

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure two (#25 and #19) of two residents reviewed for self administration of medications were assessed by the facility and a physician order was obtained to allow for the self-administration of medications related to the administration of oral and nebulized medications. Findings included: On 1/6/26 at 10:08 a.m. Resident #25 was observed lying in bed with an over-bed table within reach of the resident. A medication cup containing 10 oral tablets was sitting in the corner of the table within reach of the resident. The resident reported just getting the medication and would take them. Resident #25 reached over to the table, retrieved the cup, and swallowed all of the tablets at one time. During the observation, no staff member was in the room with the resident. Review of Resident #25s admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to acute and chronic respiratory failure with hypoxia, unspecified eye blindness one eye, uncomplicated alcohol abuse, and uncomplicated cannabis abuse. Review of Resident #25s quarterly Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 5 of 15, indicating a severe cognition impairment. Review of Resident #25s physician orders did not reveal an order allowing for the self-administration of medications. Review of Resident #25s care plan did not show a focus or intervention allowing the resident to self-administer medications. On 1/8/26 at 12:04 p.m. Resident #19 was observed lying in bed wearing a nebulizer mask and the nebulize machine was sitting within reach of the resident on the over-bed table. The observation showed no staff member was in the room with the resident or in the hallway outside of the room. The resident shut off the machine and reported getting a nebulizer treatment at the time then turned machine back on. During the observation, the medication cart was parked near the nursing station (opposite end of hallway then resident room) and the nurse was not observed in any room on the hallway. Review of Resident #19s admission Record showed the resident was admitted on [DATE] and included diagnoses not limited to chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with (acute) exacerbation, and unspecified emphysema. Review of Resident #19s quarterly MDS dated [DATE] revealed a BIMS score of 14 of 15 indicating an intact cognition. Review of Resident #19s physician orders did not reveal an order had been obtained for the self-administration of medications. Review of Resident #19s care plan did not include a focus or intervention related to the resident being assessed for and a physician ordered had been obtained allowing for the self-administration of medications. An interview was conducted with Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM) on 1/8/26 at approximately 12:08 p.m. The staff member was sitting at the nursing station and not within sight of Resident #19s room. Staff H reported Staff N, LPN, (nurse assigned to resident) was on break. Review of the Medication Self-Administration Screen dated 1/7/26 at 2:21 p.m. revealed neither Resident #19 nor Resident #25 was included on the list of two residents with the ability to self-administer medications. An interview was conducted with the Director of Nursing (DON) on 1/7/26 at 2:14 p.m. The DON stated the facility did not have any residents who self-administered medications then reiterated I don't have any. The DON later on 1/7/26 provided a list of two residents assessed to self-administer medications. During an interview on 1/8/26 at 3:37 p.m. Staff H stated (continued on next page)		

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation and interview, the facility failed to provide Meal Menus to four (Resident #24, Resident #67, Resident #105 and Resident #110) out of four residents reviewed for choices. Findings Included: During an interview on 01/05/2026 at 9:27 a.m., Resident #24 stated they have not passed out menus in a while, so she has no idea what she is getting to eat until they bring the trays in. An observation of Resident #24's wall and overside table revealed no meal menu. During an interview on 01/05/2025 at 10:02 a.m., Resident #67 stated they don't pass out menus anymore, so I never know what they are bringing me to eat. They will bring my tray, and I can order something else, but I cannot order it ahead of time since I don't know what they are serving. An observation of Resident #67's room revealed no meal menu was posted. During an interview on 01/07/2026 at 10:00 a.m., Resident #110 stated I don't know what the meal will be before I get my meal tray so I can not pre-order an alternative meal. They stopped providing us with menus in our rooms. During an interview on 01/07/2025 at 12:30 p.m., the Dietician and Certified Dietary Manager (CDM) stated we stopped passing out lunch menus because residents were not ordering nutritional meals. We had residents who just wanted to order toast, and this is not a nutritional meal. We have their preferences with their likes and dislikes so we know what we can serve them and they won't receive anything they do not want. They can order from the alternative menu but will have to wait to receive the ordered item because we must finish meal services first. An interview was conducted on 1/8/2026 at 10:45 A.M. with Staff A, Registered Nurse (RN) Unit Manager, stated residents do not receive meal menus anymore and the residents cannot pick what they want. She said, it makes more sense for the residents to have a choice. 2. An interview was conducted with Resident #105 on 1/5/26 at approximately 10:30 a.m. The resident reported not getting the food as requested, had requested a cheeseburger (multiple times) and had only received one in the month of being at the facility. The resident provided a menu ticket showing lunch and dinner items for 1/3 and breakfast on 1/4/26. The resident had requested fresh fruit for each of the meals along with numerous handwritten meal choices. During an interview on 1/5/26 at 4:00 p.m. with Resident #105 and a family member, the resident stated the handwritten choices on the meal tickets were suggestions and had not received a menu for Monday (1/5) or Tuesday (1/6). An interview was conducted on 1/7/26 at 12:08 pm, with the Dietitian and regional Certified Dietary Manager. (CDM). The Dietitian reported speaking with residents after admissions, quarterly and annually. The CDM reported the contracted kitchen vendor had started with the facility on 1/1/26 and had not completed any initial (assessments) and the facility hadn't had a consistent CDM. The Dietitian reported meeting with Resident #105 and the family member a week after admission and a copy of renal education had been provided. The CDM stated the meals were resident preference based (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the vendor had stopped passing menus due to resident's ordering just one piece of bread and not ordering a nutritional meal. The CDM stated the system could be very specific with preferences and dislikes, for example could add grilled chicken versus breaded chicken. A review of a facility provided policy revised 12/9/2025, titled, Policy and Procedure: Dietary - Food and Drink revealed the purpose is to ensure facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet. The procedure is as follows: The facility will provide to each resident: 4: Food that accommodates resident allergies, intolerances, and preferences. 5: Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure Preadmission Screening and Resident Review (PASRR)s for two (#3 and #105) were updated to include current diagnoses and screening questions were answered appropriately of two residents sampled for PASRR. Findings Included: During an interview on 01/05/2025 at 10:46 a.m., Resident #3 stated the people who speak spanish have it out for me. They are talking about me in Spanish. When I first got here, they (spanish speaking people) accused me of molesting my daughter. Resident #3 was not able to identify any certain person and just referred to the spanish speaking people. Review of Resident #3's admission Record showed Resident #3 was admitted to the facility on [DATE] with diagnoses of psychotic disorder with hallucinations due to known physiological condition (12/16/2025), bipolar disorder, current episode depressed, mild (04/17/2025), generalized anxiety disorder (11/05/2025), and unspecified dementia, unspecified severity, with psychotic disturbance, primary insomnia, other frontotemporal neurocognitive disorder (11/05/2025). Review of Resident #3's Care Plan dated 04/17/2025 revealed: Focus: Resident #3 is on antipsychotic therapy related to psychosis. Focus: Resident #3 has visual and auditory hallucinations. Exhibiting unrealistic fears with beliefs that his daughter is attempting to get him arrested. Focus: Resident #3 is on sedative/hypnotic therapy related to Insomnia. Focus: has a mood problem r/t bipolar disorder. Resident expresses some feelings of Depression and is at risk for mood decline. Resident further is exhibiting periods of visual and auditory hallucinations. Exhibiting unrealistic fears with beliefs that his daughter is attempting to get him arrested. Focus: Resident #3 has depression related to bipolar disorder. Focus: Resident #3 Has impaired cognitive function/dementia or impaired thought process related to dementia. Review of the Level I PASRR, dated 12/17/2025, revealed Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 7 were marked no. Section III: PASRR Screen Provisional admission or Hospital Discharge Exemption Not a Provisional Admission was marked. Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2025 at 11:15 a.m., Social Services Assistant and Director stated Resident #3 did come to them and about the spanish people talking about him in spanish. They notified the nurse who called psych. Resident #3 is known and care planned for having paranoid thoughts. Psych is currently seeing him and adjusting his medications as needed. During an interview on 01/09/2025 at 3:04 p.m., the Director of Nursing (DON), reviewed Resident #3's PASRR and stated, I would say question two, a. Interpersonal functioning should be marked no because Resident #3 can express his needs and wants. I would not say he has any concerns with interacting with other people. Question seven should be marked yes for the dementia. After reviewing the PASRR I would say he needs to be screened for a Level II PASRR. 2. Review of Resident #105s Preadmission Screening and Resident Review (PASRR) revealed the resident did not have a Mental Illness (MI), suspected MI, Intellectual Disability (ID) or a suspected ID based on documented history. The PASRR was completed at an acute care hospital on [DATE]. Review of Resident #105s admission Record showed the resident was admitted on [DATE] and included a diagnosis not limited to adjustment disorder with depressed mood. An interview was conducted with the Nursing Home Administrator (NHA) on 1/6/26 at 3:14 p.m. The NHA provided Resident #105s PASRR from the acute care facility and stated the facility had just updated the PASRR to include the missing diagnosis (adjustment disorder with depressed mood). Review of the policy & Social Services PASRR, effective 4/1/22, revealed The the survey shall ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID re evaluated and received care and services in the most integrated setting appropriate to their needs by coordinating with the appropriate, State-designated authority. The facility shall ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a significant change in their status occurs. According to state regulation, nursing facilities and hospitals in Florida are also delegated to complete PASRR Level 1 screenings. If the PASRR Level 1 outcome is positive (indicating a possible serious mental illness, intellectual disability, or a related condition) then a PASRR Level II evaluation and determination must be completed prior to a nursing home admission. The procedure detailed the following: 1. The External Liaison or Internal admission Staff/Designee or will obtain a completed pre-admission screen (PASRR Level 1) on all individuals being admitted to the Skilled Nursing Facility (SNF) prior to admission. 2. Individuals will be accepted for SNF admission if the PASRR (Level 1) does not indicate any serious mental illnesses (SMI) Or intellectual disability (ID) or related condition (negative Level 1 screen) OR they qualify for one of the provisional admissions or hospital discharge exemption. 3. If the result of the PASRR (Level 1) screening indicates that serious mental illness (SMI) and/ or intellectual disability (ID) or related condition appears to exist (positive Level 1 screen) and the individual does not meet a provisional or hospital discharge exemption, the individual will be referred to (screening authority) for a Level II screening prior to the individual being accepted for SNF admission. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Review instructed: 1. The facility social service director/ credentialed user shall complete a referral for Level II resident review evaluation for individuals previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews, observation, and record review, the facility failed to provide Activities of Daily Living (ADLs) related to fingernail trimming for one resident (#135) out of four residents sampled. Findings Included: During an observation and interview on 01/05/2026 at 10:30 a.m., Resident #135 was observed to have long untrimmed nails with black build-up underneath. Resident #135 stated I would like my nails trimmed. I don't like them being this long. During an interview and observation on 01/07/2026 at 9:04 a.m., Resident #135's was observed to have long untrimmed nails with black build up underneath. Resident #135 stated, I have asked them to trim my nails, but they have not done it yet. Review of Resident #135's admission record revealed an admission date of 01/02/2026. Resident #135 was admitted to the facility with diagnosis to include cerebral infarction, cerebral amyloid angiopathy, muscle weakness, unspecified lack of coordination, and need for assistance with personal care. Review of Resident #135's Care Plan dated 01/03/2026 revealed a focus - Resident #135 has an ADL self-care performance deficit related to cerebrovascular (CVA), cerebral amyloid angiopathy, dysarthria, right hemiparesis and dementia. Interventions included - Bathing/showering: check nail length and trim and clean on bath day as necessary. Report any changes to the nurse. During an interview on 01/07/2026, 11:32 a.m., Staff Q, Certified Nursing Assistant (CNA) stated, There is no schedule for nails to be trimmed and that it is done when they ask or I see it. During an interview on 01/07/2026, at 11:46 a.m., Staff R, Registered Nurse (RN) stated The CNA will do all the showers and any nail trimmings. Staff R stated they normally document it on the shower sheets, but they don't always get filled out like they should be. During an interview on 01/08/2026, at 12:03 p.m., the Director of Nursing (DON) stated her expectation was for residents' nails to be trimmed with showers or as needed. Review of the facility policy titled clinical activities of daily living (ADL's) all this happened with a revision date of 11/11/2025 revealed a purpose: To ensure residents' needs are met in a manner that promotes their quality of life, resident rights, preferences, and independence. Procedure: 1. The facility shall ensure a resident is given the appropriate treatment and services to maintain or improve his or her own ability to carry out the activities of daily living. 2. The facility shall provide care and services for the following activities of daily living as needed based on the individual care plan of each resident: a period hygiene: by not coming to bathing, dressing, grooming, and oral care.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observations, interviews and record review the facility failed to follow physician orders related to medication perimeters and wound care for two residents (#10 and #22) out of two residents sampled. Findings Included: Review of Resident #10's admission record revealed an admission date of 11/18/2025. Resident #10 was admitted to the facility with diagnosis to include hepatic failure, acute embolism and thrombosis of right femoral vein, portal hypertension, hypotension, and idiopathic hypotension, sedative, hypnotic or anxiolytic abuse. Review of Resident #10's physician orders dates active as of 01/08/2026 revealed: Midodrine Give 15 mg by mouth three times a day for Hypotension Hold if Systolic Blood Pressure (SBP) great than 130. Start Date: 12/18/2025 Review of Resident #10's Medication Administration Record (MAR) for November 2025 revealed the medication was given with a SBP greater than 130 on 11/01/2025, 11/24/2025, and 11/26/2025. Review of Resident #10's Medication Administration Record (MAR) for December 2025 revealed the medication was given with a SBP greater than 130 on 12/06/2025, 12/18/2025, and 12/20/2025. During an interview on 01/08/2025 at 3:05 p.m., the Director of Nursing (DON) reviewed Resident #10's MAR for November and December 2025 and stated the Midodrine should have been held if the blood pressure was greater than 130. During an interview on 01/08/2025 at 5:02 p.m., the Physician stated, Sometimes we can override the rules if there are circumstances that call for it. I would assume the nurse spoke with a physician getting the okay to continue to give the medication outside of the order parameters. I personally would have to check with the other providers, but I would expect there to be a nurse's note as well. Review of the facility's policy titled, Physician Orders, revised 11/11/2025 revealed a purpose: Physician/Physician extender's orders are administered upon the clear complete order of an individual lawfully authorized to prescribe. On 1/5/26 at 2:13 p.m., during an observation and interview, Resident #22 stated staff had not been putting cream on her calves like they are supposed to. The resident stated no one had applied the cream in a few days. On 1/5/26 at 2:20 p.m., Staff D, Licensed Practical Nurse (LPN)/Unit Manager (UM) entered Resident #22's room after resident had turned on call light to ask for the prescribed cream to be put on their legs. Staff D, LPN/UM removed Resident #22's socks to reveal the resident having dry, flaky skin, sores and wounds that appeared to have drainage with a strong odor present on her calves. Resident #22 told Staff D, UM no one had put their prescribed cream on their legs in a few days. Staff D stated since Resident #22 was at dialysis during wound rounds for the day of 1/5/26, she would be seen by the wound care nurse on the following day, Tuesday, 1/6/25. A review of Resident #22's admission record revealed an admission date of 8/16/25 with diagnoses to include acute on chronic diastolic (congestive) heart failure, type 2 diabetes, difficulty in walking, and stage 5 chronic kidney disease. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #22's Quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, in section C - cognitive patterns revealed a Brief Interview for Mental Status (BIMS) score of 12, meaning the resident was moderately impaired. A review of Resident #22's physician orders revealed the following: Ammonium lactate external lotion 12% (Lactic acid (Ammonium Lactate) to be applied every day and evening shift to bilateral lower legs topically starting on 9/23/25. A review of Resident #22's physician progress notes revealed on 1/8/26, 1/7/26, and 1/6/26 showed, Given clinical signs of wound infection, empirically initiated levofloxacin 250 mg orally once a day for 7 days, with plans to adjust antibiotic therapy based on wound culture and sensitivity results. On 1/7/26 another physician note showed Bilateral lower extremity skin changes noted consisted with PVD (peripheral vascular disease). Record review showed there was no further documentation on the condition of Resident #22's bilateral lower legs A review of Resident #22's care plan dated 11/28/25 revealed a focus- the resident will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform the resident/resident representative of any new area of skin breakdown. Monitor or document/report PRN (as needed) any changes in skin status. A second focus in the same care plan showed [Resident #22] has Diabetes Mellitus. The resident will have no complications related to diabetes. Interventions included to monitor/document/report PRN any s/sx (signs/symptoms) of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing. A third focus in the same care plan showed [Resident #22] has peripheral vascular disease r/t (related to) diabetes. The goal showed the resident will be free of s/sx of PVD. Interventions included to keep skin on extremities well hydrated with lotion in order to prevent dry skin and cracking of the skin. Monitor for dry skin and apply lotion as needed. A review of Resident #22's Skin Evaluation tool and wound report dated 1/1/26 and 12/25/25 referenced the resident's heel wounds. The evaluation did not include the observed bilateral lower leg flaky dry skin and the ammonia lactate orders prescribed. On 1/8/26 at 3:02p.m. an interview with Staff D, LPN/UM revealed the wound doctor was not seeing Resident #22 for the wounds on their calves. Staff D, LPN/ UM stated no report had been made to the physician or family representative on the state of Resident #22's bilateral lower legs. Staff D stated a change in condition (CIC) was not documented, but it should have been documented. On 1/8/26 at 4:17p.m., an interview was conducted with the Director of Nursing (DON). The DON revealed to have expected some kind of documentation in regards to Resident #22's bilateral lower leg wounds. The DON stated it is their expectation for the physician to have been notified about the issues, for a CIC to have been made, and a risk assessment to be completed. A review of the facility policy titled, Skin Management, dated 8/21/25, revealed a purpose to provide identification of altered skin integrate risk factors and interventions for specific risk factors. General guidelines: 1. Keep the skin clean and free of exposure to urine and fecal matter. Monitoring &dash; 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. A review of the facility policy titled, Wound Treatment Management, revised 2/21/23, revealed the following general guidelines - To promote wound healing of various types of wounds, it is the policy of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. 4. Treatment decisions will be based on: a. Etiology of the wound: Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic. Photographic Evidence Obtained.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status for three (#1, #71, and #113) residents of eight residents reviewed for nutrition. Findings include: 1. An observation on 1/5/2026 at 11:10 A.M. revealed Resident #1 had a foam water cup on his bedside table dated 1/4/2026. An observation on 1/6/2026 at 9:46 A.M. revealed Resident #1 had a foam water cup on his bedside table dated 1/5/2026. An observation on 1/8/2026 at 10:30 A.M. revealed Resident #1 had a foam water cup on his bedside table dated 1/7/2026. An interview was conducted on 01/06/2026 at 10:20 A.M. with Resident #1. He said he still hungry and asked for another breakfast tray. He had not received an additional tray. He said he does not need assistance eating his meals. A review of Resident #1's admission record revealed the resident was admitted on [DATE] and included diagnoses not limited to Type 2 diabetes mellitus, muscle weakness (generalized), and assistance with personal care. A review of Resident #1's weight summary showed on 10/08/2025 the resident weighed 137.3 pounds via mechanical lift, on 01/03/2026 the resident weighed 121.6 pounds via the bed, a weight loss of 15.7 pounds and total body weight loss of 11.43%. A review of Resident #1's physician order summary revealed the resident was to receive 4 ounces of a health shake. A review of Resident #1's medication administration record revealed the resident was consuming a daily average of 25% of the shake for the month of January 2026. A review of Resident #1's task record revealed the resident was offered fluids and snacks twice (12/29/2025 and 12/31/2025) in the past 30 days. A review of Resident #1's care plan showed the resident had a nutritional problem or potential nutritional problem. The focus was initiated on 10/15/2025 and revised on 11/21/2025. The goal for Resident #1 was the resident will exhibit gradual weight gain toward ideal body weight. The interventions for Resident #1 included monitoring/recording/reporting to medical doctor for signs or symptoms of malnutrition: significant weight loss: >3 [pounds] in one week, >[greater than] 5% in one month, >7.5% in three months, or >10% in six months. Another intervention for Resident #1 was provide and serve supplements as ordered. A review of Resident #1's progress notes revealed no attempted contact was made with the medical doctor or the registered dietitian. An interview was conducted on 1/8/2026 at 10:45 A.M. with Staff A, Unit Manager (UM). Staff A, UM said her expectation was fresh water be given to the residents before breakfast trays were delivered. 2. An observation on 1/5/2026 at 11:13 A.M. revealed Resident #71 had a foam water cup on his bedside table dated 1/4/2026. An observation on 1/6/2026 at 9:49 A.M. revealed Resident #71 had a foam water cup on his bedside table dated 1/5/2026. A review of Resident #71's admission record revealed the resident was admitted on [DATE] and included diagnoses not limited to Type 2 diabetes mellitus and dysphagia. A review of Resident #71's weight summary showed on 12/18/2025 the resident weighed 179 pounds via mechanical lift on admission. The record showed one weight documented. A review of Resident #71's physician order summary revealed the resident was to receive eight ounces of [high calorie supplement] one time a day for nutritional support. A review of Resident #71's medication administration record revealed the resident had not consumed the ordered supplement for the month of January 2026. A review of Resident #71's task record revealed the resident was offered fluids and snacks twice (12/29/2025 and 12/31/2025) in the past 30 days. A review of Resident #71's care plan showed the resident is a risk for malnutrition related to the need for therapeutic/mechanically altered diet, impaired mental status, and chronic diseases. The focus was initiated on 12/18/2025 and revised on 12/26/2025. The goal for Resident #71 was the resident will maintain weight as evidenced by no significant weight changes. The interventions for Resident #1 included provide and serve supplements as ordered and weigh per policy. 3. An interview was conducted on 01/05/2026 3:40 P.M. with Resident #113. Resident #113 said he does not like food and thinks he has lost weight. A review of Resident #113's admission record revealed the resident was admitted on [DATE] and included diagnoses not limited to muscle weakness (generalized) and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oropharyngeal phase dysphagia.A review of Resident #113's weight summary showed on 12/17/2025 the resident weighed 150.8 pounds via mechanical lift, on 01/03/2026 the resident weighed 124.2 pounds via the bed, a weight loss of 26.6 pounds and total body weight loss of 17.64%.A review of Resident #113's task record revealed the resident was offered fluids and snacks once on 12/31/2025 in the past 30 days.A review of Resident #113's care plan showed the resident is at risk for malnutrition related to the need for a mechanically altered diet, underweight status, and chronic diseases. The focus was initiated on 12/17/2025 and revised on 12/24/2025. The goal for Resident #113 was the resident will will maintain right as evidenced by no significant weight changes or have a gradual weight gain toward a healthier body mass index. One intervention for Resident #113 was monitoring/recording/reporting to medical doctor for signs or symptoms of malnutrition: significant weight loss: >3#'s in one week, >5% l one month, >7.5% in three months, or >10% in 6 months. Another intervention for Resident #113 was provide and serve supplements as ordered.A review of Resident #113's progress notes revealed no attempted contact was made with the medical doctor or the registered dietitian.An interview was conducted on 1/8/2026 at 4:00 P.M. with Staff F, Registered Dietitian (RD). Staff F, RD said she meets weekly with the interdisciplinary team to review weekly weights of residents newly admitted to the facility. Staff F, RD said to prevent the residents from losing weight, fluids and snacks are offered three times a day. Staff F, RD said Resident #1 should weigh around 130# pounds. Staff F, RD said she did not know Resident #1 had only consumed a daily average of 25% of his shake supplement and was not being offered fluids or snacks daily. Staff F, RD said resident #71 should have been weighed weekly for monitoring. Staff F, RD said she did not know that Resident #71 was not consuming his dietary supplement and was not being offered fluids or snacks daily. Staff F, RD said Resident #113's weight was documented incorrectly and there is nothing I can do about that. Staff F, RD said she did not know Resident #113 was not being offered fluids or snacks daily.An interview was conducted on 1/8/2026 at 3:20 P.M. with the Director of Nursing (DON). She said she did not know that Resident #1 or #113 had a significant weight loss. The DON said she did not know that Resident #71 was not weighed according to facility policy. The DON said she did not know that Resident #1, #71, or #113 was not being offered fluids or snacks. The DON said the resident's nurses are responsible for providing dietary supplements that are ordered by the RD. A review of a policy revised 12/9/2025, titled, Policy and Procedure: Dietary - Food and Drink revealed the purpose is to ensure facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet. The procedure is as follows: The facility will provide to each resident: 4: Food that accommodates resident allergies, intolerances, and preferences. 5: Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice. 6: Drinks, including water and other liquids consistent with resident needs, preferences, and sufficient to maintain resident hydration.A review of a facility provided policy revised 10/27/2025, titled, Process: Obtaining Resident Weights revealed the purpose is to obtain accurate and timely resident weights. The general information includes: Newly admitted or re-admitted residents are encouraged to have their weight obtained weekly for approximately four weeks or as the resident tolerates. Nursing supervisor/charge nurse or designee should review weight results for accuracy prior to documentation in the electronic medical record (EMR). Once deemed accurate and/or verified with a re-weight, the nurse will enter the weight results in the EMR. The Registered Dietitian/designee will review weights weekly, monthly, and as needed to provided recommendations for nutritional stabilization per individual resident need. The interdisciplinary team (IDT) will review the residents' weight loss/gain to determine if the weight fluctuations require care plan revisions, physician orders, nursing and/or dietary interventions, and/or meet unavoidable weight loss/gain criteria. The process is as follows: 1: Certified Nursing Assistants should: a: ensure the weight scale is zeroed out and is reading (0) before weighing each resident; d: weigh using the same weight scale as previously utilized, if possible. If unable to use the same scale, not this on the weight record; e: weigh residents in the same wheelchair each time.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure that the medication error rate was less than 5.00%. Twenty-five medication administration opportunities were observed and three errors were identified for two (#138 and #7) of five residents observed. These errors constituted a 12.00% medication error rate. Findings included: 1. On 1/6/26 at 4:10 p.m., an observation of medication administration with Staff J, Licensed Practical Nurse (LPN), was conducted with Resident #138. The staff member dispensed the following medications: Ipratropium - Albuterol sulfate 0.5 milligram (mg)/3 mg/3 milliliter (mL) vial - prescribed to Resident #137 insulin Lispro (Humalog) vial - 6 units acetaminophen extra strength 500 mg over-the counter (otc) tablets - 2 tabs ferrous sulfate 325 mg tab oral otc. The observation revealed Staff J removing a vial of Ipratropium - Albuterol from a box labeled for Resident #137. The staff member entered the resident's room with the vial and asked if the resident wanted the nebulizer and obtained a blood sugar of 328. Staff J searched the medication cart for the resident's lispro insulin before finding it in the med room refrigerator. The staff member returned to the med cart with the nebulizer vial and dispensed the oral medication and drew up 6 units of lispro insulin. Returning to the room, the staff member handed the resident the medication cup containing oral medications, cleaned back of right arm with alcohol pad and injected insulin. Staff J picked Ipratropium/Albuterol vial from over bed table, opened up the med cup on nebulizer mask, squirted contents of vial into the cup, stretched the mask's elastic band, turned to the resident and stepped toward the resident, lifting the mask with straps above the level of the resident's head. The staff member was asked to stop and to step out of room with this writer. Staff J acknowledged the Ipratropium/Albuterol was not prescribed to Resident #138 and stated she would normally not take from another resident, would check the med room and get from the electronic medication dispenser, but the resident was now not going to get the medication. Staff J returned to the room and informed the resident of him not getting the medication. Review of Resident #138's admission Record showed the resident was admitted on [DATE] with diagnoses not limited to unspecified chronic obstructive pulmonary disease, unspecified heart failure, and other nonspecific abnormal finding of lung field. Review of Resident #138's January Medication Administration Record (MAR) showed the resident was to receive Ipratropium-Albuterol Solution 0.5-2.5 mg/3 mL inhale orally via nebulizer every 4 hours for shortness of breath (SOB)/Wheezing for 3 days, starting 1/6/25 at 12:00 a.m. 2. On 1/6/26 at 4:49 p.m., an observation of medication administration with Staff I, Licensed Practical Nurse (LPN), was conducted with Resident #7. The staff member entered the resident room and was informed by unknown Certified Nursing Assistant (CNA) of the resident's blood pressure being high. The resident was observed lying in bed with microwaveable noodle bowl on the over bed table. The staff member reported having to take blood pressure again (pronoun) self. The staff member obtained the blood pressure and was unable to locate the resident's insulin on the med cart. The staff member located the insulin in the facility's medication refrigerator on the other unit. Staff I returned to the medication cart and found the resident's sevelamer and hydromorphone was not available on the cart, stating sometimes they're in Dialysis. The staff member went to the facility's electronic medication dispenser and found sevelamer was not stocked and the hydromorphone was a stock medication but the dispenser did not have any available. The staff member returned to the cart and dispensed the following medications: ferrous sulfate 325 mg tablet otc metoprolol tartrate 50 mg tablet tizanidine 4 mg tablet Humulin R 100 unit vial - 4 units. The staff member confirmed dispensing 3 oral tablets and injected the insulin into the left lower quadrant. Staff I informed the resident of not having hydromorphone and would call the pharmacy. Review of Resident #7's admission Record showed the resident was admitted on [DATE] with diagnoses not limited to end stage renal disease, chronic diastolic (congestive) heart failure, and unspecified uncomplicated cannabis use. Review of Resident #7's January MAR included the following orders: sevelamer (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Carbonate 800 mg tablet - give 1 tablet by mouth with meals for binder. Dialysis to supply. The medication was scheduled for 8:00 a.m., 12:00 p.m., and 5 p.m. The MAR showed the resident received the 5:00 p.m. dose. hydromorphone oral tablet 4 mg - give 1 tablet by mouth four times a day for nonacute pain. Hold for sedation. The medication was scheduled for 4:00 a.m., 10:00 a.m., 4:00 p.m., and 10:00 p.m. The MAR showed Staff I had documented 9 (other/see nurse notes) for the 4:00 p.m. and 10:00 p.m. dose. Review of the progress notes showed Medication Administration Notes on 1/6/26 at 9:19 p.m. and 9:21 p.m. Resident #7s hydromorphone was pending delivery from pharmacy. The note did not reveal if the pharmacy or physician was notified of the unavailable medication. Review of Resident #7s Medication Admin Audit Report for the evening shift on 1/6/26 showed Staff I had documented the administration of the 5:00 p.m. dose of sevelamer at 8:56 p.m. and at 9:21 p.m. the 4:00 p.m. dose of hydromorphone was 9 - other/see nurse notes. During an interview on 1/7/26 at 10:00 a.m. the Director of Nursing (DON) acknowledged being aware of Staff J stopped attempt to administer another residents medication to Resident #138. An interview was conducted with the DON on 1/8/26 at 5:52 p.m. The DON stated the medication error related to Resident #138 was against our policy and competency, would be a medication misappropriation. The DON stated the pain doctor is at facility 3 times a week and if staff do not have 7 days of (pain) medication they know to get a script. The observations of medication errors were discussed and the DON stated agreed with the findings and stated she could not argue. Review of the policy - Medication Administration, revised 12/10/25 revealed the purpose was To administer medication as per provider's orders and in accordance with regulatory guidelines and practice standards. The guidelines for Medication Administration included: Observe the Rights of Medication Administration: Right Resident, Right Medicine, Right Time, Right Dose, Right Route, (and) Right Documentation. The policy does not address the procedure for reordering medication to ensure a resident does not miss a dose(s). Review of the policy - Administering Medications, revised 2/21/23 revealed its purpose was To ensure that medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, and current standards of practice. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services. The policy does not address the procedure for reordering medications to ensure a resident does not miss a dose(s).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility did not follow professional standards for food service safety in the kitchen as evidenced by: a) food stored in the walk-in fridge and freezer were not labeled or stored properly b) garbage in the kitchen prep area was not contained safely or hygienically; c) food stored in the nourishment rooms were not labeled or stored properly; d) hand hygiene was not performed during a change of tasks. Findings Included: On 1/5/26 at 9:11a.m., an initial tour of the kitchen was conducted with the Dietary Director (DD). On 1/5/26 at 9:20a.m., an observation of the facility's walk-in refrigerator revealed an opened, and unlabeled gallon of milk. The DD confirmed that the milk was not properly labeled and stored. On 1/5/26 at 9:22a.m., an observation inside the facility's walk-in refrigerator revealed thawed pork loins located 2-3 inches above the floor of the walk-in on a plastic platform. The pork loin had no open date and no pull date from the freezer. The DD stated that the pork loin was not properly labeled and should have had a pull date on it. The DD confirmed that the pork loins were not properly stored being on the plastic platform that was on the ground. On 1/5/26 at 9:25a.m., an observation inside the facility's walk-in freezer revealed an open box of cinnamon rolls, not properly stored or labeled. A bag of two chicken patties twist tied with no label found on them was laying on top of an unlabeled closed box of chicken patties. An open-to-air box of chicken nuggets and beef patties, not labeled with an open date was present in the walk-in freezer. A ziplock bag of freezer burned hot dogs were present in the walk-in freezer with no stored or opened date was present on the bag. The DD confirmed that the box of cinnamon rolls, chicken patties, chicken nuggets, beef patties, and hot dogs were not properly stored, did not have an open date written on them, and should not have been left open to air. On 1/5/26 at 9:34a.m., an observation in the facility's dry storage revealed a large can of juice opened and rusted, covered with loose plastic wrap had no label of an open date found. The DD stated that this item should have been thrown out and not stored in the manner it was. On 1/5/25 at 9:41a.m., an observation of the garbage can being used in the kitchen prep line almost overflowing with trash, and without a lid containing the trash in the can. The DD stated that the garbage can should have been emptied and be covered tightly with a lid. On 1/5/26 at 9:43a.m., an observation of the kitchen prep line revealed a bag with a few pieces of bread twisted closed, and a Ziplock bag of marshmallows with no open date labeled on either item. The DD stated that those two items are not properly labeled or stored. On 1/5/26 at 9:51a.m., an observation of the facility's nourishment room down the 200 hall revealed: an open and unlabeled carton of 2% milk. An open, unlabeled bottle of water. A box of liquid thickener with an open date of 10/25. A box of liquid thickener with an open date of 12/25. An opened bottle of goat milk, unlabeled. A pitcher of juice 1/3 of the way full with no label. A soup bowl from the kitchen with no date of storage or who it belonged to. A grocery bag of chili with no label of when it was stored or who it belonged to. The refrigerator appeared to be uncleaned as there were multiple dried spills throughout and in the drawers of the refrigerator. All items, the DD confirmed were not properly stored or labeled. On 1/5/26 at 9:55a.m., an observation of the facility's second nourishment room revealed: An open and unlabeled carton of 2% [NAME] pitcher of juice 1/3 of the way full with no label. A soup bowl from the kitchen with no date of storage or who it belonged to. A container of a protein shake with no open date or who it belonged to. The refrigerator appeared to be unclean as there were multiple dried spills throughout and in the drawers of the refrigerator. All items, the DD confirmed, were not properly stored or labeled as items in the nourishment room refrigerators must be labeled with the residents name and the date it was received. The DD stated that all items in the refrigerator must be thrown out three days after the receive date. On 1/6/26 at 11:26a.m., Staff K, [NAME] was observed performing multiple tasks such as prepping food and changing food thermometers in the middle of checking food temperatures without performing hand hygiene when Staff K, [NAME] would return to taking food temperatures. On (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/6/26 at 11:40a.m., during the lunch tray line Staff K, [NAME] was observed not completing proper hand hygiene after changing tasks in between preparing meals for residents. Staff K, [NAME] was observed pureeing bread, not completing hand hygiene, then returning to serve food on the tray lines; making a grilled cheese with no hand hygiene being performed before or after preparation and returning to tray line; going to throw away garbage and returning to the tray line without performing hand hygiene before returning back to the tray line to serve food. On 1/6/26 at 11:53a.m., Staff U, Dietary Aide (DA) was observed at the end of the tray line putting drinks on trays then stacking the trays on food transporters with no gloves. Staff U, DA was observed performing multiple tasks (putting items in dish area, washing dishes for Staff K, [NAME] to use) in between building trays and not completing proper hand hygiene in between task changes or before returning to the tray line. On 1/8/26 at 3:25p.m., an interview was conducted with Staff U, DA. Staff U stated No, she did not perform proper hand hygiene and glove use. On 1/8/26 at 3:36p.m., an interview with the DD was conducted. The DD stated the expectation for proper hand hygiene and glove use is for hands to be washed before and after each glove change, and for gloves to be changed before and after each change of task. The DD also stated that proper storage of items requires them to have a receive date and opened date, as well as being covered and closed to where there are no openings of the food item. A review of the facility's Food Storage for Dry Goods revealed: All dry goods will be appropriately stored in accordance with the FDA Food Code. All items will be stored on shelves at least 6 inches above the floor. All packaged and canned food items will be kept clean, dry, and properly sealed. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. A review of the facility's Food Storage for Cold Foods revealed: All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. All food items will be stored 6 inches above the floor and 18 inches below the sprinkler unit. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of the facility's Hand Hygiene policy revealed: All staff should perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hands are to be washed with soap and water when hands are visibly dirty, and after handling contaminated objects. Photographic evidence obtained 1/5/26.		