STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106009	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross City Nursing and Rehabilitation Center	583 NE 351 Hwy Cross City, FL 32628

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 3 residents, Resident #51. Findings Include:Review of the Discharge/Return Anticipated/End of PPS [prospective payment system] Part A Stay MDS for Resident #51 dated 8/12/2025, read, Section A: Discharge Status: Home/CommunityReview of the census documented Resident #51 currently resides in the facility.During an interview on 09/09/2025 at 11:32 AM, Staff C, RN/MDS Coordinator (Registered Nurse) stated, He [Resident #51] was discharged , and we thought he was coming back. He went to an appointment on that day, was admitted to the hospital and we didn't have clear information on what was going on. We thought he was discharging home from the hospital. I didn't know if he was going to come back or not. Looking back on it, I should have coded the discharge status as 04. Short-Term General HospitalDuring an interview on 09/09/2025 at 1:04 PM, Resident #51 stated, I remember going to the hospital, but I don't remember the date. Review of the policy and procedure titled, Conducting an Accurate Resident Assessment, reviewed 12/18/2024 read, Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment by staff qualified to assess relevant care areas. Definition: 'Accuracy of assessment' means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities and psychosocial status.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the administration of insulin and to notify the physician of elevated blood glucose values for 2 of 5 residents, Residents #25 and #22) reviewed for unnecessary medications.Findings include: 1) Review of Resident #25's admission record documented diagnosis to include myocardial infarction type 2 (a heart attack), cognitive communication deficit, type 2 diabetes mellitus without complications, chronic atrial fibrillation (an irregular heartbeat), unspecified, essential (primary) hypertension (high blood pressure), hyperlipidemia, unspecified (high cholesterol), and atherosclerotic heart disease of native coronary artery (heart disease) without angina pectoris (chest pain). Review of Resident #25's physician orders dated 9/4/2025 read, Insulin Glargine-yfgn [yfgn is a unique suffix identifier assigned by the U.S. Food and Drug Administration to distinguish it from other similar products]. Subcutaneous Solution Pen-injector 100 unit/ml (milliliter) (Insulin Glargine-yfgn) inject 63 units subcutaneously at bedtime related to type 2 diabetes mellitus without complications.Review of Resident #25's Medication Administration Record (MAR) for September 2025 documented a blood sugar value of 463 on 9/5/2025 at 2000 (8:00 PM), and a blood sugar value of 454 on 9/7/2025 at 2000, there were no notes within the medical record that documented the physician was notified per the Medical Doctor's orders.Review of Resident #25's MAR for August 2025 documented on 8/26/2025 at 2000 chart code 12 (vitals outside parameters) for Insulin Glargine-yfgn Subcutaneous Solution Peninjector 100 unit/ml (Insulin Glargine-yfgn) Inject 55 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus without complications. During an interview on 9/09/2025 at 6:03 AM Staff G, LPN (Licensed Practical Nurse) stated, I did not give the insulin it was outside the parameters.During an interview on 9/11/2025 at 4:08 AM Staff F, LPN stated, The blood sugar was above 450. I should have called the doctor. I don't know if I did or not. I can't tell you if I actually called the on call person about the high blood sugar. I have no notes in the chart. I should have called and documented that.2) Review of Resident #22's admission record documented diagnosis that include, Type 2 diabetes mellitus with diabetic neuropathy, unspecified, hypothyroidism, unspecified, chronic systolic (congestive) heart failure, unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and cognitive communication deficit.Review of Resident #22's physician orders dated 8/13/2025 read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) inject 14 units subcutaneously at bedtime related to type 2 diabetes mellitus with diabetic neuropathy unspecified. Review of Resident #22's MAR documented Lantus insulin was held without parameters on the physician order on 8/22/2025 and documented a chart code of 9 (other, see nurses notes). Dated 8/26/2025 documented a chart code of 9 (other see nurses notes), and dated 8/30/2025 documented chart code of 5 (hold see nurses notes).Review of Resident #22's EMAR (Electronic Medication Administration Record) dated 8/22/2025 at 2100 (9:00 PM) read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml inject 14 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified (E11.40) hold due to bs [blood sugar] at 80.Review of Resident #22's REMAR dated 8/26/2025 at 21:24 (9:24 PM) read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml Inject 14 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified (E11.40) BS 73.Review of Resident #22's EMAR dated 8/30/2025 at 2158 (9:58 PM) EMAR read, Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml Inject 14 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified (E11.40) BS 71.During an interview on 9/10/2025 at 6:00 AM Staff G, LPN stated, I did hold the insulin. It was outside parameters based on the sliding scale. The physician order was reviewed with Staff G. Staff G stated, There are no parameters on that [Lantus SoloStar insulin]. I guess I shouldn't have held it.Review of the policy and procedure titled, Medication Administration last review date of 1/9/2025 read, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination, or infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer oxygen at physician ordered flow rates according to professional standards of practice for 2 (Resident #1 and #26) of 3 residents reviewed for oxygen administration. Findings include: 1) During an observation on 9/8/2025 at 10:00 AM Resident #1 was observed in bed. Oxygen was being administered via concentrator by nasal cannula at 4 liters per minute. Review of Resident #1's admission record documented diagnosis that include acute and chronic respiratory failure with hypoxia (a condition where the lungs are unable to exchange oxygen and carbon dioxide leading to low oxygen levels-hypoxia), chronic obstructive pulmonary disease (lung disease that cause breathing problems) with acute exacerbation (a sudden worsening of the symptoms), pneumonia, unspecified organism, and acute and chronic (systolic) congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).Review of Resident #1's physician orders dated 8/1/2025 read, Oxygen at 2 liters per min [minute] via nasal cannula every shift. Verify concentrator is set to the ordered liters per minute.Review of Resident #1's comprehensive care plan read, Focus: [Resident #1's name] is at risk for altered breathing, respiratory distress secondary to COPD [chronic obstructive pulmonary disease]. Interventions: O2 [oxygen] as per MD [Medical Doctor] order.During an interview on 9/10/2025 at 9:00 AM Staff F, Licensed Practical Nurse (LPN) stated, It [the oxygen] is on 4 liters, it should be on 2 Liters. I usually check on oxygen after I do med [medication] pass. I have not checked hers [Resident #1] yet. We should follow the orders and have it on the right rate. 2) During an observation on 9/9/2025 at 7:27 AM Resident #26 was observed in bed. Oxygen was being administered via concentrator by nasal cannula at 4 liters per minute. The oxygen concentrator was outside of the resident's reach and was facing the wall.Review of Resident #26's admission record documented diagnosis that include acute and chronic respiratory failure with hypercapnia (high [NAME] dioxide levels in the blood), chronic obstructive pulmonary disease with acute exacerbation, respiratory failure unspecified with hypoxia, atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain), paroxysmal atrial fibrillation (an irregular heartbeat), and obstructive sleep apnea adult (a sleep disorder when you stop breathing during sleep).Review of Resident #26's physician order dated 8/20/2025 read, Oxygen at 3 liters per min via nasal cannula every shift. Verify concentrator is set to the ordered liters per minute.Review of Resident #26's comprehensive care plan read, Focus: [Resident #26's name] is at risk for altered breathing, respiratory distress secondary to COPD. Interventions: O2 as per MD order.During an interview on 9/9/2025 at 7:27 AM Resident #26 stated, I never change my oxygen, the nurses always do that.During an interview on 9/10/2025 at 9:00 AM Staff F, LPN stated, Her [Resident #26] oxygen should be at 3 liters. I'm not sure how that happened. We should check oxygen every day and check oxygen sat's [saturations]. Review of the policy and procedure titled Oxygen Administration last revision date of 3/15/2025 read, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy explanation and Compliance guidelines. 1.Oxygen is administered under orders of a physician, except in the case of emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure physician ordered parameters were followed related to blood pressure medications resulting in the administration of unnecessary medications for 2 (Resident #16 and #35) of 5 residents reviewed for unnecessary medications.Findings include:1) Review of Resident #16's admission record documented diagnosis that include chronic obstructive pulmonary disease, unspecified, type 2 diabetes mellitus without complications, iron deficiency anemia, unspecified, vitamin b12 deficiency anemia, unspecified, chronic pain syndrome, major depressive disorder, recurrent, mild, unspecified atrial fibrillation (an irregular heartbeat), gastro-esophageal reflux disease without esophagitis, hyperlipidemia, unspecified (high cholesterol),and essential (primary) hypertension (high blood pressure). Review of Resident #16's physician order dated 4/27/2025 read, Labetalol HCl [labetalol hydrochloride] oral tablet give 150 mg (milligrams) by mouth two times a day hold if HR [heart rate] <60 bpm [less than 60 beats per minute], hold if BP [blood pressure] systolic 100 or below related to essential (primary) hypertension. Review of Resident #16's Medication Administration Record (MAR) for July 2025 documented that Labetalol HCL 150 mg (milligrams) was administered outside of physician ordered parameters for heart rate less than 60 at 0900 (9:00 AM) on 7/7/2025 heart rate of 58, on 7/8/2025 HR 55, on 7/11/2025 HR 59, on 7/16/2025 HR 54 on 7/17/2025 HR 51, on 7/18/2025 HR 53, on 7/22/2025 HR 57, on 7/24/2025 HR 54, and on 7/28/2025 HR 58.Review of Resident #16's MAR for July 2025 Labetalol HCL 150 mg (milligrams) was administered outside of physician ordered parameters for heart rate less than 60 at 2100 (9:00 PM) on 7/4/2025 HR 56, 7/5/2025 HR 54, 7/6/2025 HR 58, 7/8/2025 HR 58, 7/17/2025 HR 58, 7/20/2025 HR 52, 7/27/2025 HR 58 and on 7/30/2025 HR 57.Review of Resident #16's MAR for August 2025 documented that Labetalol HCL 150 mg (milligrams) was administered outside of physician ordered parameters for heart rate less than 60 at 2100 on 8/9/2025 HR 59, 8/10/2025 HR 56, 8/20/2025 HR 54, 8/22/2025 HR 58 and 8/27/2025 HR 552) Review of Resident #35's admission record documented diagnosis that include unspecified combined systolic congestive and diastolic congestive heart failure, chronic obstructive pulmonary disease unspecified, unspecified protein calorie malnutrition, essential primary hypertension, major depressive disorder recurrent mild, peripheral vascular disease unspecified, chronic kidney disease unspecified, gastroesophageal reflux disease without esophagitis, chronic embolism and thrombosis unspecified deep veins of right lower extremity, unspecified atrial fibrillation, hypothyroid unspecified, age-related osteoporosis without current pathological fracture, unilateral primary osteoarthritis and right knee pain.Review of Resident #35's physician order dated 1/15/2025 read, Midodrine HCl oral tablet 10 mg (Midodrine HCl) give 1 tablet by mouth three times a day for low blood pressure give if Systolic 120 or below. Review of Resident #35's July MAR documented Midodrine was administered at 08:00 (8:00 AM) on 7/15/2025 with a blood pressure (B/P) of 142/76, on 7/17/2025 with a B/P of 126/78, and on 7/26/2025 with a B/P of 136/64.Review of Resident #35's July MAR documented Midodrine was administered at 12:00 (12:00 PM) on 7/4/2025 with a B/P of 122/60, on 7/13/2025 with a B/P of 122/64, on 7/16/2025 with a B/P of 122/72, on 7/19/2025 with a B/P of 126/82, 7/20/2025 with a B/P of 126/82, on 7/21/2025 with a B/P of 122/60 and on 7/26/2025 with a B/P of 136/64.Review of Resident #35's July MAR documented Midodrine was administered at 1600 (4:00 PM) on 7/17/2025 with a B/P of 124/74, 7/21/2025 with a B/P of 126/60 and on 7/22/2025 with a B/P of 122/60.Review of Resident #35's August MAR documented Midodrine was administered at 0800 on 8/10/2025 with a B/P of 136/64.Review of Resident #35's August MAR documented Midodrine was administered at 1200 on 8/4/2025 with a B/P of 122/60, on 8/16/2025 with a B/P of 130/86, on 8/19/2025 with a B/P of 128/64, om 8/24/2025 with a B/P of 122/64, on 8/25/2025 with a B/P of 124/79, on 8/26/2025 with a B/P of 122/60 and on 8/28/2025 with a B/P of 124/86.Review of Resident #35's September MAR documented Midodrine was administered at 1200 on 9/3/2025 with a B/P of 126/88, on 9/7/2025 with a B/P of 122/60 and on 9/9/2025 with a B/P of 122/60.Review of Resident #35's September MAR documented Midodrine was administered at 1600 on 9/9/2025 with a B/P of 122/60.During an interview on 9/9/2025 at 8:27 AM Staff E, LPN stated, I guess I gave it [the midodrine]. I should have held it.During an interview on 9/10/2025 at 9:25 AM Staff F, LPN stated, I don't know if I gave it [the midodrine] or not, maybe I did. Usually, I will document that the parameters mean I hold the medicine. My initials without that means I must have administered it. I don't really know if I did or not.Review of the policy and procedure titled, Medication Administration last review date of 1/9/2025 read, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was served in a sanitary manner during the 9/10/2025 midday meal, of two meals observed. Findings include:During an observation on 9/10/2025 beginning at 11:20 AM of the food services midday Staff A, [NAME] was observed using gloved hands to retrieve scoops, metal containers and other items from various areas in the kitchen. At 11:30 AM Staff A, did not remove the gloves or perform hand hygiene and lifted two pieces of cornbread from a metal tray with her gloved hands and placed the cornbread on individual residents' plates for service to the residents.During an interview on 9/10/2025 at 11:32 AM, the Certified Dietary Manager stated, She [Staff A] should use tongs to lift the cornbread from the tray and place on plates for service to residents.During an observation on 9/10/2025 at 11:34 AM, Staff A was observed lifting plates and bowls to fill with food for service to the residents. Staff A lifted two bowls and two plates with her fingers touching the interior food surface of the bowls and her thumb touching the interior food surface of the plates. At 11:35 AM, Staff A doffed gloves and donned a new pair of gloves without performing hand hygiene and returned to the tray line to prepare meal plates to serve to the residents.During interview on 9/10/2025 at 11:36 AM, the Certified Dietary Manager confirmed Staff A should not touch the interior food surfaces of the plates and bowls used to serve food to residents. Review of the policy and procedure titled Maintaining a Sanitary Tray Line, last reviewed 12/18/2024 read, The facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures in order to prevent the spread of bacteria that may cause food borne illness. 3. During tray assembly, staff shall: Use utensils such as tongs, serving spoons, etc. [etcetera] to handle foods as much as possible. e. Perform hand hygiene before and after wearing or changing gloves. f. Change gloves when activities are changed, or when the type of food being handled is changed, or when leaving the workstation.