

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Crystal River Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 136 Northeast 12th Avenue Crystal River, FL 34429	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review the facility failed to ensure the residents' environment remained free of accident hazards for the main dining room by failing to secure hazardous cleaning chemicals in a resident non-accessible area. Findings include: During an observation on 4/1/2026 at 8:48 AM, a lower cabinet located in the main dining room was observed unlocked and accessible. Inside the cabinet, two bottles of cleaning chemicals were observed: Virex II 256 One-Step Disinfectant Cleaner and Deodorant and Virex TB Ready-to-Use Disinfectant Cleaner. There was no locking mechanisms or other security measures observed to restrict access to the chemicals. Review of the Safety Data Sheet (SDS) information for Virex II 256 documented the product is classified as corrosive and may cause eye and skin burns, and may be harmful if inhaled, absorbed through the skin, or swallowed. The product is labeled for industrial/institutional use and is intended to be handled with appropriate precautions and stored safely to prevent exposure. Review of the SDS for Virex TB Ready-to-Use Disinfectant Cleaner documented the product contains chemical agents intended for institutional disinfecting and may cause irritation to the eyes, skin, and respiratory tract with exposure routes including inhalation, ingestion, skin, and eye contact. The product is labeled for industrial/institutional use and is intended to be handled with appropriate precautions and stored safely to prevent exposure. During an interview on 4/1/2026 at 9:41 AM the Administrator stated cleaning products observed in the lower cabinet of the main dining room were not secured and should always be secured when not in use by facility staff. The dining room is open for access throughout the day to ambulatory residents. His expectations are that all cleaning chemicals are stored in a secure manner to prevent accidental ingestion or exposure to residents at the facility.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an effective pest control program to eradicate common household pests. Findings include:</p> <p>During an observation on 03/30/2026 at 9:32 AM, a live brown-colored insect was observed crawling on the wall, and a dead brown-colored insect was observed on the windowsill of the training room adjacent to the kitchen and dining area. (Photographic evidence obtained)</p> <p>During an observation on 04/01/2026 at 8:48 AM, a live brown-colored insect was observed crawling under a cabinet in the dining area. (Photographic evidence obtained)</p> <p>During an observation on 04/01/2026 at 9:02 AM, a live brown-colored insect was observed crawling on the floor immediately outside of Resident #45's doorway in the [NAME] Wing, down the hallway from the kitchen entrance.</p> <p>During an observation on 04/01/2026 at 11:48 AM, a dead brown-colored insect was observed on the floor near the exit door leading from the kitchen food preparation area. (Photographic evidence obtained)</p> <p>During an observation on 04/01/2026 at 1:29 PM, a live brown-colored insect was observed crawling around the drain area of the dishwashing machine in the dish room, an area where food contact items are processed. (Photographic evidence obtained)</p> <p>During an interview on 04/02/2026 at 10:29 AM, the Dietary Manager stated the Maintenance Department is notified of pest control concerns and is responsible for contacting the pest control company.</p> <p>During an interview on 04/02/2026 at 11:25 AM, the Maintenance Director stated each wing maintains a pest log for reporting concerns and that a contracted pest control company conducts weekly visits to review logs and address reported issues. He stated service reports are reviewed and corrective actions are taken as needed. However, ongoing pest activity observed during the survey indicated the facility's pest control program was not effective in identifying, correcting, and preventing pest presence.</p> <p>During an interview on 04/02/2026 at 12:55 PM, the Facility Administrator confirmed the expectation for the facility is to maintain a pest-free environment.</p> <p>Review of the [Name of exterminator company] reports dated 04/11/2025, 04/28/2025, 05/30/2025, 07/30/2025, 10/14/2025, 12/09/2025, and 02/20/2026 documented repeated identified concerns in the kitchen, all three resident wings.</p> <p>During an interview on 4/02/2026 at 10:23 AM Staff R, LPN stated that she knew they came around and sprayed for roaches every week, but it didn't seem to be helping. She did see roaches on the unit.</p> <p>During an observation on 3/30/2026 at 10:01 AM Resident #99's bathroom there was a live brown color insect by the base board. (Photographic evidence obtained)</p> <p>During an observation on 4/1/2026 at 4:12 PM with the Maintenance Director when entering Resident (continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>#38's room, when the resident's bathroom door was opened and the light was turned on there were three small dark brown insects running toward the baseboard of the bathroom.</p> <p>Review of the facility policy and procedure titled Resident Environment Quality with a last review date of 1/13/2026 read, Standard: Maintain an effective pest control program so the facility is free of pest and rodents.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had a clean, homelike environment for 1 of 3 units. Findings include:During an observation on 3/30/2026 at 10:04 AM of Resident #38's room the base boards were missing on the left side of the bathroom doorway, the wall was peeling and had black stains. Inside of the bathroom there were tiles lifting around the toilet seat and some were missing. The bathroom sink wall had cracks and gaps and the bathroom vent was covered in a gray matter. [Photographic evidence obtained]During an observation on 3/30/2026 at 10:24 AM of Resident #24's room the wall paint was missing exposing the wall. [Photographic evidence obtained]During an observation on 3/30/2026 at 10:25 AM of Resident #2's room the wall pain was peeling and had holes near the base board. [Photographic evidence obtained]During an observation on 3/30/2026 at 10:28 AM of Resident #15's room the door handle was loose, the toilet paper holder was missing one of the mounts, and the sink wall had gaps and cracks. [Photographic evidence obtained]During an observation on 3/30/2026 at 10:31 AM of Resident #57's room the door handle to the bathroom was loose. [Photographic evidence obtained]During an observation on 4/1/2026 at 4:12 PM with the Maintenance Director of Resident #38's room the base board was missing on the left side of the bathroom doorway, the wall was peeling and had black colored stains. Inside the bathroom tiles around the toilet there was a brown substance, the tiles were lifting, and there were missing portions from some of the tiles. The bathroom sink wall had visible cracks and gaps. The bathroom vent was covered with gray matter.During an interview on 4/1/2026 at 4:12 PM the Maintenance Director stated, This is horrible this is the room [Resident #38's room] I was looking for the plumbing company to come out and fix. They told me about this room about a month ago, but I couldn't figure out what room it was. The vent looks filthy.During an observation on 4/1/2026 at 4:20 PM with the Maintenance Director, the Maintenance Director confirmed Resident #2's room the wall paint was peeling exposing the wall and had holes near the base board. During an observation on 4/1/2026 at 4:22 PM with the Maintenance Director of Resident #15's the room the door handle was loose, the toilet paper holder was missing one of the mounting brackets, the floor tiles were heavily stained, and the bathroom sink wall had cracks and gaps in the paint.During an interview on 4/1/2026 at 4:22 PM the Maintenance Director stated, The sink is coming off maybe the resident put pressure on it. The door handle needs to be adjusted, and the toilet paper holder needs to be replaced.During an observation on 4/1/2026 at 4:24 PM with the Maintenance Director, the Maintenance Director confirmed Resident #57's room bathroom door handle was loose.During an interview on 4/1/2026 at 4:25 PM the Maintenance Director stated, Normally I try to go around and fix stuff when I see it. I just took over in January 19 [2026]. I am doing mostly large projects right now. The smaller details I will tell my assistant to do. When asked for documentation of these repairs being reported the Maintenance Director stated, Normally I will get calls or text messages to my phone of things to be repaired. I am waiting on a laptop to have access to it [maintenance repair log]. I do not have access to it on my phone. It is really hard to be able to look back and see if these rooms have been reported. I was going to do boards on each unit, but it was a daunting task. I would not be able to look back.Review of the [maintenance system] work history report for the months of January 2026 through March 2026 did not contain any information regarding these residents' room repairs or need of repair. During an interview on 4/2/2026 at 10:00 AM the Director of Nursing stated, Typically I am entering into the maintenance repair log. I also communicate verbally with maintenance as I am going down the hall or shoot a message and let them know. I also report to the unit manager and any leadership if I identified anything that needs to be repaired. No reports are given to me about any pending repairs.During an interview on 4/2/2026 at 12:30 PM the Administrator stated, When staff go around in their angel rounds, they put any repairs needed in [the maintenance repair log] and maintenance will follow up. They can also communicate (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with the Maintenance Director to let him know. There has been a delay in getting his laptop in order for his use [maintenance repair log]. This way we could put it in [maintenance repair log] and have a paper trail. I would expect that these areas would have been corrected. I know he is always walking the unit and never sits at his desk. He is newer to the building. Review of the facility policy and procedure titled Resident Environment Quality with a last review date of 1/13/2026 read, Purpose: The facility should be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. Standard: According to federal regulation, the facility must: Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. Process: Preventive maintenance schedules, for the maintenance of the building and equipment, should be followed to maintain a safe environment.</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a bed hold notice for 1 of 3 residents, Resident #138, reviewed for hospitalizations. Findings include:Review of Resident #138's progress note dated 01/28/2026 read, Physician office requested for patient to go [Hospital Name]. Reached out to hospital and ortho floor stated unable to take patient without direct admit. Called office back and got in touch with [Doctor's Name] who stated to send her to closest hospital to assess right hip. Called non-emergent transport [Name of the transport company] and they picked up patient at 5:45 PM and taking to [Hospital Name]. Son at bedside and agreeable with POC [Plan of Care].Review of Resident #138's Nursing Home Transfer and Discharge Notice Resident was sent to hospital on [DATE]Review of Resident #138 Hospital Transfer Form dated 1/28/2026 read, send to ER [emergency room] to eval [evaluate] and treat.During an interview on 03/31/2026 at 3:37 PM Staff O, Licensed Practical Nurse Medical Records stated, We have no 3 day bed hold policy stating bed reserve payment for Resident #138 in her paper chart. It must not have been done.During an interview on 04/02/2026 at 10:05 AM with the Director of Nursing stated, The floor nurse or unit manager gets bed holds completed if the resident goes out of the facility. If family is at bedside staff should have family sign the bed hold form.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on observation, interview, and record review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 4 residents, Resident #2, reviewed for respiratory services. Findings include: During an observation 3/31/2026 at 8:15 AM Resident #2 was lying in bed. Oxygen was being administered via nasal cannula at 2 liters per minute. Review of Resident #2's physician order dated 2/2/2026 read, O2 [oxygen] at 2L/min [2 liters per minute] via nc [nasal cannula] for shortness of breath as needed. Review of Resident #2's Minimum Data Set titled Significant Change dated 2/23/2026 in Section O Special Treatments, Procedures, Programs did not document oxygen was in use by the resident. During an interview on 3/31/2026 at 3:52 PM Staff G Licensed Practical Nurse MDS stated, Oxygen use was documented in the notes a few times. It should have been coded as in use, it will need to be corrected. Review of Resident #2's progress note date 2/22/2026 read, Pulmonary/Respiratory Service: Oxygen Therapy (indicate L/P/M [liters per minute] and delivery) 2L-95% [two liters- 95 percent]. Review of Resident #2's progress note date 2/21/2026 read, O2 [oxygen] - 90% via nasal cannula 2 L [liter]. Review of the facility policy and procedure titled Resident Assessment Instrument [RAI] with a last review date of 1/13/2026 read, Purpose: Resident are assessed, using a comprehensive assessment process, in order to identify care needs and to develop a plan of care. Standard: According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the state.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the implementation of person-centered comprehensive care plans for 1 of 6 residents, Resident #89, reviewed for safety concerns. Findings include:</p> <p>Review of Resident #89's clinical record documented re-admission on [DATE] with medical diagnosis that included foot drop right foot, bradycardia (slow heart rate), heart failure (fluid buildup in heart), dementia, abnormal auditory perceptions, psychotic disturbance, mood disturbance and anxiety, and absence epileptic syndrome (seizures).</p> <p>Review of Resident #89's physician orders dated 6/2/2025 read, BL [bilateral] floor mats at bedside when in bed</p> <p>Review of Resident #89's Care Plan documented the care plan was initiated 4/11/2025 and updated 3/23/2026. Focus: Problem potential for falls, seizure disorder, foot drop. Interventions: Encourage bed in lowest position while occupied, BL [bilateral both sides of the bed] floor mats at bedside when in bed.</p> <p>During an observation on 3/30/2026 09:20 AM Resident #89 was lying in bed. The bedside rails were in the up position, and the bed was in the low position. There was one floor mat on the right side of the bed. (Photographic evidence obtained).</p> <p>During an observation on 3/30/2026 2:23 PM Resident #89 was lying in bed side. The beside rails were in the up position, and the bed was in the low position. A floor mat was observed lying on the floor on the right side of Resident #89's bed. There was no floor mat observed to the left side of the bed.</p> <p>During an observation on 3/31/2026 at 10:15 AM with Staff J, CNA (Certified Nursing Assistant) of Resident 389's room a floor mat was observed on the floor on the right side of the bed only.</p> <p>During an interview on 3/31/2026 at 10:15 AM Staff J, CNA stated that he knows his residents but does not know if she [Resident #89] should have fall mats on both sides of the bed, she has always had just one.</p> <p>During an observation on 3/31/2026 at 10:30 AM with Staff I, RN a floor mat was observed on the floor by the right side of the bed only.</p> <p>During an interview 3/31/2026 at 10:30 AM Staff I, Registered Nurse (RN) stated that she will have to check the orders and see [if bilateral floor mats are ordered].</p> <p>During an interview on 3/31/2026 at 1:30 PM the Director of Nursing stated, I expect the staff to follow physician orders and the resident [Resident #89] should have fall mats on each side of her bed</p> <p>Review of the policy and procedures titled Person Centered Care Plans last reviewed dated 1/13/2026 read, Person centered plans of care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals of the resident/guest, consistent with the (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident/guest(s) rights. Standard: According to federal regulations, the facility develops and implements a baseline plan of care within 48 hours of admission that includes the minimum healthcare information necessary to properly care for the immediate needs of the resident/guest. f) Upon completion of baseline care plan or comprehensive care plan and when reviewed quarterly/significant change, the MDSC [Minimum Data Set Coordinator] will ensure care plan intervention(s) are entered into Care Guide ADLs/intervention [ADLs = activities of daily living] in the electronic medical record that are considered outside of routine care. This will provide the CNA with individualized information needed to meet the resident's care needs.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>Based on record review and interview the facility failed to ensure the provision of necessary care and services of medication administration to maintain appropriate blood pressure control for 1 of 1 resident, Resident #111, reviewed for surgical coordination.</p> <p>Findings include:</p> <p>Review of Resident #111's clinical record documented an admission 1/29/2024 with diagnosis including but not limited to hypertension, anxiety, depression, and anemia.</p> <p>During an interview on 3/30/2026 at 10:20 AM Resident #111 stated I did not receive my medications before surgery and the surgery was cancelled because my blood pressure was too high. I still do not have a date scheduled for my surgery.</p> <p>Review of Resident #111's pre-operative instructions from [surgical center name] read Surgery date 3/23/2026, no food, drink or water after midnight. Medications: day of surgery, Take heart medications, blood pressure medications, thyroid medications, with a small amount of water. Do not take diuretics or water pills. If you use an inhaler, bring it with you.</p> <p>Review of Resident #111's physician orders dated 1/29/2024 read Amlodipine [used to treat high blood pressure] 10 mg [milligrams] daily 1 tablet every day 09:00 AM.</p> <p>Review of Resident #111's Medication Administration Record (MAR) documented medication was held on the morning of 3/23/2026 due to NPO (nothing by mouth) status.</p> <p>Review of Physician orders for Resident #111 dated 2/19/2025 read, Metoprolol Tartrate [used to treat high blood pressure] 50 mg twice daily 9:00 AM and 8:00 PM.</p> <p>Review of Resident #111's MAR documented Metoprolol Tartrate was held on the morning of 3/23/2026 due to NPO status.</p> <p>Review of Resident #111's physician orders dated 10/10/2025 read, Hydralazine [used to treat moderate to severe high blood pressure] 50 mg four times daily 09:00AM, 01:00 PM, 05:00 PM and 09:00 PM.</p> <p>Review of Resident #111's MAR documented Hydralazine was held on the morning of 3/23/2026 due to NPO status.</p> <p>Review of Resident #111's physician orders dated 3/9/2026 read Lisinopril [used to treat high blood pressure] 40 mg daily every day 09:00 AM.</p> <p>Review of Resident #111's MAR documented Lisinopril was held on the morning of 3/23/2026 due to NPO status.</p> <p>Review of Resident #111's physician orders did not have NPO orders documented in the system.</p> <p>Review of Resident #111's MAR for March 2026 read, Eye Center for right cataract surgery on 3/23/2026 at 10:30 AM. (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #111's nursing progress note dated 3/5/2026 1:11 PM read, Resident out of facility this AM to [name of eye center] for consultation for right eye cataract surgery on 3/23/26 at 10:30 am. Orders received: NPO after midnight day before surgery. Continue medication as ordered except diuretics.</p> <p>Review of Resident #111's nursing progress note dated 3/23/2026 read, The resident returned from the surgery center without undergoing surgery due to elevated systolic blood pressure ranging from 198&ndash;202 mmHg.</p> <p>During an interview on 4/1/2026 at 9:57 AM Staff K, Licensed Practical Nurse (LPN) stated, I held his [Resident #111] morning medication including his blood pressure medications because I was told in shift report that he was NPO. I was not told that he was supposed to get his AM hypertension medications. I did not review the physician orders or MAR. I did not contact the physician for clarification.</p> <p>During an interview on 3/31/2026 at 09:40 AM Staff I, Registered Nurse (RN) stated, I received the pre-operative instructions verbally from the eye center when I called for a time. I did not enter the orders into the computer and do not recall being told to administer the hypertensive medications. I only remember that he was NPO after midnight. I shared his NPO status with the nurses and aids and they shared with the oncoming shift during report. A Shift report is utilized but not retained. The written instructions were found only after the surgery cancellation. They were in his [Resident #111] room. The surgery was cancelled because of his blood pressure being too high and he required a medical follow-up and clearance. I am just waiting for the surgery center now to call me back to reschedule.</p> <p>During an interview on 4/1/2026 at 12:44 PM the Director of Nursing stated, There are no orders in the system for NPO status or continue medication except for Lasix. Physician orders should have been entered and followed as directed from the surgery center.</p>		

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NAME OF PROVIDER OR SUPPLIER Crystal River Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 136 Northeast 12th Avenue Crystal River, FL 34429	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 7 residents, Resident #11, reviewed for medication pain management. Findings include: During an interview on 3/30/2026 at approximately 3:00 PM, Resident #11 stated he has pain in his right shoulder. He received medication for the pain, but he continued to have pain. He used his feet to push himself in his wheelchair because he was not able to use his hands/arms. During an observation on 3/30/2026 at approximately 3:00 PM Resident #11 was propelling himself backwards in his wheelchair using only his feet. He held his right arm against his body in a protective manner. Review of Resident #11's physician orders documented dated 1/10/2026 Lyrica (pregabalin) [a nerve medication used to treat neuropathic pain] tablet 25 mg [milligrams] oral: 1 tablet Twice A Day. Review of Resident #11's medical record documented the resident was admitted on [DATE] with medical diagnoses that included Epilepsy, unspecified, not intractable, without status epilepticus; Personal history of traumatic brain injury; Contracture of muscle, multiple sites; Parkinsonism, unspecified; Other: chronic pain. Review of Resident #11's MAR (Medication Administration Record) for the period of 3/01/2026 through 4/01/2026 documented an entry which read, Lyrica (pregabalin)- [used for pain management] capsule; 25 mg; 1 tablet; oral twice a day - 01/10/2026 - 04/01/2026 [to be administered from 01/10/2026 to 04/01/2026 and then discontinued]. There was no documentation on the MAR of Lyrica being administration on 3/26/2026 through 3/31/2026, resulting in 12 doses of Lyrica not being administered as order by the physician. The MAR documented nine of the doses of Lyrica were not administered due to Drug/Item Unavailable, one of the doses not administered due to Drug/Item Unavailable OOS [out of stock], one of the doses not administered due to Drug/Item Unavailable - Comment: awaiting on approval from insurance dated 3/30/2026, and one does not administered due to Not Administered: Other - Comment: awaiting approval, dated 4/01/2026. During an interview on 4/01/2026 at 8:50 AM Resident #11 stated he had been having more pain in his right arm recently. He had not received pain medications routinely for the last several days. During an observation on 4/01/2026 at 8:50 AM Resident #11 was sitting in his wheelchair in his room. He was holding his right arm against his body. During an interview on 4/01/2026 at 8:54 AM Staff A, Unit Manager, stated she had not charted anything regarding discussions with the pharmacy about not being able to get the Lyrica approved or any other measures regarding finding an alternative option. During an interview on 4/01/2026 at approximately 10:00 AM the DON (Director of Nursing) stated the expectation was for nurses to contact the pharmacy if a resident was out of a medication to see if it was on the way. If there was a problem with obtaining the medication, the nurses should contact the physician. During an interview on 4/01/2026 at 3:22 PM APRN (Advanced Practice Registered Nurse) 2 stated Pain Management [a group that specializes in pain management control] had been managing Resident #11's prescription for Lyrica, and she did not know anything about insurance coverage for the medication. She had not received a call regarding Resident #11's pain or an alternate medication for his Lyrica. During an interview on 4/01/2026 at 5:45 PM the PA (Physician's Assistant) #2 stated he had raised Resident #11's Lyrica about one month after he started the prescription. There was a Lyrica prescription sent [to the pharmacy] on 3/25 [2026]. There was no telephone encounter [from the facility] regarding Resident #11 being out of Lyrica. He did not see a request for a prior authorization [for Resident #11's Lyrica]. He was in the facility on Friday [3/27/2026] and spoke with Staff A, Unit Manager, but there was no discussion or request about Lyrica or an alternative medication for Resident #11's pain. The prn analgesic he had ordered would not be effective for his neuropathic pain. During an interview on 4/01/2026 at 6:06 PM PA #2 stated the pharmacy informed him that Resident #11 should have had one dose of Lyrica still (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>available through the e-kit [emergency medication kit designed to provide medications in the facility]. He was concerned that no one had called him from the facility, as they were usually able to get prescriptions out the next day after a request was made. During an interview on 4/02/2026 at 2:00 PM Staff S, LPN (Licensed Practical Nurse) stated he had called PA #2 on 3/25/2026 regarding Resident #11's Lyrica prescription and PA #2 put in a script [prescription]. Staff S, LPN called the pharmacy, and the pharmacy faxed a code [to get into the e-kit in the automated medication dispensing machine] and a sheet stating the medication was not covered by Resident #11's insurance and the facility would need to pay for the medication. He did not withdraw or administer the Lyrica. He left the sheet for the Unit Manager. He did not attempt to get an alternative pain medication for Resident #11. During an interview on 4/02/2026 at 2:41 PM Staff T, LPN stated on 3/26/2026 she had called the pharmacy and asked if Resident #11's Lyrica was on its way. She was informed that it was not, and it was something to do with insurance. She did not write a note about the phone call with pharmacy, but she thought it would be an expectation for her to write such a note. She believed that she had been told that the doctor had been told [about Resident #11 not having his Lyrica] and there was nothing comparable. She did not contact the doctor herself. During an interview on 4/02/2026 at 3:55 PM Staff U, LPN stated on 3/29/2026 when she did not administer a scheduled dose of Lyrica for Resident #11, she was in training, working with Staff S, LPN. Basically, when it came to medications not being available, Staff S, LPN told her just to press the button [in the electronic medical record] for a refill. She was just following what she was told to do by Staff S, LPN. Review of Resident #11's medical record progress notes for the period of 3/25/2026 through 3/31/2026 did not contain documentation regarding Resident #11's Lyrica not being administered or an alternative for the scheduled pain medication. Review of Resident #11's most recent MDS (Minimum Data Set) Assessment, a quarterly assessment dated [DATE] documented his BIMS [Brief Inventory of Mental Status] Score as 10 out of 15 which indicated he had some cognitive deficit. He received scheduled and PRN pain medications. He frequently had pain which occasionally interfered with his sleep and that frequently limited his day-to-day activities. He received opioid and anticonvulsant medications which were documented to be high-risk medications. Review of Resident #11's Care Plan documented, Problem: Resident has complaints of chronic pain. Start Date: 01/12/2026. Last Reviewed/Revised 03/18/2026. Goal: Resident will verbalize reduction of pain. Approaches included: Administer medications: Start Date 01/12/2026; refer to pain management team. Problem: Requires pain management. Additional Information: R/T [related to] impaired mobility, contracture and dx [diagnosis] of muscle spasms. Start Date 02/01/2026. Goal: I will not have unrelieved pain X 90 days AEB [as evidenced by] no moaning, groaning, or facial grimaces {sp}. Approaches included: Medications as ordered. Review of a report titled Item Expiration Tracking Report dated 3/30/2026 documented that Pregabalin (Lyrica) 25mg capsule was available in the automated medication dispensing machine and had an expiration date of 10/31/2026. Review of the policy and procedure titled Pain Management and Assessment, last reviewed on 1/13/2026 read, Purpose: The detection of the presence of pain, determining the frequency and intensity of pain, and identification of effective pain management interventions can help to avoid adverse outcomes that impact the resident/guests functional status and quality of life. Process: I. General Information - a) pain is any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does. b) Pain can be suffering and is associated with inactivity, social withdrawal, depression, and functional decline. f) Most resident/guests with moderate to severe pain will require regularly dosed pain medications, and some will require additional PRN pain medications for breakthrough pain. III. Pain Management - b) If the resident's/guest pain is not controlled by the current treatment regimen, the physician should be notified.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review the facility failed to ensure all residents were free from unnecessary medications for 1 of 5 residents, Resident #80, reviewed for unnecessary medications. Findings include: Review of Resident #80's physician order dated 3/2/2026 read, Midodrine tablet, 5 mg [milligrams], 1 tablet oral, three times a day (8:00 AM, 12:00 PM, 5:00 PM), special instructions: Hold for systolic BP [blood pressure] over 110. Review of Resident #80's Medication Administration Record (MAR) for March 2026 documented 13 administrations of midodrine outside of the physician ordered parameters. During an interview on 4/1/2026 at 3:10 PM Staff L, LPN (Licensed Practical Nurse) stated, The documentations for administration of Midodrine was a documentation error, I always check the resident's blood pressure prior to administration of a medication with parameters and would not have administered the medication if the blood pressure was outside the ordered parameters. During an interview on 4/1/2026 at 3:20 PM Staff M, LPN stated, I always check the blood pressure prior to administering the medication, if the blood pressure was outside parameters I would not have administered the medications and I believe that I made a documentation error. During an interview on 4/1/2026 at 9:38 AM the DON stated, My expectations are that the nursing staff would follow the physicians' orders including specific parameters before administering the medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review the facility failed to prevent the possible spread of infection for respiratory equipment for 3 of 4 residents, Residents #2, #12, and #54, reviewed for respiratory services.</p> <p>Findings include:</p> <p>1) During an observation on 3/30/2026 at 10:26 AM of Resident #2's room, the resident was not in the room. In the room there was an oxygen concentrator and coiled on top of the concentrator was oxygen tubing dated 3/14/2026 and the tubing was not bagged.</p> <p>During an observation on 03/31/2026 at 8:15 AM Resident #2 was lying in bed. Oxygen was being administered via nasal cannula at 2 liters per minute. The oxygen tubing was dated 3/14/2026. Resident #2's wheelchair was in front of the bed. On the wheelchair there was nasal cannula tubing that was not bagged and coiled around the arm rest.</p> <p>During an interview on 3/31/2026 at 1:44 PM Staff Q, Licensed Practical Nurse (LPN) stated, Oxygen tubing should be bagged when not in use. I am not sure how often the tubing is changed. That is supposed to be done on the night shift.</p> <p>During an interview 3/31/2026 at 1:44 PM Staff A, Registered Nurse Unit Manager stated, Tubing is changed every Friday.</p> <p>During an observation on 3/31/2026 at 1:49 PM with Staff Q, LPN Resident #2 was in bed with oxygen being administered via nasal cannula. The date on the tubing was 3/14/2026.</p> <p>During an interview on 3/31/2026 at 1:49 PM Staff Q, LPN confirmed the tubing was dated 3/14/2026 and Resident #2 was being administered oxygen through the tubing.</p> <p>Review of Resident #2's physician order dated 2/2/2026 read, O2 [oxygen] at 2L/min [2 liters per minute] via nc [nasal cannula] for shortness of breath as needed.</p> <p>During an interview on 4/2/2026 at 9:48 AM the Director of Nursing stated, Tubing is changed weekly and dated and stored in a bag when not in use.</p> <p>2) During an observation 3/30/2026 at 10:22 AM of Resident #54's room a nebulizer machine was lying on the floor behind the bed. The nebulizer mask and tubing were lying across the nebulizer machine on the floor. The tubing attached to the nebulizer was not dated.</p> <p>During an observation on 3/31/2026 9:15 AM of Resident #54's room a nebulizer machine was lying on the floor behind the bed. The nebulizer mask and tubing were lying across the nebulizer machine on the floor, and the tubing was not dated. (Photographic evidence obtained).</p> <p>During an interview on 3/30/2026 at 10:22 AM Resident #54 stated I have not used that [nebulizer] in forever.</p> <p>During an interview on 3/31/2026 at 1:24 PM the Director of Nursing stated the mask must be covered when not in use and tubing has to be dated when changed. She [Resident #54] does not even (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>have orders for nebulizer treatments and has not been receiving nebulizing treatments. The machine and mask should have been removed, cleaned and stored.</p> <p>3) During an observation on 3/30/2026 at 09:40 AM of Resident #12's room an uncovered nebulizer mask was lying across the nebulizer machine that was on the bedside table. The tubing to the nebulizer machine was not dated.</p> <p>During an observation on 3/31/2026 at 08:45 AM of Resident #12's room an uncovered nebulizer mask was lying across the nebulizer machine that was on the bedside table, and the tubing was not dated.</p> <p>During an interview on 3/31/2026 at 08:48 AM Staff I, Registered Nurse (RN) stated, the nebulizer should be covered after each use. Tubing is changed weekly and should be dated. If the resident no longer has orders for nebulizing treatments we should remove the machine, clean and store it for future use. The tubing is thrown away. She [Resident #12] does not have orders for nebulizing treatments.</p> <p>During an interview on 3/31/2026 at 1:24 PM the Director of Nursing stated, the mask must be covered when not in use and tubing has to be dated when changed. She [Resident #12] has not received nebulizing treatments since October 2025 and the machine and mask should have been removed.</p> <p>Review of the policy and procedure titled Oxygen Administration dated 1/13/2026 read 11. Cannulas and masks should be changed weekly. 14. O2 cannula/mask should be stored in a plastic bag when not in use.</p>		