

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42CG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/03/2025
NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CEN1		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) COMPLETE DATE
M 000	Initial Comments On 04/03/25 the State Agency (SA) conducted an on site complaint investigation (CI MS# 28467, CI MS# 27933 and CI MS# 27848) for concerns related to the environment and resident rights. The SA did not substantiate the complaints and no deficiencies were cited. The SA determined that the facility was in compliance with the requirements for The Aged and Infirm. The facility census was 85 and the facility held a license for 110 beds.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

04/14/25