

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

PRINTED: 11/26/2024
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 10/24/2024
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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey with a complaint investigation (CI MS #26450) at the facility from 10/22/24 through 10/24/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F677 and F656 for both CI MS# 26450 and the annual survey for failure to provide Activities of Daily Living (ADLs). The SA also cited F550, F582, F583, F584, F641, F687, F688, F865, F880, F882 and F925. The census at the time of the survey was 96 with a bed capacity of 110 beds.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550			11/22/24

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

TITLE

(X6) DATE

Electronically Signed

11/14/2024

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 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to ensure that residents' dignity was not compromised as evidence by Multi Drug Resistant Organism (MDRO) signs on resident's doors for 12 of 96 residents reviewed for dignity. Findings Include: Record review of the facility policy titled, "Resident Rights" with a revision date of 1/11/24 revealed that..."Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside Facility. Facility must protect and promote the rights of each resident, including each of the following rights: 1. Exercise of Rights	F 550	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F550- Resident Rights/Exercise of Rights On 10/22/24, Infection Preventionist removed the Multi Drug Resistant Organism (MDRO) signs from the doors of resident rooms 110, 111, 122, 125, 128,		

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F 550	Continued From page 2 ...c. Resident has the right to be treated with dignity and respect for the personal integrity of the individual ..." An observation on 10/22/24 during initial tour of the resident doors in the facility revealed there were MDRO signs on the doors of the following rooms: 110, 111, 122, 125, 128, 132, 208, 215, 218, 223, 225, and 228. An interview and observation on 10/23/24 at 8:45 AM, with Registered Nurse (RN) #1 confirmed that Residents #4 and #19 had signs on their room doors that read, "Multi Drug Resistance Organisms-MDRO is a threat to the residents". She stated that neither of these residents had MDRO. She revealed she thinks they put that up on their doors because those residents needed Enhanced Barrier Precautions (EBP). She revealed she thinks these MDRO signs would be a dignity issue for the resident since it implied the resident had MDRO. An interview and observation on 10/23/24 at 9:00 AM, with the Assistant Director of Nurses (ADON)/Infection Preventionist (IP) confirmed that Resident #4, #19, and #38 had signs on their door that read MDRO, and they do not have MDRO. She realizes that is the wrong sign to have put on their door. She confirmed that none of these residents have MDRO, but even if they did, we would not put that on their doors. She confirmed they had put those signs on the doors of any resident that needed Enhanced Barrier Precautions (EBP) but revealed she has the correct signs for EBP. She stated there was only one resident in the building that has MDRO. She confirmed that those signs were inappropriate and would be a dignity issue for those residents.	F 550	132, 208, 215, 218, 223, 225, and 228. Proper signage for droplet isolation was placed on residents' doors of rooms 110, 111, 122, 125, 128, 132, 208, 215, 218, 223, 225 and 228. 2. All residents have the potential to be affected. 3. On 10/24/24, Corporate Clinical Specialist (CCS) educated the Director of Nursing (DON) and the Infection Preventionist/Assistant Director of Nursing (ADON) on applying the appropriate signage to residents' doors and on Residents Rights. 4. Beginning on 10/24/24, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON)/Infection Preventionist will conduct observations of residents' doors three (3) times a week for four (4) weeks then monthly for three (3) months to ensure proper signage is placed. The DON or ADON will report findings to the Quality Assurance Performance Improvement Committee on 11/19/24 and monthly for three (3) months for review and further recommendations.		

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F 550	Continued From page 3 An interview on 10/23/24 at 9:15 AM, with the Administrator confirmed that having signs on resident doors that read "MDRO is a threat to our residents" would be a dignity issue for the residents residing in those rooms. Record review of the MDRO signage revealed it read; "Multidrug-resistant organisms (MDROs) are a threat to our residents" in bold print at the top of the sign. Below the header it read "Enhanced Barrier Precautions (EBP) Steps ..."	F 550			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582			11/22/24

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F 582	Continued From page 4 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNOC) was provided for two (2) of three (3) residents reviewed for beneficiary notices. Resident A and Resident B. Findings included: Review of the facility policy "Form Instructions for	F 582	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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.		

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F 582	Continued From page 5 the Notice of Medicare Non-Coverage (NOMNOC) CMS-10123" revealed " When to deliver the NOMNOC, A Medicare provider ...must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNOC) to beneficiaries/enrollees receiving covered skilled nursing ...services. The NOMNOC must be delivered at least two calendar days before Medicare covered services end ..." A completed Beneficiary Protection Notification Review was provided by the Business Office Manager (BOM) on 10/22/24 at 2:05 PM, that indicated Resident A had a Medicare Part A stay from 6/7/24 through 7/19/24, and Resident B had a Medicare Part A stay from 6/14/24 through 6/21/24, with no supporting documentation, such as a NOMNOC or Advanced Beneficiary Notice (ABN). An interview on 10/23/25 at 8:05 AM, with the BOM revealed that Resident A and Resident B were discharged from skilled services and the facility when their therapy goals were met. She verified that Resident A had 58 skilled days remaining and Resident B had 93 skilled days remaining when they were discharged. She verified that she did not provide either resident with a NOMNOC. She stated that she was not aware that she should have provided the residents with a NOMNOC. She revealed that she thought that NOMNOC's were only provided to residents receiving Medicare Part A services if they were managed care and the managed care determined that they were no longer going to pay for the resident's services. She agreed there was no documentation that either resident initiated their discharge from Medicare Part A services. The BOM added that she is not notified of a	F 582	F582 On 10/25/2024 Revenue Cycle Specialist educated Business Office Manager (BOM) on when Notice of Medicare Non-Coverage (NOMNC) notices should be given and how the NOMNC should be filed. NOMNCS were not issued to residents A or B. Residents that receive skilled services have the potential to be affected. On 10/28/24 NOMNC audit was conducted by the BOM and Revenue Cycle Specialist, with no additional issues identified. Beginning the week of 11/4/2024 the Administrator and BOM will audit potential discharges three (3) times a month to ensure appropriate documentation is completed. Will observe three (3) audits a week for four (4) weeks then monthly for three (3) months and then quarterly. The administrator will report to Quality Assurance Improvement Committee beginning 11/19/2024 and monthly for three (3) months and then quarterly for further review and recommendations. The administrator is responsible for monitoring and compliance.		

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F 582	Continued From page 6 resident's discharge from Medicare Part A services until on or after their discharge date. An interview with the Administrator on 10/23/24 at 8:07 AM, she agreed that the NOMNOCs should have been provided to Resident A and Resident B prior to discharge. She stated that the BOM must not have known to do it.	F 582			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable	F 583		11/22/24	

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F 583	Continued From page 7 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to secure electronic health records as evidenced by an Electronic Medication Administration Record (EMAR) visible while the medication cart was unattended on the East Short Wing medication cart for one (1) of three (3) medication carts. Resident #13 Findings Include: Review of the facility policy titled, "Resident Rights" with a revision date of 1/11/24 revealed, "12 ... Privacy and Confidentiality. Resident has the right to personal privacy and to confidentiality of his/her personal and clinical records". An observation on 10/23/24 at 8:05 AM, of a computer that was located on an unattended medication cart on the East Short Wing revealed the computer was opened with Resident #13's EMAR information visible on the screen and the screen was visible to anyone passing by the cart. The visible information included Resident #13's name, medications, and room number. An interview on 10/23/24 at 8:08 AM, Registered Nurse (RN) #1 revealed she is assigned to the medication cart and confirmed that the EMAR for Resident #13 was visible on the screen to anyone walking by and was supposed to be closed when	F 583	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F583- Personal Privacy/Confidentiality of Records On 10/23/24, Registered Nurse (RN) #1 was in-serviced by Assistant Director of Nursing (ADON) on Resident Rights with confidentiality of residents personal and clinical records. RN #1 cleared resident #13 clinical information from the computer screen. All residents have the potential to be affected. On 10/28/24, licensed nurses were in-serviced by Director of Nursing (DON) on Residents Rights with confidentiality of resident personal and clinical records. On 10/28/24, Director of Nursing (DON) or		

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F 583	Continued From page 8 she was away from the cart. She revealed that this is a violation of keeping the resident's medical records private. An interview on 10/23/24 08:44 AM, the Assistant Director of Nurses (ADON) revealed that a resident's information should never be left up on the computer screen while the cart is unattended and revealed that there is a privacy button that is supposed to be pushed before the nurse steps away from the computer. The ADON confirmed this is a privacy issue. Record review of Resident #13's "Admission Record" revealed the resident was admitted to the facility on 05/29/2021 with diagnoses that included Aphasia, Cerebral infarction, and Traumatic Hemorrhage of Cerebrum.	F 583	Assistant Director of Nursing (ADON) will make rounds observing/auditing three (3) medication carts three (3) times a week for four (4) weeks and then monthly for three (3) months to ensure privacy and residents rights are maintained as it pertains to residents personal and clinical records. Director of Nursing (DON) or Assistant Director of Nursing (ADON) will report findings to the Quality Assurance Performance Improvement Committee starting 11/19/24, then monthly for three (3) months. Any concerns will be addressed immediately and any corrective action will be evaluated by the QAPI committee for further recommendations. The Director of nursing (DON) is responsible for ongoing compliance.		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		11/22/24	

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F 584	Continued From page 9 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary and comfortable resident environment, as evidenced by flies in residents room (Resident # 2 and Resident #7), dirty sheet and leaking air conditioning unit (Resident # 13), a dirty personal fan (Resident # 29) and a dirty floor and foul odor in resident's room (Resident # 86) for five (5) of 25 sampled residents. Findings Include: Review of the facility policy titled, "Building	F 584	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F584- Safe/Clean/Comfortable/Homelike Environment On 10/22/24, housekeeping immediately		

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F 584	Continued From page 10 Inspections" undated, revealed under, "Policy: Conduct routine building inspections on a monthly basis to identify potential problems and perform any required maintenance." Review of the facility policy titled "Cleaning and Disinfection of Resident-Care Items and Equipment" with a revision date of 3/23, revealed under, "Policy Interpretation and Implementation: c... (3)... Disinfection is performed with an EPA (Environmental Protection Agency)-registered disinfectant labeled for use in healthcare settings." A review of a letter on company letterhead, dated 10/23/24 and signed by the Administrator, revealed the facility does not have a policy for cleaning resident personal fans. Review of the facility policy titled "Pest Control" undated, revealed under, "Policy: Conduct pest control by an outside vendor on a routine basis to maintain the Community in a safe and sanitary condition." Also, revealed under, "Procedures: 1. Perform pest control on a consistent basis to ensure that the building is maintained in a pest-free condition." Resident # 2 and Resident #7 An observation of Resident #2 on 10/22/24 at 9:56 AM, revealed that the resident was lying in his bed with the cover pulled up over his head. Further observation revealed four (4) flies on the bed spread, three (3) flies on the privacy curtain, and one (1) fly on the footboard. A blue plastic bin was sitting on the floor at the end of the bed that held shoes with five (5) flies hovering over the bin and landing inside.	F 584	deep cleaned residents #2 and #7 room. On 10/22/24, maintenance removed flies from residents #2 and #7 room. On 10/22/24, Certified Nursing Assistant (CNA) changed Resident #13 leaking air conditioning unit. On 10/22/24, Housekeeping Manager deep cleaned resident #86 room. On 10/23/24, a service ticket was called in to Pest Control to come treat for flies. Pest control treated residents #2 and #7 room on 10/24/24. All residents have the potential to be affected. On 10/23/24, in-service was held for all housekeeping personnel by District manager on housekeeping job descriptions and cleaning methods. On 10/23/24, in-service was held by Director of Nursing (DON) with Certified Nursing Assistants on changing bed linen when soiled and placing work orders in Technology Based System (TELS) for any pest control concerns. On 10/23/24, in-service was held with the Maintenance Director by the Regional Maintenance Director on making timely repairs on leaking air conditioning units, and the policy regarding equipment being in good working condition was reviewed. On 10/24/24, housekeeping manager implemented increased cleaning of residents #2 and #7 room to three (3) times daily. On 11/11/24, the Maintenance Director will make walking rounds three (3) times a week for four (4) weeks then monthly for		

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F 584	Continued From page 11 An observation of Resident #7 (roommate to Resident #2) on 10/22/24 at 9:50 AM, revealed the resident lying in his bed with the cover over his head. Further observation revealed eight (8) flies on top of the bed spread and two (2) flies on the privacy curtain. An interview with Housekeeping #1 on 10/22/24 at 9:59 AM, confirmed the flies in Resident #2 and #7's room. He revealed the flies had been an ongoing concern in the room. He explained it was difficult to handle the flies and cleanliness of the room. An interview with the Assistant Director of Nursing (ADON) on 10/22/24 at 10:58 AM, confirmed the flies had been an issue for a while. She revealed they had a couple of doors at the back of the building that were opened and closed frequently throughout the day, and explained that was probably where they came in. An observation of Resident #2 on 10/22/24 at 12:36 PM, revealed he was sitting on the side of his bed eating his lunch meal with four (4) flies seen flying over and landing on the meal tray. The resident made no attempts to swat the flies. An interview with Certified Nurse Aide (CNA) #5 on 10/23/24 at 9:58 AM, confirmed flies and cleanliness had been a concern for Resident #2 and #7's room for a while. She revealed they both smear feces and take their briefs off and throw them in the floor. An interview with the ADON on 10/23/24 at 10:08 AM, revealed housekeeping was in the room all the time to address the uncleanliness of the room	F 584	three (3) months to identify leaking air conditioning units in resident rooms. On 10/24/24, the housekeeping manager will make walking rounds three (3) times a week for four (4) weeks then monthly for three (3) months to identify any foul odors, dirty floors in resident rooms, and any personal fans that need to be cleaned. On 10/24/24, housekeeping manager will conduct an audit of residents #2 and #7 room twice daily for four (4) weeks to monitor pest control concerns. On 10/24/24, Director of Nursing (DON) will make walking rounds three (3) times a week for four (4) weeks and then monthly for three (3) months to ensure bed sheets are clean and dry. Each department will report findings to the Quality Assurance Performance Improvement Committee monthly for three (3) months, starting 11/19/24. The Administrator is responsible for on-going monitoring and compliance.		

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F 584	Continued From page 12 and the flies and verbalized it was a challenge because both residents smeared feces. She revealed keeping the residents' environment clean was everybody's responsibility and had to be a group effort. An interview with Maintenance #2 on 10/23/24 at 1:04 PM, revealed he had not been made aware of any fly issues in the building. An interview with the Administrator (ADM) on 10/23/24 at 1:13 PM, revealed she had not been made aware of any fly concerns in the building. She revealed that she makes daily rounds and stated she had not seen any flies or been told by staff that flies were an issue. She revealed that the resident's room stayed nasty because both of those residents played in stool. The ADM explained housekeeping cleaned the room every day and more often, verbalizing it was a "constant thing". She revealed they had not taken any extra measures to combat fly activity in the building. She acknowledged the residents should have a clean and sanitary environment. An interview with the ADON on 10/24/24 at 8:16 AM, confirmed that anytime flies were around or got onto the food there was a risk for illness. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 2/26/03 with medical diagnoses that included schizophrenia and vascular dementia. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 10/3/22 with a medical diagnosis of vascular dementia.			F 584			

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F 584	Continued From page 13 Resident #13 An observation of Resident #13's room on 10/22/24 at 10:12 AM, revealed two (2) white sheets with a yellowish-brown substance on them that were placed underneath the air conditioning unit. An observation and interview with Housekeeping #3 on 10/22/24 at 10:16 AM, confirmed the sheets were under the unit to capture water because the unit was leaking onto the floor. He revealed they had several units in disrepair, but they do not have a full-time maintenance person. He revealed they have someone who comes once a week to help fix things. An interview with Registered Nurse (RN) #1 on 10/23/24 at 9:01 AM, revealed if they have an issue that needs to be repaired, they were to add it into the computer work-order system for maintenance. An interview with the ADON on 10/23/24 at 10:08 AM, revealed they use a computer system for work order, to input the things needed to be fixed by maintenance. She revealed if something came up that required immediate attention, they would call the administrator, and she would call corporate. An interview with Maintenance #2 on 10/23/24 at 1:04 PM, revealed he had been filling in since February 2024 because the facility did not have a maintenance person. He revealed he comes to the facility once weekly and makes random room rounds. He revealed he gets the maintenance issues from the computer work order system, and the administrator shows him some of the things	F 584			

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F 584	Continued From page 14 that need repairing. Maintenance #2 revealed he had not been made aware of any issues regarding Resident #13's leaking air conditioning unit. He explained the only reason the unit would leak would be if the filter was dirty and needed cleaning. An interview with the ADM on 10/23/24 at 1:13 PM, revealed she was not aware of Resident #13's leaking air conditioning unit and confirmed a repair request had not been submitted into the work order system for maintenance. She acknowledged the resident's equipment should be in good repair. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 5/29/21. Resident #86 An observation of Resident #86's room on 10/22/24 at 10:54 AM, revealed a foul odor upon entry. Further observation revealed the resident lying in her bed. There were eight (8) to 10 spots on the floor that were dried, smeared, dark brown and irregular in size, with the largest being approximately five (5) inches by three (3) inches in size. An interview and observation with the ADON on 10/22/24 at 10:58 AM, confirmed the foul odor in Resident #86's room and replied, "What is that smell?" She confirmed the brown substance on the floor looked like stool and acknowledged the resident should have a clean room and confirmed this was not acceptable conditions for the resident.	F 584			

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F 584	Continued From page 15 An interview with the ADON on 10/23/24 at 10:08 AM, revealed keeping the resident's environment clean was everybody's responsibility. She revealed the aides and nurse were responsible for cleaning the stool off the floor when it was encountered. Record review of the "Admission Record" revealed the facility admitted Resident #86 on 9/12/24 with medical diagnoses that included altered mental status. Resident # 29 An observation and interview with Resident #29 on 10/22/24 at 9:01 AM, revealed a 20-inch round auscultating fan on Resident #29's bedside table with the entire fan blades and the external outer covering of the fan covered in a thick black buildup. Resident #29 stated she uses the fan every night. She confirmed she had asked multiple staff, including housekeeping, to please clean the fan for the last few months, but stated staff always told her they will get the maintenance director to take care of it. An observation of the fan on Resident #29's bedside table with Certified Nurse Assistant (CNA) #2 on 10/23/24 at 10:00 AM, she confirmed the fan was covered in a thick black buildup including the fan blades and the outer cover of the fan. She then stated the fan needed to be cleaned because the dust particles could blow all over the resident and possibly make her sick. An observation of the fan in Resident # 29's room from the doorway with Housekeeper #1 on	F 584			

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F 584	Continued From page 16 10/23/24 at 10:10 AM, he confirmed the fan was covered in a thick black dust built up and stated the housekeepers clean in here every day and should have cleaned the fan to prevent dust build up from blowing on the resident. Review of the "Admission Record" revealed the facility admitted Resident # 29 on 1/26/2019. Record review of Resident # 29's Section C of the Annual Minimum Data Set (MDS) with an Assessment Reference Date of 8/16/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.	F 584			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, facility policy review, and Resident Assessment Instrument (RAI) review, the facility failed to ensure that the Minimum Data Set (MDS) was coded accurately for four (4) of 26 sampled residents. Resident #13, # 47, 56, and #62. Findings Include: Review of the facility policy titled, "MDS Coding Policy" with a revision date of January 4, 2023, revealed, "Proper facility Name affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment,	F 641	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F641- Accuracy of Assessments On 10/24/24, Minimum Data Set (MDS) nurse reviewed annual MDS with	11/22/24	

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F 641	Continued From page 17 timely and accurately." Resident #13 Record review of the MDS with an Assessment Reference Date (ARD) of 8/12/24 revealed that Resident #13 is taking an anticoagulant medication and was not taking an antiplatelet. Record review of the August 2024 Medication Administration Record (MAR) revealed that Resident #13 did not receive anticoagulant medications for the month of August but did receive Aspirin (ASA) An interview with the Registered Nurse (RN)/MDS on 10/23/24 at 3:40 PM confirmed the MDS was coded wrong and stated that Resident #13 did receive an antiplatelet (ASA) but not an anticoagulant. She confirmed the MDS should be done accurately so that the resident got the care he needed. An interview with the Assistant Director of Nurses (ADON) on 10/24/24 at 8:15 AM revealed her expectation was for the MDS to be coded correctly and when signing off on the assessment ensure it was correct before closing. Record review of Resident #13's "Admission Record" revealed the facility admitted the resident on 5/29/21. Resident #47 Record review of the MDS with an ARD of 08-19-2024, revealed under section N, Resident #47 received seven (7) days of Anticoagulant medication for the observation look back period	F 641	Assessment Reference Date (ARD) date of 8/12/24 section N for resident #13 for accuracy and corrected and resubmitted resident #13 as receiving an antiplatelet instead of an anticoagulant. On 10/23/24, MDS nurse reviewed, corrected and resubmitted annual MDS with ARD date 8/19/24 section N for resident #47 as receiving an antiplatelet instead of an anticoagulant. On 10/23/24, MDS nurse reviewed, corrected and resubmitted annual assessment with ARD date 11/20/2023 section A questions 1500 A, B, and C to identify that resident #56 as having a diagnosis of mental illness. On 10/23/24, MDS nurse reviewed, corrected and resubmitted resident #62 quarterly MDS assessment dated 9/3/24 section GG 0115 A, B, to include that resident #62 having an impairment to one side of his upper body and impairment of both sides of his lower extremities. All residents have the potential to be affected. On 10/23/24, an in-service was conducted by Regional Case Mix RN with MDS nurses on the requirements to accurately code MDS assessments in accordance with the Resident Assessment Instrument manual. On 10/29/24, and audit of MDS assessment that were submitted in the past ninety (90) days of current residents was completed by Regional Case Mix nurse with no other issues identified. On 10/29/24, Minimum Data Set (MDS) will conduct weekly audits for five (5) MDS		

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F 641	Continued From page 18 of 8/13/24 through 8/19/24. Record review of the MAR for the MDS 7-day observation look-back period for anticoagulant medication revealed Resident #23 did not receive anticoagulant medication between 8/13/24 and 8/19/24. An interview with the MDS Coordinator on 10/23/24 at 1:15 PM confirmed that Resident #47 was coded on the 7-day look-back period for receiving an anticoagulant medication. She revealed that Resident #47 did not receive an anticoagulant medication, and it was coded in error. Record review of the Admission Record for Resident #47 revealed he was admitted to the facility on 03/12/2021. Resident #56 Record review of the "Admission Record" for Resident #56 revealed the facility admitted the resident on 12/6/21 and has a diagnosis of Schizophrenia. Record review of Resident #56's annual MDS with an ARD of 11/20/23 revealed in Section A question 1500 that the resident has not been identified as having a diagnosis of mental illness as defined by PASRR (Pre-Admission Screening and Resident Review). Record review of the summary of findings report from PASRR Office for Resident #56 dated 12/16/23 indicated that the individual meets criteria for having a diagnosis of mental illness as defined by PASRR.	F 641	assessments for four (4) weeks and then monthly for three (3) months and quarterly thereafter to review for accuracy of coding. A report of audit findings will be submitted by MDS nurse to the Quality Assurance Performance Improvement Committee beginning 11/19/24 and monthly for three (3) months for further review for monitoring, compliance and recommendations. Regional Case Mix Reimbursement Specialist is responsible for monitoring and ongoing compliance.		

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F 641	Continued From page 19 An interview with the RN/MDS Nurse on 10/23/24 at 1:30 PM verified that Resident #56's MDS with an ARD of 11/20/23 was coded incorrectly. She agreed that the importance of correctly coding MDS was to ensure residents received the care they needed. Resident #62 Review of item GG0115 of the Minimum Data Set (MDS) dated 9/3/24 : Functional Limitation in Range of Motion: coded 0 for no impairment to upper or lower extremities. A record review of the physician's order for Resident #62 revealed "Staff to apply L hand splint before breakfast and remove after dinner daily for 8 (eight) hours, wear as tolerated and provide skin hygiene before and after wear every shift". An interview with RN/MDS on 10/23/24 at 1:47 PM, she revealed after review of the section GG of the MDS dated 9/3/24 for Resident #62 that it was coded incorrectly. She stated the purpose of coding the MDS correctly is to ensure a correct depiction of the resident is obtained and the resident receives the care and services needed. Review of the "Admission Record" revealed the facility admitted Resident #62 on 3/1/23 with a diagnosis of Hemiplegia and Hemiparesis following nontraumatic intracerebral hemorrhage affecting left non dominant side.	F 641			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656			11/22/24

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F 656	Continued From page 20 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656			

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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 10/24/2024
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 656	Continued From page 21 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for a resident that was dependent on staff for nail care and shaving (Resident #11, #13, #47, #51) and failed to implement a care plan for a resident requiring a hand splint (Resident #62) for five (5) of 29 care plans reviewed. Findings Include A review of the facility policy titled, "Care Plans, Comprehensive, Person-Centered," revealed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident 's physical, psychosocial and functional needs is developed and implemented for each resident..." Resident #11 - Cross Reference F677, F687 Record review of the Care Plan for Resident #11 revealed "I have Diabetes Mellitus... Interventions, Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails...Diabetic Nail care weekly per nurse". During an observation and interview with Resident #11 on 10/22/24 at 10:05 AM, she removed her left sock and shoe and pointed to	F 656	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 656 Develop/Implement Comprehensive Care Plan On 10/25/2024 the Podiatrist trimmed Resident # 11 toenails. On 10/23/2024 Register Nurse (RN) trimmed Resident # 13 fingernails. On 10/23/2024 Certified Nurse Assistant (CNA) shaved Resident #47 face and trimmed the resident's fingernails. On 10/23/2024 Registered Nurse trimmed Resident # 51 toenails. On 10/23/2024 Certified Nurse Assistant (CNA) applied splint to Resident # 62 left hand. All residents have the potential to be affected. On 10/28/2024 Director of Nursing (DON) in-serviced Nurses and Certified Nursing		

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F 656	Continued From page 22 her left great toe, which was one-half inch (1/2) long and jagged. Resident #11 expressed that she had not seen a podiatrist recently nor could she recall the last time her toenails were cut. Record review of the "Podiatric Services Report" for Resident #11 revealed that she had not been seen by a podiatrist since 5/1/23. In an observation and interview on 10/23/24 at 9:00 AM, with Registered Nurse (RN) #1, she verified that Resident 11's left great toenail was long and jagged. She also acknowledged that she was unaware of the last time Resident #11's toenails were cut but confirmed that they needed trimming. Interview with the Registered Nurse (RN)/Minimum Data Set Nurse (MDS) on 10/23/24 at 1:35 PM confirmed that if Resident #11 did not receive toenail care or see podiatrist then the care plan was not followed. A record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/4/24 for Resident #11 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact. The "Admission Record" review indicated that the facility admitted Resident #11 on 1/7/16 with a diagnosis of Diabetes Mellitus. Resident #13 Record review of the Care Plans for Resident #13 revealed under, "Focus: I have a self-care deficit related to impaired mobility, left	F 656	Assistants (CNA) on trimming fingernails and toenails and apply splints per the care plan. On 10/28/2024 Director of Nursing (DON) or Assistant Director of Nursing (ADON) will make walking rounds to ensure Activities of Daily Living (ADLS) to include trimming toenails, fingernails and apply splints are being performed per the care plan to ensure no other residents are affected. DON will observe fifteen (15) residents a week for four (4) weeks then monthly for three (3) months and then quarterly. DON will report to Quality Assurance Performance Improvement Committee beginning on 11/19/2024 and monthly for three (3) months and then quarterly for further review and recommendations. DON is responsible for monitoring and compliance.		

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F 656	Continued From page 23 hemiplegia/hemiparesis, contractures, and seizures." Also revealed under, "Interventions:.. Bathing/showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse... prefers nails to be cut short." An observation of Resident #13 on 10/22/24 at 10:12 AM revealed he was lying in bed with his eyes open. The fingernails on both hands were long, measuring approximately one-half (1/2) inch in length past the tip of his fingers. An observation and interview with RN #1 on 10/23/24 at 8:58 AM, confirmed Resident #13 had long nails. An interview with the RN/MDS Nurse on 10/23/24 at 3:40 PM revealed the purpose of the care plan was to help ensure the staff were doing the best care for the residents. She confirmed Resident #13's care plan was not followed for nail care. Record review of the Admission Record revealed the facility admitted Resident #13 on 5/29/21 with medical diagnoses that included type 2 Diabetes Mellitus, and Hemiplegia and Hemiparesis following Cerebral Infarction. Resident #47 Record review revealed a care plan in place for Resident #47 with a focus of Activities of Daily Living (ADL) self-care performance deficit related to impaired balance, limited mobility due to Hemiplegia and Hemiparesis following cerebral infarction with an intervention of prefers bathing on M, W, F (Monday, Wednesday and Friday); check facial hair & nails, prefers mustache and	F 656			

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F 656	Continued From page 24 beard trimmed, prefers nails to be cut short. During an observation and interview on 10/22/24 at 9:50 AM, revealed Resident #47's fingernails on bilateral hands were approximately one-half (1/2) inch long past the tips of his fingers, and a brown substance was underneath the fingernails. Resident #47 had facial hair on his chin and neck, approximately one and a half (1.5) inches long. Resident #47 revealed that it's been over two months since his nails were cut and face shaved. He revealed that he goes to the beauty shop monthly, and she cuts his hair, but if he wants to be shaved by her, it costs extra, and he can't afford that. He revealed that the Certified Nurse Assistant's (CNA) don't shave him or even offer. Resident #47 revealed, I like to be shaved and for my fingernails to be cut short. An interview and observation on 10/23/24 at 9:35 AM, with the Assistant Director of Nurses (ADON) revealed that the CNA's are responsible for shaving Resident #47 and cutting and cleaning his fingernails. She confirmed that he needed to be shaved, and his fingernails needed to be cleaned and trimmed and revealed that Resident #47's ADL care plan was not being followed. An interview on 10/23/24 at 1:20 PM, the RN/MDS Nurse revealed she is part of the team that develops each residents' individualized care plan. She revealed if the resident's ADL care plan was not followed then it is a concern because he is not getting the care that he is supposed to be receiving. Record review of the Admission Record for Resident #47 revealed he was admitted to the facility on 03/12/2021 with diagnoses that	F 656			

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F 656	Continued From page 25 included Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side, and Muscle Weakness. Record review of the MDS with an ARD of 8/19/2024, revealed under Section C, BIMS score of 15 indicating Resident #47 is cognitively intact. Resident #51 In an interview with Resident #51 on 10/22/24 at 9:45 AM, she revealed she had been asking staff about trimming her toenails for over two months. An observation of Resident # 51's nails revealed all toenails to be long and jagged with the right great toenail observed to be approximately one inch in length and jagged in appearance. A review of a care plan for Resident # 51 titled, "I have an ADL performance deficit related to (r/t) Activity Intolerance, Impaired balance and Limited Mobility," revealed, Interventions: "nails trimmed and clean." In an interview with the ADON on 10/23/24 at 10:12 AM confirmed that staff failed to implement Resident #51's care plan for trimming nails. Review of the Admission Record revealed the facility admitted Resident # 51 on 6/30/22 with diagnoses of Morbid Obesity and Cellulitis. Record review of Resident #51's Section C of the MDS with an ARD of 7/22/24 revealed a BIMS) score of 14, indicating the resident was cognitively intact. Resident #62- Cross Reference F688			F 656			

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F 656	Continued From page 26 A review of a care plan titled, "I have an ADL performance deficit" for Resident # 62 revealed, Interventions: Staff to apply L (left) hand splint before breakfast and remove after dinner daily for 8 (eight) hours wear as tolerated and provide skin hygiene before and after wear every day shift. Every shift related to Hemiplegia and Hemiparesis affecting the left non-dominant side. An observation and interview on 10/22/24 at 10:15 AM, with Resident # 62 revealed the resident to have a left-hand contracture with no hand splint in use. No hand splint was observed in the resident's room. In an interview with Resident # 62, he revealed that the staff didn't put anything on his hand. In an interview with CNA #2 on 10/23/24 9:37 AM, she confirmed that Resident #62 did not have his splint on his left hand on Tuesday, 10/22/24, because he only wears his left-hand splint on Monday, Wednesday, and Friday. In an interview with the ADON on 10/23/24 at 10:12 AM confirmed that staff failed to implement Resident # 62's care plan for the hand splinting device when the device was not applied. She revealed that the purpose of the care plan is to direct the individual care needs of residents. Review of the Admission Record revealed the facility admitted Resident # 62 on 3/01/23 with a diagnosis of Hemiplegia and Hemiparesis following a nontraumatic intracranial hemorrhage. Record review of Resident #62's Section C of the MDS with an ARD of 9/3/24 revealed a BIMS) score of 08, indicating the resident was moderately cognitively impaired.	F 656			

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide personal hygiene for four (4) of 26 sampled residents as evidenced by failure to provide nail care (Resident #11, #13, #47, and #51) and shave a resident (Resident # 47). Findings Include: Review of the facility policy titled, "Activities of Daily Living (ADL) Supporting" with a revision date of March 2018 revealed, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." Resident #11- Cross Reference F687 An interview and observation on 10/22/24 at 10:05 AM with Resident #11 revealed the resident is non-verbal but indicated that she does not receive toenail care. The resident pulled off her left sock and shoe and pointed to her left great toe and her left 5th small toe. This observation revealed that the resident's left great toenail was jagged and 1/2 inch long with a band aid dated	F 677	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 677/M610 ADL Care Provided for Dependent Residents On 10/25/2024 Podiatrist trimmed Resident # 11 toenails. On 10/23/2024 Register Nurse (RN) trimmed Resident # 13 fingernails. On 10/23/2024 Certified Nursing Assistant (CNA) trimmed Resident # 47 fingernails and shaved Resident # 47. On 10/23/2024 Registered Nurse trimmed Resident # 51 toenails. On 10/29/2024 The Director of Nursing (DON) and The Assistant Director of Nursing (ADON) assessed all residents for personal care needs. All residents have the potential to be affected. On 10/28/2024 Director of Nursing	11/22/24	

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F 677	Continued From page 28 10/21/24 on her left 5th toe. Resident #11 picked up a 1/2-inch sized item off of her bed and verified it was the toenail from her left 5th toe, by shaking her head yes. The resident indicated, by shrugging her shoulders, that she had not recently seen a Podiatrist, nor did she recall the last time her toenails had been cut. An observation and interview on 10/23/24 at 9:00 AM with Registered Nurse (RN) #1 she verified that Resident #11's left great toenail was long and jagged. She stated that if the resident is diabetic then it is the RN's responsibility for cutting the resident's nails. She verified that she had no idea when the resident had last seen the Podiatrist or had her toe nails cut, but that the resident did need them cut. An interview with the Assistant Director of Nursing (ADON) on 10/23/24 at 9:15 AM she confirmed that the nurses were responsible for cutting toenails for residents who were diabetic. She stated that residents' toenails should be checked daily during care and cut if needed. She stated that they did not have a schedule for checking and cutting toenails. She verified that Resident #11 had lost the toenail on her left 5th toe, but she was unsure how. The ADON agreed that the lack of nail care could have contributed to the resident losing her toenail. Record review of the Podiatric Services Report for Resident #11 revealed that she was last seen by a podiatrist on 5/1/23. An Interview with the ADON on 10/23/24 at 1:45 PM verified that Resident #11 had not seen a podiatrist since 5/1/23. She stated that they currently did not have a podiatrist to see the	F 677	in-serviced Nurses and Certified Nursing Assistants' (CNA) on performing Activities of Daily Living (ADL) to include trimming fingernails, toenails, and shaving residents. On 10/28/2024 Director of Nursing (DON) and Assistant Director of Nursing (ADON) will make walking rounds to ensure Activities of Daily Living (ADL) are provided to resident to include fingernail, toenail, and shaving. Will observe fifteen (15) residents a week for four (4) weeks then monthly for three (3) months and then quarterly. Director of Nursing (DON) will report to Quality Assurance Improvement Committee beginning on 11/19/2024 and monthly for three (3) months and then quarterly for further review and recommendations. Director of Nursing and Assistant Director of Nursing is responsible for monitoring and compliance.		

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F 677	Continued From page 29 residents and was unsure of how long they had been without one. She verified that foot care and nail care had not been provided for Resident #11 and this could have contributed to her losing her toenail. A review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/4/24 for Resident #11 revealed a Brief Interview of Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact. The "Admission Record" review revealed that the facility admitted Resident #11 on 1/7/16 with a diagnosis of Diabetes Mellitus. Resident #13 An observation of Resident #13 on 10/22/24 at 10:12 AM revealed he was lying in bed with his eyes open. The fingernails on both hands were long, measuring approximately one-half (1/2) inch in length. An observation and interview with RN #1 on 10/23/24 at 8:58 AM confirmed Resident #13 had long nails and could potentially scratch someone or himself. She revealed the nails should be checked with bathing and stated the resident was diabetic and his nails must be cut by a nurse. She revealed the nails should be checked every week to see if they needed trimming. An interview with the ADON on 10/23/24 at 9:05 AM revealed a nurse must cut Resident #13's nails because he was diabetic. She confirmed he could scratch himself and with him being diabetic that could cause issues. She revealed the facility did not have a task set up for the diabetics to get	F 677			

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F 677	Continued From page 30 nail care routinely, it was just something they knew to do. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 5/29/21 with medical diagnoses that included Type 2 Diabetes Mellitus, Hemiplegia and Hemiparesis following Cerebral Infarction. Resident #47 An observation and interview on 10/22/24 at 9:50 AM, revealed Resident #47's fingernails on both hands were approximately one-half (1/2) inch long past the tips of his fingers with a brown substance underneath the fingernails. Resident #47 had facial hair on his chin and neck, approximately one and a half (1.5) inches long. Resident #47 revealed that it's been over two months since he had his nails cut or his face shaved. He revealed that he goes to the beauty shop every month, and she cuts his hair, but if he wants to be shaved by her, it costs extra, and he can't afford that. He revealed that the Certified Nurse Assistants (CNA) do not offer to shave him. Resident #47 revealed he likes to be shaved and for his fingernails to be short. An observation on 10/22/24 at 1:50 PM revealed that Resident #47's appearance had not changed from the earlier observation. An observation on 10/23/24 at 08:36 AM revealed Resident #47's appearance was unchanged from the previous day. An interview and observation on 10/23/24 at 9:05 AM, Certified Nurse Aide (CNA) #7 revealed that she is assigned to Resident #47 today, and it is the CNA's responsibility to shave the resident and	F 677			

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F 677	Continued From page 31 do his nail care. She confirmed that Resident #47 needed to be shaven, and his fingernails were long and dirty. An interview on 10/23/24 at 9:25 AM, the Activities Director (AD) revealed Resident #47 goes to the beauty shop every month to have his hair cut, and sometimes the beauty shop worker will trim up his beard, but she does not shave him. She revealed that shaving him is the responsibility of the CNAs. During an interview and observation on 10/23/24 at 9:35 AM, the ADON revealed that the CNA's are responsible for shaving the resident and cutting and cleaning his fingernails. She confirmed that Resident #47 needed to be shaved, and his fingernails needed to be cleaned and trimmed. Resident #47 stated to ADON that it had been two months since he had been shaved and had his fingernails cleaned and cut. Record review of the "Admission Record" for Resident #47 revealed he was admitted to the facility on 03/12/2021 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side and Muscle Weakness. Record review of the MDS with an ARD of 8/19/2024, revealed under Section C, BIMS score of 15 indicating Resident #47 is cognitively intact. Resident #51 An observation and interview on 10/22/24 at 9:45 AM, Resident #51 revealed she has been asking staff about trimming her toe nails for over two	F 677			

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F 677	Continued From page 32 months. An observation of the resident's nails revealed all toenails to be long and jagged with the right great toenail to be approximately one inch in length and jagged in appearance. She stated she is not a diabetic and can't understand why staff won't cut them. She then stated a nurse told her she would get podiatry to come cut them but that was months ago and that never happened. An observation and interview on 10/23/24 at 9:22 AM of Resident # 51's toenails with Licensed Practical Nurse (LPN) #3, she confirmed the resident's toenails were very long and jagged with the right great toe to be very long. She confirmed the nails appeared that they had not been trimmed in a while and stated there was no medical reason that the nurses or CNAs could not trim them. She then revealed that possible concerns from not trimming the nails are that she could scratch her legs with the jagged nails and also the nails could have grown into the skin causing skin concerns. An interview with the CNA #3 on 10/23/24 at 10:08 AM she revealed she was unaware of why Resident # 51's toenails had not been trimmed. She stated the CNA'S switch sections every other day and stated the nurse trimmed the toenails earlier today and confirmed they were really long and jagged. Review of the "Admission Record" revealed the facility admitted Resident # 51 on 6/30/22 with diagnoses of Morbid Obesity and Cellulitis. Record review of Resident #51's Section C of the MDS dated 7/22/24 revealed a BIMS score was 14, indicating the resident was cognitively intact.	F 677			

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F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record reviews and facility policy review, the facility failed to ensure foot care was completed for one (1) of four (4) sampled residents. Resident #11. Cross Reference: F 677 Findings Include: Record review of "Foot Care" policy revised October 2022 revealed "Policy Statement, Residents receive appropriate care and treatment in order to maintain mobility and foot health. Policy Interpretation and Implementation, 1. Residents are provided with foot care and treatment in accordance with professional standards of practice...3. Residents are assisted in making appointments with...specialists (podiatrist, endocrinologist, etc.) as needed. 4. Trained staff may provide routine foot care (e.g. toenail clipping) within professional standards of practice..."	F 687	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F687- Foot Care On 10/25/24, the Podiatrist trimmed Resident #11 toenails. Facility had already obtained a contract with a Podiatrist. Podiatrist's first day to start was 10/25/24. All residents have the potential to be affected. On 10/28/24, Director of Nursing (DON) in-serviced Nurses and Certified Nursing		11/22/24

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F 687	Continued From page 34 On 10/22/24 at 10:05 AM, during an observation and interview with Resident #11 she removed her left sock and shoe and pointed to her left great toe, which was one-half inch (1/2) long and jagged. Resident #11 expressed a desire to have her toenails trimmed and indicated that she had not seen a podiatrist recently nor could she recall the last time her toenails were cut. Resident #11 then picked up a one-half inch (1/2) item from her bed and pointed to her left fifth toe, which was covered with a bandage. She indicated that the item was the toenail from her left fifth toe, which had come off. On 10/23/24 at 9:00 AM, an observation and interview with Registered Nurse (RN) #1, she verified that Resident #11's left great toenail was long and jagged. She stated that if a resident is diabetic, it is the nurse's responsibility to trim the resident's nails. She acknowledged that she was unaware of the last time Resident #11's toenails were cut but confirmed that they needed trimming. A review of the "Podiatric Services Report" for Resident #11 showed that she was last seen by a podiatrist on 5/1/23. On 10/23/24 at 9:15 AM, an interview with the Assistant Director of Nursing (ADON) she revealed that the nursing staff is responsible for trimming toenails for diabetic residents. She stated that residents' toenails should be checked daily during routine care and trimmed as needed, though there is currently no schedule for this. The ADON also confirmed that Resident #11 had lost the toenail on her left fifth toe but was unsure how it occurred.	F 687	Assistants (CNA) on performing Activities of Daily Living (ADL) on providing nail care to residents and the importance of scheduled and as needed nail care, and reporting to the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) if a resident needs to be seen by the Podiatrist. On 10/28/24, Director of Nursing (DON) and Assistant Director of Nursing (ADON) will make walking rounds to ensure Activities of Daily Living (ADL) are provided to residents to include trimming toenails. The Director of Nursing (DON) and Assistant (ADON) will assess fifteen (15) residents a week for four (4) weeks then monthly for three (3) months then quarterly to ensure nail care is sustained. Any findings of concern will be addressed immediately. The Director of Nursing (DON) will report findings to the Quality Assurance Performance Improvement Committee beginning 11/19/24 and monthly for three (3) months and then quarterly for further review and recommendations. Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are responsible for monitoring and compliance.		

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F 687	Continued From page 35 On 10/23/24 at 1:45 PM, a follow-up interview with the ADON she confirmed that Resident #11 had not seen a podiatrist since 5/1/23. She mentioned that the facility is in the process of securing a podiatrist, though one is currently unavailable. She was unsure how long the facility had been without podiatric services. The ADON verified that foot and nail care had not been provided for Resident #11 and acknowledged that this lack of care could have contributed to the loss of the toenail. A review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/4/24 for Resident #11 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact. The "Admission Record" review indicated that the facility admitted Resident #11 on 1/7/16 with a diagnosis of Diabetes Mellitus.	F 687			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		11/22/24	

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F 688	Continued From page 36 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide the services, care, and equipment to assure a resident maintained, and improved to his/her highest level of range of motion (ROM) and mobility for one (1) of five (5) residents for positioning and mobility reviewed. (Resident # 62). Findings include: A review of the facility policy titled, "Contracture Management Program," revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of Range of Motion..." An observation on 10/22/24 at 10:15 AM revealed Resident #62 to have a left-hand contracture with no splinting device in use, and no device observed in the resident's room. In an interview with Resident #62, he revealed that the staff did not put anything on his hand. A review of the physician's order for Resident #62 dated 2/23/24, revealed "Staff to apply (L) left-hand splint before breakfast and remove after dinner daily for eight (8) hours wear as tolerated and provide skin hygiene before and after wear every day shift. every shift related to Hemiplegia and Hemiparesis following affecting the left non	F 688	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 688/M625 Increase/Prevent Decrease in ROM/Mobility On 10/23/2024 Certified Nursing Assistant (CNA) applied left hand splint to Resident # 62. On 10/23/2024 Certified Nursing Assistant was given a one-on-one in-service by the Assistant Director of Nursing (ADON) on reading the Kardex to identify when splints need to be applied. All residents have the potential to be affected. On 10/28/2024 Director of Nursing (DON) in-serviced Nurses and Certified Nursing Assistants (CNA) on apply splints to increase/prevent decreased range of motion. On 10/28/2028 Director of Nursing (DON)		

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F 688	Continued From page 37 dominant side." An observation of Resident #62's hands on 10/22/24 at 3:15 PM, revealed no splinting device observed on Resident #62's left hand. On 10/23/24 at 9:37 AM, an interview with Certified Nurse Assistant (CNA) #2 she confirmed that Resident #62 did not have his splint on his left hand on Tuesday, 10/22/24 because he only wears his left-hand splint on Monday, Wednesday, and Friday. She then stated she believed therapy was supposed to apply the splint on those days. In an interview with Licensed Practical Nurse (LPN) #3 on 10 /23/24 at 9:50 AM, she confirmed that Resident #62 should have been wearing his left-hand splint on 10/22/24. She revealed the left-hand splint should be applied every morning before breakfast by the CNAs and removed at bedtime by the CNAs. She then revealed that staff not applying the splinting device could result in worsening of the contracture. In an interview with the Occupational Therapist on 10/23/24 at 10:47 AM, she confirmed that Resident #62 should be wearing a left-hand splint daily. She confirmed that staff not applying the splint could result in a decline in ROM. In an interview with the Assistant Director of Nursing (ADON) on 10/23/24 at 10:12 AM, she confirmed staff failed to follow the physician's orders for applying Resident #62's left-hand splint when the splint was not applied as ordered. Review of the "Admission Record" revealed the facility admitted Resident # 62 on 3/01/23 with a	F 688	or ADON will make walking rounds to observe five (5) residents a week for application of splints for four (4) weeks then monthly for three (3) months then quarterly for thereafter. The Director of Nursing (DON) will report to the Quality Assurance Improvement Committee beginning on 11/19/2024 and monthly for three (3) months then quarterly for further review and recommendations. Director of Nursing (DON) and Assistant Director of Nursing (ADON) are responsible for monitoring and compliance.		

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F 688	Continued From page 38 diagnosis of Hemiplegia and Hemiparesis following a nontraumatic intracranial hemorrhage. Record review of Resident #62's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/24 revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating the resident was moderately cognitively impaired.	F 688			
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each	F 865		11/22/24	

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F 865	Continued From page 39 annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:	F 865			

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F 865	Continued From page 40 §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure	F 865	Preparation and submission of this plan of correction by Crystal Rehabilitation and		

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F 865	Continued From page 41 there was an effective Quality Assurance and Performance Improvement (QAPI) program, as evidenced by repeat deficiencies for Activities of Daily Living (ADL) F677 over the last three annual surveys. Findings Include Review of the facility policy titled, "(Proper facility name) QAPI Program" with no revision date revealed under the "Purpose Statement ...The purpose of Quality Assurance Performance Improvement committee is to create a system for improving the care for our residents ..." An interview on 10/24/24 at 10:54 AM with the Corporate Nurse revealed the QAPI committee met with all department heads after the last survey in 6/2023, in 7/23 they met and went over anything that was trending based on the monitoring that was put into place after the survey that resulted in deficiencies and in 9/23, they went back to reviewing normal stuff. She stated that monitoring was supposed to have continued for the deficiencies from the last survey, but she is not sure that it did. She revealed that she thinks that there are repeat deficiencies due to a new Administrator and a new Assistant Director of Nurses (ADON). An interview on 10/24/24 at 11:15 AM with the Administrator confirmed that she understands that the facility should not have had an ADL issue for three years in a row. She thinks the problem is communication between the nurses and the Certified Nursing Assistants (CNA) and the supervision of the CNAs by the nurses to make sure the work is done.	F 865	Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 865 QAPI On 10/28/2024 the Administrator held a Quality Assurance and Performance Improvement (QAPI) meeting with discussion on focus area trending with Activities of Daily Living (ADL) care and annual survey results. All residents have the potential to be affected. On 10/29/2024 the Administrator was in-serviced by Senior Administrator on Quality Assurance Improvement (QAPI) and bringing survey results for the past three (3) years to address trends to include Activities of Daily Living (ADL) care and focus areas that need improvement. Beginning on 11/19/2024 a Quality Assurance Improvement meeting will be held with the interdisciplinary team monthly for six (6) months and then quarterly thereafter to discuss survey results to include ADL care and focus areas of improvement.		

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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 10/24/2024
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 865	Continued From page 42 An interview on 10/24/24 at 11:25 AM with the Corporate Nurse agreed that there should not be repeated deficiencies for ADLS . She confirmed she had made rounds and every so often she would find issues with the nails. She stated that the Registered Nurses (RN) would fix it, but she is not sure why they would not continue. She confirmed that continued monitoring by the administrative nursing staff could have confirmed ADL issues. Record review of the Corporate Nurse's rounds revealed that on 2/21/24 and 4/10/24 ADL issues were found related to fingernails, toenails and shaving. Record review of the CASPER3 (Certification and Survey Provider Enhanced Reports) confirmed that the facility had an ADL deficiency for their last two annual surveys.	F 865			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		11/22/24	

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F 880	Continued From page 43 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880			

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F 880	Continued From page 44 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to inform staff and visitors of residents that were in Transmission-Based Precautions (TBP) for six (6) of six (6) positive COVID-19 residents reviewed. Residents #6, #28, #29, #38, #81, and #84. Cross Reference F882 Findings Include: Record review of the facility policy titled, "COVID-19 Policy and Procedures" with a revision date of 9/15/23 revealed under, "Training: Signage should be posted describing ways to prevent the spread of germs and protect against COVID-19 virus". This record review revealed under "Core Principles of COVID-19 Infection Prevention ...Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene) and appropriate staff use of Personal Protective Equipment (PPE). An interview on 10/22/24 at 9:05 AM, with	F 880	Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 880/M1570 Infection Prevention Control On 10/22/2024 the appropriate Transmission Based Precaution (TBP) signage was placed on the door of Residents #6, #28, #29, #38, #81, and #84 to let staff and visitors know the resident was in droplet isolation due to Covid-19. On 10/29/2024 Corporate Clinical Specialist (CCS) in-serviced the Director of Nursing (DON) and the Infection Preventionist on Transmission Based Precautions (TBP) and appropriate signage for resident doors to let staff and visitors know that a resident is in isolation.		

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F 880	Continued From page 45 Certified Nurse Assistant (CNA) #1 revealed the facility is in a COVID-19 outbreak and she thinks they have about 30 residents positive. An observation on the initial tour of the facility on 10/22/24 at 9:15 AM, revealed there was no signage on the residents' doors identifying who was on TBP. An interview on 10/22/24 at 9:50 AM, with the Assistant Director of Nurses (ADON)/Infection Preventionist (IP) confirmed the facility has been in a COVID-19 outbreak for a week and she thinks she was the first positive, but she is not certain. She stated she tested positive on 10/14/24 and had worked that day passing medications on the 100 halls. She stated that she was off work for several days and the Director of Nurses (DON) covered for her, but now she is sick with COVID-19. She stated that on 10/16/24 Resident #6 was lethargic and got sent to the hospital where he tested positive for COVID-19. She stated that after this resident was sent to the hospital, they tested all the residents and found 27 positives, but no one had any symptoms. She confirmed that signs should have been put on the residents' doors indicating they were in TBP. She stated that she just failed to follow-up and make sure it was done after she returned to work on Friday 10/18/24. An interview on 10/23/24 at 2:50 PM, with the Administrator confirmed that signage should have been put on the COVID-19 resident's doors for staff and visitors to know the resident was in Transmission-Based Precautions. She admitted that they needed to be stricter on their infection control to prevent the spread of infections and ensure that all staff and visitors were aware which	F 880	All residents have the potential to be affected. On 10/28/2024 the Director of Nursing (DON) in-serviced nursing staff on appropriate signage on residents' doors for residents who are on Transmission Based Precautions. On 10/28/2024 the Infection Preventionist will make observation rounds on five (5) resident rooms that are in Transmission Based Precautions to see if the door has the appropriate signage weekly times four (4) weeks and then monthly for three (3) months. The infection Preventionist will report to the Quality Assurance Improvement Committee (QAPI) beginning on 11/19/2024 and then monthly for three (3) months for review and recommendations.		

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F 880	Continued From page 46 residents were in TBP. She stated that they continued to monitor residents for symptoms, staff worked to keep residents at least 6 feet away from other staff and residents as possible and require everyone wear a mask when they enter the facility. She also stated that staff self-monitor and let their supervisor know if they are symptomatic. She revealed that the facility COVID-19 vaccination rate for 2023 was 66% and for 2024 so far it is 76%. Record review of facility vaccination rates for COVID-19 confirmed that 2023's rate was 66% and for 2024 so far, the rate is 75.80%. Record review of the resident testing for COVID-19 from 10/16/24 revealed there were 27 positive residents identified that included Residents #6, #28, #29, #38, #81, and #84. Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 5/22/24. Record review of Resident #28's "Admission Record" revealed the resident was admitted to the facility on 2/27/20 with. Record review of Resident #29's "Admission Record" revealed the resident was admitted to the facility on 1/26/19 Record review of Resident #38's "Admission Record" revealed the resident was admitted to the facility on 4/19/24. Record review of Resident #81's "Admission Record" revealed the resident was admitted to the facility on 5/16/24.			F 880			

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F 880	Continued From page 47	F 880			
F 882 SS=F	Record review of Resident #84's "Admission Record" revealed the resident was admitted to the facility on 7/5/24. Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to ensure the Infection Preventionist fully implemented the Infection Control Program, as evidence by failure to ensure signage was applied to resident's rooms that were under Transmission-Based Precautions and complete surveillance for the current COVID-19 outbreak for one (1) of three (3) days of survey. Cross Reference F880	F 882		11/22/24	
			Preparation and submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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.		

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F 882	Continued From page 48 Findings Include: Record review of the facility policy titled, "COVID-19 Policy and Procedures" with a revision date of 9-15-23 revealed under, "Training: Signage should be posted describing ways to prevent the spread of germs and protect against COVID-19 virus...Core Principles of COVID-19 Infection Prevention ...Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene) and appropriate staff use of Personal Protective Equipment (PPE). An interview on 10/22/24 at 9:05 AM, with Certified Nurse Assistant (CNA) #1 stated that the facility is in a COVID-19 outbreak, and she thinks they have about 30 residents that are positive. On the initial tour of the facility on 10/22/24 at 9:15 AM it was observed that there were no signage on resident's doors identifying who was in transmission base precautions due to COVID-19. An interview on 10/22/24 at 9:50 AM, with the Assistant Director of Nurses (ADON)/Infection Preventionist (IP) confirmed the facility has been in a COVID-19 outbreak for a week. She confirmed that signs should have been put on the residents' doors indicating they were in transmission base precautions. She admitted that she had not done any surveillance for this outbreak or had an in-service with staff. She	F 882	F 882 Infection Preventionist Qualification Role On 10/22/2024 the appropriate Transmission Based Precaution (TBP) signage was placed on the door of Residents #6, #28, #29, #38, #81, and #84 to let staff and visitors know the resident was in droplet isolation due to Covid-19. On 10/29/2024 Corporate Clinical Specialist (CCS) in-serviced the Director of Nursing (DON) and the Infection Preventionist on Transmission Based Precautions (TBP) and appropriate signage for resident doors to let staff and visitors know that a resident is in isolation and surveillance of infections. All residents have the potential to be affected. On 10/28/2024 the Director of Nursing (DON) in-serviced nursing staff on appropriate signage on residents' doors for residents who are on Transmission Based Precautions. On 10/28/2024 the Director of Nursing (DON) will make observation rounds on five (5) resident rooms that are in Transmission Based Precautions to see if the door has the appropriate signage weekly times four (4) weeks and then monthly for three (3) months. The DON will report to the Quality Assurance Improvement Committee (QAPI) beginning on 11/19/ 2024 for review and recommendations.		

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F 882	Continued From page 49 stated that someone had sent a text message out to staff to let them know we were in an outbreak. She stated that she did not realize she needed to do surveillance and just failed to make sure signs were put on the positive resident's doors. An interview on 10/23/24 at 9:30 AM, with the Occupational Therapist revealed that she felt that the facility was not communicating outbreaks to therapy in order for them to be informed to prevent the spread of infection when they were in resident rooms providing care. She confirmed that she had not seen any signage on resident doors prior to entering. An interview on 10/23/24 at 2:50 PM, with the Administrator confirmed that they needed to be stricter on their infection control to prevent the spread of infections. Record review of the facility in-services revealed that the last in-service regarding infection control was on 10/9/24 indicating "all trays need to be picked up after every meal". Record review of the resident testing from 10/16/24 revealed there were 27 positive residents identified.	F 882			
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain an	F 925	Preparation and submission of this plan of correction by Crystal Rehabilitation and		11/22/24

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F 925	Continued From page 50 effective pest control regimen against flies as evidenced by fly sightings in a resident room for two (2) of 89 residents. Resident #2, and #7. Findings Include: Cross-Reference F584 Review of the facility policy titled "Pest Control" undated, revealed under, "Policy: Conduct pest control by an outside vendor on a routine basis to maintain the Community in a safe and sanitary condition." Also, revealed under, "Procedures: 1. Perform pest control on a consistent basis to ensure that the building is maintained in a pest-free condition." On 10/22/24 at 9:50 AM, an observation of Resident #7 revealed, the resident lying in his bed with the cover over his head. Further observation revealed that there were eight (8) flies on top of the bed spread and two (2) on the privacy curtain. On 10/22/24 at 9:56 AM, an observation of Resident #2 (roommate to Resident #7) revealed the resident was lying in his bed with the cover pulled up over his head. Further observation revealed 4 flies on the bed spread, three (3) flies on the privacy curtain, and one (1) on the footboard. A blue plastic bin was sitting in the floor at the end of the bed that held shoes with five (5) flies hovering over the bin and landing inside randomly. On 10/22/24 at 9:59 AM, an interview with the Housekeeping #1 confirmed the presence of flies in Resident #2 and #7's room. He revealed the flies had been an ongoing concern in their room. He explained the room was cleaned daily, but it	F 925	Healthcare Center does not constitute an admission or agreement by the provider of truth of the facts alleged or the 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. F 925/M970 Maintains Effective Pest Control Program On 10/22/2024 the Maintenance Director killed the flies in residents #2 and #7 room. On 10/24/2024 the pest control company ECO came to the facility to spray pests. All residents have the potential to be affected. On 10/28/2024 the Director of Nursing in-serviced nursing staff to report any citing of pests in the facility to the Director of Nursing, Assistant Director of Nursing, Administrator and Maintenance. On 11/11/2024 Maintenance Director will make walking rounds monitoring for flies in fifteen (15) resident room three (3) times a week for four (4) weeks then monthly for three (3) months. The Maintenance Director will report the findings to the Quality Assurance Improvement Committee (QAPI) beginning 11/19/2024 monthly for three (3) months and then every three (3) months for review and recommendations.		

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F 925	Continued From page 51 was difficult to handle all the flies and cleanliness of that room. On 10/22/24 at 10:58 AM, an interview with the Assistant Director of Nursing (ADON) confirmed the flies had been an issue for a while. She revealed they have a couple of doors on the back that were opened and closed frequently throughout the day and explained that may be where they came in. On 10/22/24 at 12:36 PM, an observation of Resident #2 revealed, he was sitting on the side of his bed eating his lunch meal, with four (4) flies seen flying over and landing on the meal tray. The resident made no attempts to swat the flies. On 10/23/24 at 9:58 AM, interview with Certified Nurse Aide (CNA) #5 confirmed flies and cleanliness had been a concern for Resident #2 and #7's room for a while. She revealed that both residents smear feces and take their briefs off and throw them in the floor. On 10/23/24 at 10:08 AM, an interview with the ADON revealed housekeeping was in the room all the time to address the uncleanliness of the room and the flies. She stated it was a challenge because both residents smeared feces. She revealed keeping the residents' environment clean was everybody's responsibility and had to be a group effort. On 10/23/24 at 1:04 PM, an interview with Maintenance #2 revealed he had been filling in for the position since February 2024 because the facility did not have a maintenance person. He revealed he comes to the facility once weekly and makes random room rounds. He revealed he had	F 925			

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F 925	Continued From page 52 not been made aware of any fly issues in the building. On 10/23/24 at 1:13 PM, interview with the Administrator (ADM) revealed, she had not been told about any concerns with flies in the building. She revealed that she makes daily rounds and stated she had not seen any flies or been told by staff that flies were an issue. She revealed that the room stayed nasty because both of those residents played in stool. The ADM revealed the pest control company came out on 10/16/24 and they had not done any extra measures to combat fly activity. She acknowledged the residents should have a clean and sanitary environment. On 10/24/24 at 8:16 AM, an interview with the ADON confirmed that anytime flies were around or got onto the food there was a risk for illness.	F 925			