STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	**902 SGT JOHN A PITTMAN DRIVE , GREENWOOD, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted five (5) Complaint Investigations (CI MS #2602935, CI MS #2642536, CI MS #2642546, CI MS #2644846, and CI MS #2684512) at the facility from 12/8/25 through 12/9/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA cited F686 related to pressure ulcer treatment for CI MS #2642536 and CI MS #2642546. There were no citations for CI MS #2602935, CI MS #2644846, and CI MS # 2684512. The census at the time of the survey was 75 with a bed capacity of 110 beds.	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and facility policy review, the facility failed to ensure timely assessment, physician notification, and initiation of appropriate treatment for an identified pressure ulcer to prevent further deterioration and promote healing for one (1) of three (3) residents reviewed for pressure ulcers. Resident #1.	F0686		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0686 SS = G	Continued from page 1 Findings Include:Record review of facility policy " The [Proper Name of Corporation] Skin Integrity Prevention and Treatment Program" revealed "...Weekly Skin Integrity Checks a. Weekly assessment looking for new wounds-completed by a licensed nurse; b.Document on/in Treatment Record; c. If new area found...Notify Medical Doctor (MD) -obtain treatment orders..." Record review of a Progress Note dated 1/17/25 documented by Licensed Practical Nurse #1 (LPN #1) revealed Resident #1 was noted with an open wound to the left upper extremity below the elbow with sanguineous drainage present. The note indicated first aid treatment was initiated and that the oncoming nurse and treatment nurse would be notified; however, there was no documentation to support that a physician was notified or that treatment orders were obtained at that time. Interview with Resident #1 on 12/9/25 at 12:30 PM, revealed the resident was unable to recall when or how the wound to the left elbow occurred. Record review of the January 2025 Treatment Administration Record revealed no wound care treatment orders were obtained from 1/17/25 until 1/22/25. Record review of a Surgical Note dated 1/22/25, from the wound care physician revealed Resident #1 had a Stage IV Pressure Ulcer to the left elbow with pre-op measurements of 1.5 centimeters (cm) length by 1.0 cm width with depth undetermined. The wound presented with moderate serosanguineous drainage, unhealthy surrounding tissue, and slough present requiring surgical debridement of devitalized subcutaneous, muscle, fascia and tendon tissue. Post-op measurement was 1.5 cm length by 1 cm width by 0.3 cm depth. Interview with the Treatment Nurse on 12/9/25 at 12:45 PM, revealed she stated that when a wound is identified, the physician should be notified for treatment orders. Telephone interview with LPN #1 on 12/9/25 at 1:02 PM, revealed she verified the resident had an open wound to the left elbow and acknowledged she did not notify the physician for treatment orders. She agreed the physician should have been notified. Interview with the Director of Nursing (DON) on 12/9/25 at 1:30 PM, revealed there was no documentation to support that wound care treatment was initiated prior to the wound care physician's assessment on 1/22/25.	F0686		

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F0686 SS = G	Continued from page 2 The DON agreed treatment orders should have been obtained when the wound was identified. Record review of the “Admission Record” revealed that the facility admitted Resident #1 on 10/15/21 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-dominant Side. Record review of the “Minimum Data Set Assessment” (MDS) with an Assessment Reference Date (ARD) of 10/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.	F0686		