

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

PRINTED: 07/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2024
NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930		
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F 000	INITIAL COMMENTS *** The State Agency (SA) revised the 2567 on 7/12/24. Two changes were made. Under F689, the word "room" was added to CNA #4 interview dated 6/26/24 at 11:41 AM for clarification and the resident identifier "#2" was changed to "#1" for the interview with CNA#2 dated 6/26/24 at 1:36 PM due to a misidentification. *** The State Agency (SA) conducted a Complaint Investigation (CI) MS #25469 related to accidents and hazards at the facility on 6/26/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F689.	F 000			
F 689 SS=D	At the time of survey the facility had a census of 87 residents and was licensed for 110 beds. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide adequate supervision and monitoring to reduce the risk of accident and hazards for a cognitively impaired ambulatory resident for (1) one of (4)	F 689	Preparation and submission of this plan of correction by Crystal Rehabilitation & Healthcare Center, does not constitute an admission or agreement by the provider of truth of the facts alleged or the		7/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/12/2024

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.

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F 689	Continued From page 1 four residents reviewed for accidents. (Resident # 1) Findings include: Review of the facility policy titled, "Safety and Supervision of Residents," dated July 2017 revealed "Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities." ... Systems approach to safety: 2.) Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment... 3.) The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment or if there is a change in the resident's condition..." A record review of a facility reported incident revealed, on 6/12/24, around 6:35 AM, LPN (Licensed Practical Nurse) #2, who was assigned to Resident #2, observed Resident #1 exiting the room of Resident #2. LPN #2 then heard Resident #2 gasping for air, and upon entering her room, she saw a pillow and sheet covering Resident #2's face. The nurse yelled for help from CNA (Certified Nursing Assistant) #2 who was right outside the room. They immediately removed the sheet and the pillow, grabbed some wipes to dab her face to calm her down. RN (Registered Nurse) Supervisor #1 took vital signs and noted that Resident #2 had an increased	F 689	correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. On 6/12/24, the LPN (License Practical Nurse) #2 and CNA (Certified Nursing Assist) #2 immediately removed the pillow and sheet from Resident #2 face, applied wipes to calm her down. RN (Registered Nurse) Supervisor assessed and completed vitals on Resident #2. Resident #2 was evaluated by NP (Nurse practitioners) at the facility, then sent to ER (Emergency Room) to be further evaluation. Resident #1 was immediately placed on one-on-one supervision, then sent out for a psych evaluation on 6/13/24. Resident #1 remained on one-on-one supervision until she left the facility. On 6/12/24, body audits/assessments were completed on all residents with BIMS 12 and under. 89 residents had the potential to be affected. On 6/12/24, the DON (Director of Nursing) in serviced all nursing staff on Abuse/Neglect, Resident Rights, and the Vulnerable Adults Act. On 6/27/24, all nursing staff were in serviced by DON on policy "Safety & Supervision of residents" and "Policy for resident incidents & accidents" and behaviors. The QA committee reviewed said policies with no recommended changes to policy.		

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F 689	Continued From page 2 respiratory rate and a reddened face. Both nurses continued to check all vitals, performed incontinent care, and positioned Resident #2 comfortably in bed before exiting the room. An interview with the Director of Nursing (DON) on 6/26/24 at 9:25 AM revealed on 6/11/24, the afternoon before the incident, Resident #1 had been moved to another room because of a minor leak in the bathroom. Resident was ambulatory, and they did not want her to be injured until the water leak could be fixed in the bathroom. She stated that Resident #2, her roommate, remained in the room because she is bed bound and would not need to utilize the bathroom. She stated that the move was temporary and was explained to Resident #1. She stated when Resident #1 asked why Resident #2 was not moved, staff explained to her that Resident #2 was not ambulatory and did not use that bathroom. In an interview with CNA #4 on 6/26/24 at 11:41 AM, she revealed she worked 7:00 AM -7:00 PM on 6/11/24 and was assigned to Resident #1's prior room. She stated she observed Resident #1 attempting to enter her previous room at least three times, and she had to be redirected not to go in the room because it was not safe for her. She stated Resident #1 kept stating she could not understand why Resident #2 got to stay in the room and she didn't. CNA #4 stated she was unaware if any increased monitoring was put in place to observe Resident #1 closer. An interview with Resident #1's Resident Representative on 6/26/24 at 11:00 AM, revealed for the most part Resident #1 is alert and oriented but has frequent bouts of confusion and is very forgetful and change is hard for her. He then	F 689	Starting 6/27/2024 DON began monitoring behaviors weekly for 4 weeks to ensure the appropriate amount of monitoring is in place and then as behaviors occur. DON will take the findings to the QA committee. The QA Committee will evaluate the DON findings. QA committee will be reviewing findings of weekly behavior monitoring on 7-19-2024 and then monthly times three months and then quarterly. Completion date- 7/26/24		

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F 689	Continued From page 3 stated his sister has made the statement several times to him that she was upset and could not understand why she had to move out of her room and Resident #2 did not have to move and that she was upset about it. A phone interview with LPN #2 on 6/26/24 at 12:30 PM revealed she worked 7:00 PM-7:00 AM on 6/11/24 and was assigned to Resident #1's prior room. She stated that before the incident in the early morning of 6/12/24, she had observed Resident #1 going into her prior room on two separate occasions, and she had to be redirected. She stated each time Resident #1 expressed that she did not understand why Resident #2 got to stay in the room and she didn't. She stated she explained the safety reason to Resident #1 but confirmed Resident #1 has some confusion at times. She stated on the morning of 6/12/24 at approximately 6:35 AM she was making her final rounds and observed Resident #1 exiting her prior room. LPN #2 stated she asked Resident #1 what she was doing, and Resident #1 aggressively stated, "I have not been in there because the door is locked." She stated she then told Resident #1 she had to be careful there was a leak in that bathroom, and she was going to get hurt. LPN #2 then revealed she heard gasping sounds and coughing coming from the room and she and CNA #2 entered the room and observed Resident #2 with the top sheet and a pillow covering Resident #2's face and immediately removed it. She stated she and CNA #2 stayed with Resident #2 calming her down. LPN #2 was asked if she had increased monitoring of Resident #1 when she observed her on two previous occasions attempting to go into her prior room. She stated no she did not, she just redirected her to stop her from going into the	F 689			

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F 689	Continued From page 4 room because she was going to get hurt. In a phone interview with CNA #2 on 6/26/24 at 1:36 PM, she revealed she was assigned to Resident #1's previous room on 6/11/24, 11:00 PM-7:00 AM. She stated she saw Resident #1 walking the halls on the morning of 06/12/24 but thought nothing of it because she often does that. She stated she was making rounds that morning at about 6:30 AM and heard LPN #2 hollering for help and entered the room and observed the top sheet and pillow over Resident #2's face. She stated she and LPN #2 immediately removed the pillow and began calming Resident #2 down. She stated the last time she had seen Resident #2 was at 4:15 AM, and she repositioned her and made sure she was dry. In an interview with the Licensed Social Worker (LSW) on 6/26/24 at 3:00 PM, she revealed she was unaware that Resident #1 had attempted on several occasions to go into her prior room or that she was upset about the room move. She then confirmed that staff should have put increased monitoring in place to reduce her risk of injury because she kept attempting to enter the room. Record review of the June 2024 progress notes and physician's orders revealed no increased monitoring for Resident #1 after the move on 6/11/24 until 6/12/24 at 7:00 AM. In an interview with the DON on 6/26/24 at 3:00 PM, she revealed she was not made aware that Resident #1 had been attempting, on multiple occasions, to go back into her prior room or that she was upset about the move out of her room. In an interview with the Administrator on 6/26/24	F 689			

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F 689	Continued From page 5 at 4:00 PM, she verbalized that Resident #1 had been moved to different rooms in the past, and she had attempted to go back to those rooms too because that was the room she was used to. Record review of the Admission Record revealed the facility had admitted Resident #1 to the facility on 1/29/24 with diagnoses including Unspecified Convulsions and Seizure Disorder. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 5/6/24, revealed that Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated that she was severely cognitively impaired. Record review of the Admission Record revealed the facility admitted Resident #2 to the facility on 10/27/21 with diagnoses including Hydrocephalus, Aphasia, and Quadriplegia. Record review of the MDS, Section C with an ARD of 05/15/24, revealed that Resident #2 is "rarely or never understood," which indicated severe cognitive impairment.	F 689			