances that result is be reported within 2 h	in serious bodily injury must nours."				
	Class III					

AHCA Form 3020-0001

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-0391

		MEDICAID SERVICES				CIVID IV	J. U938-U391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COME	SURVEY
		105317	B. WING			02	10/2022
	ROVIDER OR SUPPLIER RIVER HEALTH AND RE	EHABILITATION CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 36 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	•	F	000			
F 609 SS=F	conducted on at Crystal R Rehabilitation Center compliance with 42 C Long Term Care Faci Substandard quality F609- Reporting of A extended survey was	of care was identified at lleged Violations. An conducted on	F	609			
	§483.12(c) in respon- neglect, , , , , , , , , , , , , , , , , , ,	se to allegations of , or mistreatment, the facility					
	involving neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily night events that cause and do not rese administrator of the officials (including to adult protective servi for jurisdiction in long for jurisdiction in long for jurisdiction in long for jurisdiction in long for preserved.	ng injuries of unknown priation of resident property, telely, but not later than 2 titon is made, if the events liton involve or result in or not later than 24 hours if the allegation do not involve ut in serious bodily injury, to the facility and to other the State Survey Agency and sees where state law provides telem care facilities) in elaw through established					
	investigations to the	administrator or his or her			TITLE		IXED DATE

Electronically Signed

/2022

Any deficiency statement ending with an asteriak (1) denotes a deficiency, which the institution may be excused from correcting providing it is determined that other adequaries provide sufficient protection to the patients. (See instructions). Except for nursing homes, the findings stated above are readiled to the provided and the provided and the state of the provided and the

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID: 8SFG11

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105317	(X2) MUL A. BUILD B. WING	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 02/10/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			436 HODTUEACT 43TH AVENUE	

MIND PLUM OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG_		- 60	MPLETED
		105317	B. WING _				2/10/2022
NAME OF PE	ROVIDER OR SUPPLIER			S'	FREET ADDRESS, CITY, STATE, ZIP CODE		
				13	66 NORTHEAST 12TH AVENUE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		С	RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	accordance with State Survey Agency, within incident, and if the ali appropriate correction. This REQUIREMENT by: Based on record revi failed to ensure the ai- reported to the State officials for 3 of 3 resi response to ali #59, and #69.  Findings: Review of the facility- reve voiced an allegation of Coertified Nursing Assi name.  Review of the facility- reveale an allegation that he brief, and he was not Review of the facility- reveale an allegation that he brief, and he was not Serview of the facility- reveale and the service of the facility- reveale and the ser	ative and to other officials in a law, including to the State 1s working days of the gged violation is verified a action must be taken, is not met as evidenced ew and interview, the facility legations of, were Survey Agency and other dents reviewed for facility egations, Residents #10, grievances report dated aled Resident #10 had f, that a stant had called him a grievances report dated d Resident #69 had voiced was told to urinate in his getting water.  grievances report dated aled Resident #69 had voiced was told to urinate in his getting water.  grievances report dated aled Resident #50 had not all gation that Resident in the shower and was	F6	09	In preparation, submission, and implementation of this plan of correction does not constitute an admission of agreement with the conclusions set for on the survey report. Our plan of correction is prepared and executed to continuously improve the quality of car and comply with all applicable state and federal regulatory requirements.  F609  RESIDENTS WILL HAVE ALLEGED VIOLATIONS REPORTED.  The facility will continue to report allege violations.  CRITERIA 1:  Grievance reports for residents #10, #6 agencies on  CRITERIA 2:  Remaining grievance reports for last 6 months reviewed to ensure that allegations were not missed for reporting the properties of Nursing on No further grievances were noted as allegations.  CRITERIA 3:	hh ∋ ∃ ∃ ded	
			1				

During an interview on ....... at 10:22 AM, the

Facility ID: 30901

Event ID: 8SFG11

Re-education provided to staff on

PRINTED: 04/06/2022

FORM APPROVED

### PRINTED: 04/06/2022 DEPARTMENT OF HEALTH AND HISMAN SERVICES

DELITATION THE TENTON	D HOM STOLINGED		FURW APPROVE			
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039			
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	IDENTIFICATION NUMBER					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CENTER CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 609 Continued From page 2 F 609 Administrator acknowledged the requirement for reporting requirements of allegations by the incidents involving Resident #10, Resident Staff Development Coordinator. #69, and Resident #59 to have been reported. Completed by ...... CRITERIA 4: During an interview on at 11:42 AM, the Social Worker stated Resident #10 had voiced NHA/designee to audit grievance logs the allegation on ...... , Resident #69 had weekly to ensure allegations are not voiced the allegation on missed for reporting x 3 months or until Resident #59's daughter had voiced the substantial compliance is achieved and allegation on results brought to monthly QA meeting and any additional interventions added as During an interview on at 8:30 AM, the necessary. Administrator stated he knew that the incidents involving Resident #10, Resident #59, and Resident #69 had occurred and he had signed off on them. He stated, "After I reviewed these, we really should have reported them. I'm aware we to report. These seemed so subtle, we just didn't realize. But we really should have identified them after the second occurrence and come up with a plan." Review of the facility policy titled " ...., Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source. " reviewed on "Purpose: This Policy (the "Policy") is concerned with all incidents and accidents involving resident/guest(s). The facility will investigate and document all incidents and accidents involving resident/quest(s). Certain incidents and accidents involving residents/guests must also be reported to the appropriate agencies. All of our resident/quest(s) have the right to be free from ..., neglect, ......, and misappropriation of resident/quest property. This includes but is not limited to freedom from corporal punishment. involuntary , and physical or chemical .. not required to treat the

### PRINTED: 04/06/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES

	105317	B. WING	02/10/2022
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
CENTERS FOR MEDICARE &	MEDICAID SERVICES	1	OMB NO. 0938-039
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AND POWOF CORRECTION IDENTIFICATION HOMBER.		A. BUILDIN	A. BUILDING			COMPLETED		
		105317	B. WING			02/	10/2022	
NAME OF P	ROVIDER OR SUPPLIER		<del> </del>	5"	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2022	
(OULL DITT	CONDEN ON OUT DEN		- 1		36 NORTHEAST 12TH AVENUE			
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER						
				_	RYSTAL RIVER, FL 34429			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609	Continued From page	13	F 6	09				
	resident/guest(s) med	lical symptoms This						
	policy addresses the	acts and occurrences that						
	constitute , neg							
		sident/guest property and						
	suspicious injuries of							
	includes but is not lim							
		involuntary , and						
	physical or chemical	not required to						
	any type, by anyone;	st(s) medical symptoms of						
		, it must be reported to						
		outside of the facility; the						
		edures to be used in such						
		employees regarding such						
		and reporting procedures;						
	and the investigation							
	occurrences and repo	orting procedures. The policy						
	also addresses the pr	oper investigation and						
	documentation of inci	dents and accidents						
		est(s) that are not caused by						
		nd misappropriation of						
	resident/guest proper							
	Policy, the following to							
	following meanings: A							
	is the willful int	a broad scope of behavior.						
	unreasonable confine							
	punishment with resu							
		dition. includes						
		/guest of goods and/or						
		essary to attain or maintain						
	physical, mental, and							
		ental or physical condition.						
	Any act considered	towards an alert and						
		st should also be considered						
	to the	, , or						
		ul means the individual must						
		ly (not inadvertently or						
		the individual must have						

accidentally), not that the individual must have

## DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/08/2022 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

NO DEAN OF CORRECTION DENTIFICATION NUMBER:				OND NO. 0936-039
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02.10.2022
			136 NORTHEAST 12TH AVENUE	

		103317	B. WING			02/10/2022	
NAME OF P	ROVIDER OR SUPPLIER			- 4	STREET ADDRESS, CITY, STATE, ZIP CODE		
					136 NORTHEAST 12TH AVENUE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		-	CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 609	intended to inflict injuinesident/gues another resident/gues another resident/gues another resident/gues another resident/gues for 1. Ve of oral, written or gest sounds that includes terms to resident/gue families/representation distance, regardless of comprehend, or the nexamples of not limited to: threate things to frighten a real resident/guest that: see his/her family aga and leave for hours, wyourself, if you don't a taken away, isolating interaction or activitie resident/guest, blamit their condition and en of a resident/guest, blamit their condition and en of a resident/guest, blamit their condition and en a resident/guest, blamit their condition and en a resident/guest, blamit hat could be Facility Response to 1 The facility will report suspected inc, neglect, suspingin, an resident/guest proper b) Investigation and f Administrator of any tacility, whether report he Administrator of any tacility, whether report he Administrator/De State Agency and all-regulations. All allega	ny or harm. A	F	2009			

### PRINTED: 04/06/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES C					
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
	105317	B. WING		02/10/2022	
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		105317	B. WING		02/10/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS. CITY, STATE, ZIP CODE  136 NORTHEAST 12TH AVENUE  CRYSTAL RIVER, FL 34429	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 695 SS=D	CFR(s): 483.25(i)  § 483.25(i)  a care an The facility must ensu needs care care and succere, consistent with practice, the compreh care plan, the residen and 483.65 of this sub This REQUIREMENT by: Based on observatior review, the facility fails needed care consistent with practice, for 1 of 3 resi administration, Reside 54 residents. Findings: Review of Resident Review of Resident gairflow and makes it d in the practice for 1 of 3 resi administration, Reside fail for a fail for a fail for a fail for a fail call for a fail for a fail for a fail call for a fail call for a fail call for a fail call	d suctioning, re that a resident who is, including towing, is provided such professional standards of ensive person-centered is goals and preferences, part. is not met as evidenced in, interview, and record at one sure a resident who re services received such rofessional standards of dents reviewed for with the surface of the control of the surface and the surface and the surface and the control of the surface and the	F 699	F695 RESIDENTS WILL HAVE CARE CONSISTENT WITH PROFESSIONAL STANDARDS OF PRACTICE. The facility will continue to provide	ed ed

CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES	T		FORI OMB NO	D: 04/06/2022 M APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		SURVEY PLETED
		105317	B. WING _		02	10/2022
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		136 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	REMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	minute via 00 humidification bottle c During an observation Resident #8 was receminute via 00 humidification bottle c Review of the physici Resident #8 revealed minute as needed for During an interview o G, Licensed Practical is not suppos doctor's orders for 21 on 4 liters. The humic	ncentrator, with the	F 6	CRITERIA 3: Licensed Nurses re-educated on administration by Staff Developmer Coordinator, completed  CRITERIA 4: D.O.Nidesignee to audit three resident with administration twice with administration twice with achieved and results brought to 7 QA meeting and any additional interventions added, as necessary.	ents ekly x ance	
F 761 SS≃F	During an interview o Director of Nursing (C should be administer orders. I can't believe bottle was on the floo holder. I expect that if every shift and makin administered accordit Label(Store Drugs an CFR(s): 483.45(g)(h)) §483.45(g) Labeling c Drugs and biologicals	n at 2:45 PM, the ON) stated, " d according to the doctor's that the humidification r. It needs to be in the neurose are assessing g sure that it is being g to the doctor's orders." d Biologicals 1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the yand cautionary	F7	761		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		105317	B. WING			02/	10/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 36 NORTHEAST 12TH AVENUE RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	\$483.45(h)(1) In accc Federal laws, the facibility for the fact follows: Federal laws, the facibility for the fact follows: Federal laws, the facibility for the fact for the	f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized zess to the keys.  Sillity must provide separately affixed compartments for drugs listed in Schedule il of rug. Prevention and not other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced no, interview, and record ed to ensure the he facility were labeled and with currently accepted as and included the applicable in 5 of 6 weed.  MM, the surveyor observed this Staff A, Licensed o, and found one opened h no opened or expiration spro with no sproy and the staff of the compared or expiration spro with no sproy opened bottle of opened or expiration dates, e of Ofloxacin.	F	761	F761 DRUGS AND BIOLOGICALS WILL BE LABELED IN ACCORDANCE WITH CURRENTLY ACCEPTED PROFESSIONAL PRINCIPLES. The facility will continue to label drugs biologicals in accordance with currently accepted professional principles.  CRITERIA 1: The one open	and y	

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	J. 04/06/2022 MAPPROVED J. 0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY		
		105317	B. WING		02/	10/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  136 NORTHEAST 12TH AVENUE  CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	During an interview of A, LPN, stated, "All be labeled when they why they aren't. This  On at 9:30 / Medication Cart #2 w  (RN), and found one with no opened or ex y  dates, one opened w  expiration date of of Refresh te	at 9:25 AM, Staff and , should are opened. I'm not sure is not my cart."  MM, the surveyor observed the Staff B, Registered Nurse opened or expiration dates, one opened with no opened or expiration of tears with an opened one opened ottle or one opened obttle ars with an opened one with an opened of expiration with one opened obttle or swith an opened obttle or swith an opened obttle or swith an opened of the opened of the opened of the or swith an opened of the opened	F7I	tears, and one bottle of from cart #2, one , one , one . , one . , one bottle of . tears, one bottle of . from cart #3, ar two , one bottle of , from cart #4, ar one bottle of Langrost , or bottle of Loursigan , one bottle of Loursigan , on	one , pottle ad ne,	

opened bottle of ......... with an opened date of .......... and pharmacy instructions to discard after 42 days, one opened bottle of ..., . with no opened or expiration dates, two opened bottles of tears with no resident identifiers and no opened or expiration dates, and one opened bottle of . . . . . . . . . . . . with no opened or expiration dates.

During an interview on at 9:35 AM, Staff B, RN, stated, "I'm not sure why the expired medications are still on the cart. They should be thrown out. All . . . . , and . . should have the date opened and when they expire."

at 9:40 AM, the surveyor observed Medication Cart #3 with Staff C. LPN, and found one opened , with no opened or expiration dates, one opened with no opened or expiration dates, one .... with an expiration date of , one opened Aspart with no opened or expiration dates, one opened bottle of discarded and newly opened medication dated on ..... by Licensed Nurses.

CRITERIA 2: Remaining medication cart #6 audit completed ...... by Licensed Nurse, no undated or expired medications observed.

CRITERIA 3: Re-education of Licensed Nurses regarding medication storage and labeling completed by Staff Development Coordinator on

CRITERIA 4: D.O.N/designee to audit medication carts to ensure expired medication and/or biologicals are not present weekly and medication is labeled x 3 months or until substantial compliance is achieved and results brought to QA monthly and any additional interventions added, as necessary.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	04/06/2022
FORM.	APPROVED
OMB NO.	0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		105317	B. WING		02/1	0/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	one opened bottle of date of, an will dates.	o 9 o pened or expiration dates, with an expiration d one opened bottle of the no opened or expiration	F 76			
	C, LPN, stated, "The are expired, and they They should have be	and the should not be on the cart.				
	Medication Cart #4 w one opened expiration dates, one with an expirat opened expiration dates, one tears with an expiration opened bottle of no opened or expiration of and one op	with no opened or opened bottle of on date of				
	D, LPN, stated, "That are expired, and we s and gotten new ones	hould have discarded them				
		AM, the surveyor observed ith Staff E, LPN, and found 0.005%				

., . with no opened or expiration dates, one

### PRINTED: 04/06/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES

	105317	B. WING	02/10/2022				
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039				
DEFACTMENT OF HEAETT AND HOWAIN SERVICES							

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ODVOTAL DIVER HEALTH AND DEHABILITATION OFFICE			136 NORTHEAST 12TH AVENUE				
CRYSTAL	RIVER HEALTH AND REHABILITATION CENTER	CRYSTAL RIVER, FL 34429					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 761	Continued From page 10 opened bottle of Lumigan 0.01%	F 761					
F 835	Review of the facility policy number 5.3 titled "Storage and Expiration of Medications." Biologicals. Syringes and Needles" with the last revision date of reads, "Procedure" 4. Facility should ensure that medications and biologicals: 4.1 Have an expiration date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the expiration date once opened. 5.1 Facility staff may record the expiration date based on date opened on the medication container."	F 83					
SS=F	Arministration.  \$483.70 Administration.  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical. mental, and , well-being of each resident.	1 000					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/06/2022 FORM APPROVED

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO.	0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	
		105317	B. WING		02/1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				36 NORTHEAST 12TH AVENUE		
CRYSTAL	RIVER HEALTH AND RE	EHABILITATION CENTER	(	CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
				DEFICIENCY)	-	
F 835	This REQUIREMENT	e 11 Γ is not met as evidenced	F 835			
	by:					
		iew and interview, the facility		F835		
		to ensure the facility was		Residents will have facility administ	ered in	
		nner to maintain the highest		a manner that enables it to use its		
	practicable physical,			resources effectively and efficiently		
		esidents reviewed for facility		attain or maintain their highest prac	ticable	
		legations, Residents #10,		physical, mental, and , . ,		
	#59, and #69.			well-being.		
	Findings:			The facility will continue to be		
				administered in a manner that enab	iles it	
		scription for the Administrator		to use its resources effectively and		
	with an effective date			efficiently to attain or maintain their		
		ads, "General Purpose: To		highest practicable physical, mental	i, and	
		functions of the facility in ent Federal, State and local		, , well-being.		
		long-term care facilities to				
		st practicable level of care is		CRITERIA 1:		
	provided to the reside			Grievance reports for residents #10 and #59 were reported to required	, #69,	
	Pavian of the job des	scription for the Director of		agencies, such as DCF, AHCA and	law	
		tive date of and		enforcement on		
	review date of	reads, "General Purpose:		Social Service Director re-educated		
		f the Administrator, plans,		policy for allegations and requireme		
		and directs the overall		reporting on		
	operation of the Nurs	ing Services Department in				
	accordance with curr	ent federal, state and local		CRITERIA 2:		
		the facility. Ensure that the		Remaining grievance reports for las	st 6	
		vel of quality of care is		months reviewed to ensure that		
	maintained at all time	s."		allegations were not missed for repo		
				by Director of Nursing on . No	)	
		grievances report dated		further grievances were noted as		
		ealed Resident #10 had		allegations.		
		of that a		ODITEDIA O		
	name.	istant had called him a		CRITERIA 3: Re-education provided to NHA, DO	M and	
	name.			Social Service Director on reporting		

Review of the facility grievances report dated

requirements of allegations by corporate

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/06/2022 MAPPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105317	B. WING			02/	10/2022
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	13	TREET ADDRESS, CITY, STATE, ZIP CODE 36 NORTHEAST 12TH AVENUE RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 835	reveale an allegation that he ibrief, and he was not Review of the facility-reve. daughter had volced. #59 had been locked screaming.  During an interview o Social Worker verified reported the allegation Resident #10, Reside During an interview o Administrator acknow the incidents involving #69, and Resident #50. During an interview o Social Worker stated	ad Resident #69 had voiced was told to urinate in his getting water.  grievances report dated aled Resident #59's an allegation that Resident in the shower and was  n at 9:27 AM, the that the facility had not ns of involving in #69, and Resident #59.  In at 10:22 AM, the ledged the requirement for g Resident #10, Resident 9 to have been reported.  n at 11:42 AM, the Resident #10 had voiced , Resident #69 had	F	835	regional nurse. Completed	g x ce	

voiced the allegation on Resident #59's daughter had voiced the

During interview on at 1:14 PM, the Director of Nursing confirmed the . . . . /neglect allegations of 3 residents (Resident #10, Resident #69, Resident #59) were not reported because "no one stated they were abused, no one stated they were hit, and someone stated they were called a name."

During an interview on at 8:30 AM, the Administrator stated he knew that the incidents involving Resident #10, Resident #59, and Resident #69 had occurred and he had signed off

allegation on

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CENTERS FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-039
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	105317	B. WING		02/10/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CENTER CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 835 Continued From page 13 F 835 on them. He stated, "After I reviewed these, we really should have reported them. I'm aware we have an ... .... to report. These seemed so subtle, we just didn't realize. But we really should have identified them after the second occurrence and come up with a plan." Review of the facility policy titled " Misappropriation of Resident/Guest Property. Suspicious Injuries of Unknown Source. " reviewed on ....., read, "Purpose: This Policy (the "Policy") is concerned with all incidents and accidents involving resident/guest(s). The facility will investigate and document all incidents and accidents involving resident/guest(s). Certain incidents and accidents involving residents/guests must also be reported to the appropriate agencies. All of our resident/guest(s) have the right to be free from , neglect, , and misappropriation of resident/guest property. This includes but is not limited to freedom from corporal punishment. involuntary ....., and physical or chemical not required to treat the resident/quest(s) medical symptoms ... This policy addresses the acts and occurrences that constitute . . . , neglect, . , . . . and misappropriation of resident/quest property and suspicious injuries of unknown source; this includes but is not limited to: freedom from corporal punishment, involuntary . . . . , and physical or chemical not required to treat the resident/quest(s) medical symptoms of any type, by anyone; when such acts and occurrences transpire, it must be reported to agencies and officials outside of the facility; the proper reporting procedures to be used in such instances; training of employees regarding such

acts and occurrences and reporting procedures;

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		105317	B. WING _			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER			YSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	۲	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	also addresses the production and addresses the proper folion of inci involving resident/guest proper Policy, the following the following the encompasses is the willful in unreasonable confine punishment with resumental anguish. In adepriving the resident services that are necophysical, mental, and irrespective of any m Any act considered oriented resident/gue to the tother than the proper formation of the following the services that accidentally), not that intended to inflict injuresident/gue another resident/gue another resident/gue sometiment of the following the services of the following the services of the following the formation of the following	of such acts and rriting procedures. The policy open investigation and dents and accidents sets(s) that are not caused by stell procedures. We have been such as the control of the contro	F	335			

a resident/guest that: he/she will never be able to

DDINTED: 04/06/2022

		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES	1				0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) DATE COMP	PLETED
		105317	B. WING			02/	10/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER			36 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	15	F	835			
		ain, will take to shower room					
		will leave a bed all day to soil					
		eat fast enough food will be					
		a resident/guest from social					
		s. Using profanity to a					
		ng the resident/guest for nplovee altercations in front					
	of a resident/quest, m						
		/guest are also examples					
		. VI. Investigations and					
	Facility Response to I	Incidents or Accidents: a)					
		all instances of alleged or					
		luding verbal and mental					
		cious injuries of unknown					
	origin, an	ty in the following manner,					
		Reporting Steps: - Notify the					
		unusual situation in the					}
	facility, whether repor	table or not immediately					
		signee will report to the					
		other required agencies, per					
	regulations. All allega						
	be reported within 2 h	n serious bodily injury must					
F 842		dentifiable Information	-	842			
SS=E				0-12			
	§483.20(f)(5) Resider	nt-identifiable information.					
		elease information that is					
	resident-identifiable to						
		lease information that is					
	resident-identifiable to						
		ntract under which the agent					
		disclose the information					
	to do so.	he facility itself is permitted					
			1				

§483.70(i) Medical records.

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CENTERS FOR MEDICARE & MEDICAID SERVICES C					
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	105317	B. WING		02/10/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE		

136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CENTER CRYSTAL RIVER, FL 34429 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES. COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 842 Continued From page 16 F 842 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete: (ii) Accurately documented: (iii) Readily accessible; and ( ) Systematically organized \$483,70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-(i) To the individual, or their resident representative where permitted by applicable law: (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506: ( ) For public health activities, reporting of neglect, or domestic violence, health oversight activities, judicial and administrative proceedings. law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law: or (iii) For a minor, 3 years after a resident reaches

### PRINTED: 04/06/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DELITATING TO THE TENTH OF TOWN AT DELITIONS						
CENTERS FOR MEDICARE & MEDICAID SERVICES CONTROL OF THE PROPERTY OF THE PROPER						
FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	105317	B. WING		02/10/2022		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			

		105317	B. WING			02/10	0/2022
NAME OF P	ROVIDER OR SUPPLIER			5	FREET ADDRESS, CITY, STATE, ZIP CODE		
COVETAL	RIVER HEALTH AND RE	HARM ITATION CENTER		13	66 NORTHEAST 12TH AVENUE		
CRISIAL	RIVER HEALIH AND RE	HABILITATION CENTER		С	RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 842	legal age under State \$483.70(i)(5) The mec (i) Sufficient informatic (ii) A record of the res (iii) The comprehensiv provided; ( ) The results of any and resident review et determinations condu (v) Physician's, nurse' professional's progres (vi) Laboratory, services reports as re This REQUIREMENT by: Based on record revi failed to maintain acc records for 2 of 4 resis'	law.  dical record must contain- port oldentify the resident; ident's assessments; re plan of care and services preadmission screening raluations and cted by the State; s, and other licensed s notes; and other licensed s, and other diagnostic quired under \$483.50. is not met as evidenced ew and interview, the facility rately documented medical fents reviewed for	F	842	F842 RESIDENTS WILL CONTINUE TO HAV	;	
		ing and Resident Review #126 and #127, in a total s.			REULTS OF ANY PREADMISSION SCRENING AND RESIDENT REVIEW EVALUATIONS AND DETERMINATION CONDUCTED BY STATE.	S	
	revealed the resident with diagnoses to incli symptoms affecting m abilities severe enough, and a mental disconnection from reducing the mental head of the mental he	emory, thinking, and social h to interfere with daily life), characterized by a ality), and major , alth characterized sed or loss of interest ignificant in			The facility will continue to have medical records contain results of any preadmission screening and resident review evaluations and determinations conducted by staff.  CRITERIA 1: Resident #127 level 1 preadmission screening review redone by D.O.N. Resident #126 was a short term rehabilitation resident and discharged home.		
	for Medicaid Long-Ter	127's Medical Certification m Care Services and			CRITERIA 2: Remaining 130 level 1 preadmission		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DETTACT	WEITT OF THE TETT	D HOME OF CENTION					JRIM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		IATE SURVEY OMPLETED
		105317	B. WING				02/10/2022
NAME OF PE	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
				13	36 NORTHEAST 12TH AVENUE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		С	RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X5) COMPLETION DATE
F 842	Patient Transfer Form Medical Condition. P. Review of Resident # Screening and Resid-completed on was not sele PASRR Screen Decis [Mental Illness] or question for primary of answered as "No" in for PASRR Screen Decis [Mental Illness] or Question for Primary of answered as "No" in For PASRR Screen Director of Nursing (E PASRR was not correquestion in Section II checked as "Yes."  Review of Resident # revealed the resident with diagnoses to inc (general changes in	n dated reads, "E. imary Diagnosis: "  127's Preadmission ent Review (PASRR) revealed cted under Section I: sion-Making, Subsection A. suspected , and the liagnosis of was Section II: Other Indications ecision-Making, Subsection ecision-	F	842	screenings for residents audit comple by Social Service Director resulting in two level 1 screens had to redone and four level 2 screens completed by	be sing audit	

Review of Resident #126's hospital records dated revealed the resident was brought to

### PRINTED: 04/06/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES

DELITACINETY OF THE CITY	FURW APPR	OVEL				
CENTERS FOR MEDICARE &	ENTERS FOR MEDICARE & MEDICAID SERVICES ON					
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	105317	B. WING _			02/10/202	2
NAME OF PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
		1	136	NORTHEAST 12TH AVENUE		
CRYSTAL RIVER HEALTH AND RE	EHABILITATION CENTER		CRY	YSTAL RIVER, FL 34429		
	ATEMENT OF DEFICIENCIES	ID PROFESTI		PROVIDER'S PLAN OF CORRECTION	po consti	

						UL.	10/2022
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					136 NORTHEAST 12TH AVENUE		
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		1	CRYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 842	the emergency room apartment a management and evalua for acute usually developed ow Review of Resident # instructions dated diagnosis of acute or a	after	F	84			

#### PRINTED: 04/06/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

ENTERS FOR MEDICARE & MEDICAID SERVICES O					
STEMENT OF DEFICIENCIES O PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105317	B. WING	02/10/2022		

		105317	B. WING_			02/	10/2022
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
COVETAL	RIVER HEALTH AND RE	HARM ITATION CENTER		1	36 NORTHEAST 12TH AVENUE		
CRISIAL	RIVER REALIN AND RE	HABILITATION CENTER		C	RYSTAL RIVER, FL 34429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 842	name and maybe a m PASRR is filled out. I based on documental for individual or family out prior to admission information."  Review of the facility "Pre-Admission Scree [MR] and Mental Illine date of	y only have the resident's edication list at the time the don't know why! I checked iton. I usually select the one report. The form is filled , usually before I have any policy number SS.III-2 titled shing for Mental set [1] with an effective and last review date of oose: To ensure that all or mental end or mental end services they need, in setting and have medical heir mental needs eminations must be signed at the admitting nursing the date of admission. The onsible for ensuring that a simpleted, submitted and nation and/or a Level II if en urusing home admission ment source. Residents PASRR process as having a must be assessed by the ongoing process to identify s. Those residents significant change must	F8	342	DEFICIENCY		
F 865	of the significant char documents for the Le determinations will be chart behind the Soci QAPI Prgm/Plan, Dis-	nge The original vel I and/or Level II retained in the medical al Services tab." closure/Good Faith Attmpt	F	365			
SS=F	CFR(s): 483.75(a)(2)						

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CENTERS FOR MEDICARE & MEDICAID SERVICES C					
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
	105217	R WING			

		105317	B. WING		02/10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02010/2022
			- 1	136 NORTHEAST 12TH AVENUE	
CRYSTAL	RIVER HEALTH AND RE	HABILITATION CENTER		CRYSTAL RIVER, FL 34429	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 865	Continued From page	121	F 86	35	
, , ,	, ,	surance and performance	, 00	~	
		t its QAPI plan to the State er than 1 year after the egulation;			
		ary may not require rds of such committee ch disclosure is related to th committee with the			
	and correct quality de a basis for sanctions. This REQUIREMENT by: Based on record revi quality assurance and committee failed to id- performance improve failure to report allega for 3 of 3 residents re	by the committee to identify ficiencies will not be used as is not met as evidenced ew and interview, the facility performance improvement entify and implement a ment plan related to the stons of as required viewed for facility response Residents #10, #59, and		F865  QAPI PROGRAM/PLAN, DISCLOSURE/GOOD FAITH ATTEMP  The facility will continue to identify and implement a plan related to reporting o allegations.	
	voiced an allegation of Certified Nursing Assi name.	grievances report dated laled Resident #10 had of that a stant had called him a grievances report dated		CRITERIA 1: Grievance reports for residents #10, #6 and #59 were reported to required agencies on and brought to emergency QAPI  CRITERIA 2: Remaining grievance reports for last 6 months reviewed to ensure that	<b>:9</b> ,
		4 D 14 400 b 4 1			

revealed Resident #69 had voiced

allegations were not missed for reporting

## DDINTED: 04/08/2022

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		105317	B. WING_			02/	10/2022
NAME OF PE	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL RIVER HEALTH AND REHABILITATION CENTER			136 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	brief, and he was not Review of the facility — reve- daughter had voiced .#59 had been locked screaming. During an interview o Social Worker verifier reported the allegatio Resident #10, Reside During an interview o Administrator acknow the incidents involving #69, and Resident #5	was told to urinate in his getting water. grievances report dated aled Resident #59's an allegation that Resident in the shower and was   at 9.27 AM, the that the facility had not	F	865	by Director of Nursing onNo further grievances were noted as allegations.  CRITERIA 3:  Re-education provided to staff on reporting requirements of allegations by Staff Development Coordinator.  Completed by	l H	
	Social Worker stated	Resident #10 had voiced					

During interview on ......... at 1:14 PM, the Director of Nursing confirmed the /neglect allegations of 3 residents (Resident #10, Resident #69. Resident #59) were not reported because "no one stated they were abused, no one stated they were hit, and someone stated they were called a name."

During interview on ...... at 8:23 AM, the Director of Nursing stated the facility quality assurance committee had not identified and implemented a performance improvement plan related to facility failure to submit a federal report

Event ID: 8SFG11

#### PRINTED: 04/06/2022 ST

	105317	B. WING	02/10/2022	
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
CENTERS FOR MEDICARE & MEDICAID SERVICES (				
DEPARTMENT OF REALTH AN	ID HUMAN SERVICES		FORM APPROVE	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 136 NORTHEAST 12TH AVENUE CRYSTAL RIVER HEALTH AND REHABILITATION CENTER CRYSTAL RIVER, FL 34429 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 865 Continued From page 23 F 865 related to allegations of staff ...... /neglect of residents. During an interview on at 8:30 AM, the Administrator stated he knew that the incidents involving Resident #10. Resident #59, and Resident #69 had occurred and he had signed off on them. He stated, "After I reviewed these, we really should have reported them. I'm aware we have an to report. These seemed so subtle, we just didn't realize. But we really should have identified them after the second occurrence and come up with a plan," Review of the facility policy titled " ...., Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source. , read. " reviewed on "Purpose: This Policy (the "Policy") is concerned with all incidents and accidents involving resident/quest(s). The facility will investigate and document all incidents and accidents involving resident/quest(s). Certain incidents and accidents involving residents/guests must also be reported to the appropriate agencies. All of our resident/quest(s) have the right to be free from , neglect, , and misappropriation of resident/quest property. This includes but is not limited to freedom from corporal punishment, involuntary , and physical or chemical .... not required to treat the resident/quest(s) medical symptoms ... This policy addresses the acts and occurrences that constitute nealect. misappropriation of resident/quest property and suspicious injuries of unknown source; this includes but is not limited to: freedom from

corporal punishment, involuntary

physical or chemical .... not required to

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and

# DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/08/2022 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDERSURPLUENCIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY		
		105317	B. WING		02/	10/2022		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CRYSTAL RIVER HEALTH AND REHABILITATION CENTER				136 NORTHEAST 12TH AVENUE CRYSTAL RIVER, FL 34429				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 865	treat the resident/gue any type, by anyone; occurrences transpire agencies and officials proper reporting proc instances; training of acts and occurrences and the investigation	st(s) medical symptoms of when such acts and b, it must be reported to coutside of the facility; the edures to be used in such employees regarding such and reporting procedures;	F 86					

Policy, the following terms shall have the following meanings: A. . The definition of . . . . encompasses a broad scope of behavior. is the willful infliction of injury. unreasonable confinement, intimidation, or punishment with resulting physical harm, , , or mental anguish. In addition, . . . . includes depriving the resident/quest of goods and/or services that are necessary to attain or maintain physical, mental, and , well-being irrespective of any mental or physical condition. Any act considered towards an alert and oriented resident/guest should also be considered to the , , or 

also addresses the proper investigation and documentation of incidents and accidents involving resident/guest(s) that are not caused by and misappropriation of resident/guest property. For purpose of this

. Wilflul means the individual mushave acted deliberately (not inadvertently or accidentally), not that the individual must have intended to inflict injury or harm. A resident/guest that intentionally hits another resident/guest may be considered

another resident/guests, may be considered

. The following are definitions of specific types of :1. Verbalof oral, written or gestured communication or sounds that includes disparaging and derogatory terms to resident/guest(s) or their

#### PRINTED: 04/06/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES ST

CENTERS FOR MEDICARE & MEDICAID SERVICES				
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	105317	B. WING	02/10/2022	

						02/1			
NAME OF F	ROVIDER OR SUPPLIER			51	FREET ADDRESS, CITY, STATE, ZIP CODE				
ODVOTAL	DIVED HEALTH AND DEL	ADU ITATION OFFITED		13	6 NORTHEAST 12TH AVENUE				
CRYSTAL RIVER HEALTH AND REHABILITATION CENTER				CRYSTAL RIVER, FL 34429					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES WUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 865	distance, regardless of comprehend or the na Examples of not limited to: threaten things to frighten a resis a resident/guest that: his see his/her family again and leave for hours, with yourself, if you don't estaken away, isolating a interaction or activities. resident/guest, blaming their condition and emy of a resident/guest, to midiculing the resident/guest mortificating the resident/guest mortification and Resident/guest mortification and resident/guest property by Investigation and Re Administrator of any ur facility, whether report The Administrator/Desi State Agency and all allegating the regulations. All allegating the regulations. All allegating the resident of the regulations. All allegating the resident of the regulations. All allegating the regulations. All allegating the resident of the regulations. All allegating the regulations all allegating the regulations all allegating the regulations. All allegating the regulations all allegating the regulatio	s, or within their hearing their ages, abilities to ture of their could include, but are ng to hurt and a saying dent/guest, such as telling eishe will never be able to him will also a support of the saying dent/guest, such as telling eishe will never be able to him will take to shower room! It leave a bed all day to soil tast enough food will be resident/guest from social Using profamity to a him resident/guest for lookee alteroations in front cking, insulting, or uperstand and control of the saying	F	865	DEFICIENCY)				