STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 recertification survey from 3/4/19 through 3/7/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid requirements for participation. The SA cited deficiencies at F644, F656, F658, and F880. The census at the time of survey was 97 and the facility held a license for 110 beds.	F 000		
F 644 SS=F	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy, review the facility failed to refer residents for a Level II evaluation that was later identified with a new Mental Disorder diagnosis.	F 644	1. Resident's #46,#30, and #66 had a psychiatric diagnosis added after the initial Level I Pre-Admission Screening and Resident Review (PASRR). A level II	4/6/19

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

Electronically Signed | 04/09/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 644	Continued From page 1 This occurred for three (3) of three (3) Pre-admission Screening and Resident Review (PASRR) reviews completed. Resident #30, Resident #46, and Resident #66. Findings include: A review of the facility's policy PASRR Policy and Procedure, dated 7/18/18, revealed the facility uses the most current version of PASRR Rules of the Administrative Code, Medicaid Title 23, Part 207, Chapter 1 as they pertain to PASRR Level I, Level II (PE), Specialized Services and IDT meetings. Resident #30 A review of Resident #30's medical record revealed the Resident was admitted to the facility on 7/12/16, and a Pre Admission Screening (PAS) was completed on 7/13/16. Further review of Resident #30's medical record revealed a new diagnosis of Schizoaffective Disorder, Bipolar Type on 1/21/17. There was no evidence to indicate a Level II evaluation was completed at the time of the new diagnosis. Resident #66 A review of Resident #66's medical record revealed the resident was admitted to the facility on 1/18/17, and a Level I PAS was completed on 2/17/17. A Level II screening was not required at that time. Further review of Resident #66's medical record revealed a new diagnosis of Paranoid Schizophrenia on 6/15/18. A review of Resident #66's medical record revealed a Level II evaluation was not performed when Resident #66 received the new diagnosis of Paranoid Schizophrenia, which should have been done at that time.	F 644	significant change PASRR was submitted for further Medicaid consideration on 03/14/19 by Registered Nurse (RN)Supervisor. No changes have been noted at this time. 2.All resident have the potential to be affected by this deficient practice. An audit was completed on 03/11/19 on six residents that have a mental illness diagnosis noted after admission by the Social Services Director. Three more residents were identified as having had new psychiatric diagnosis added after admission. Level II significant change PASRR was submitted for further Medicaid consideration on 03/14/19 by RN Supervisor. No changes have been noted at this time. 3. Social Services Director, Administrator, and the Director of Nursing were educated on the PASRR Level II significant change when new psychiatric diagnosis is added by Corporate Clinical Specialist on 03/11/19. 4. Beginning the week of 03/11/19, the physician orders regarding new diagnosis will be reviewed against existing diagnosis daily for five (5) days, weekly for four (4)weeks, and monthly thereafter, by the Director of Nursing/Assistant Director of Nursing, for any new psychiatric diagnosis added after admission and validate a Level II Change in Status Request has been submitted. The Director of Nursing will report findings to the Quality of Assurance Performance Improvement Committee for review and further recommendations. The Director of Nursing is responsible for monitoring and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 644	Continued From page 2 On 3/7/19 at 8:12 AM, during an interview, the Director of Social Services (DSS) stated she was responsible for ensuring Level II evaluations were completed. She stated a Level II was not done when the resident received a diagnosis of Paranoid Schizophrenia and should have been done at that time. The DSS stated normally she is notified in the morning stand up meeting of a new diagnosis, but was not aware of this residents diagnosis. On 3/8/19 at 10:20 AM, an interview with the Administrator revealed Level I and Level II evaluations are performed by Social Services. The Administrator stated Level I and Level II evaluations are completed upon admission as needed and when a new diagnosis requiring a Level II is received. The Administrator stated a new diagnosis requiring a Level II should be discussed in the morning meeting. Resident #46 Record review for Resident #46 revealed the resident was admitted on 05/08/2018, with a Preadmission Screening and Resident Review (PASRR) and a negative level 1 screening on 05/14/2018. Record review of Resident #46's diagnosis sheet revealed that Resident #46 had a new Mental Disorder diagnosis of Schizophrenia on 05/28/2018, with no level II documented at that time. An interview on 03/06/2019 at 9:33 AM, with the Business Office Manager, confirmed that Resident #46 had not been referred for a level II evaluation after a new Mental Disorder diagnosis of Schizophrenia on 05/28/2018.	F 644	Compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 644	Continued From page 3 An interview on 03/06/2019 at 10:00 AM, with the Social Service Director confirmed that it was her responsibility to complete the PASRR and referral for a level II determination. The Social Service Director stated that the purpose of the level II evaluation is to determine the care that the resident needs and confirmed that Resident #46 should be referred for a level II evaluation with a new mental illness diagnosis of Schizophrenia. The Social Service director confirmed that Resident #46 had not been referred for a level II screening after a new Mental Disorder diagnosis of Schizophrenia. An interview with the Director of Nursing (DON) on 03/06/2019 at 10:12 AM, revealed that the staff responsible for completing the PASRR and referral for a level II screening was informed in morning interdisciplinary meetings of any new diagnosis.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		4/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 656	Continued From page 4 (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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan related to administration of medication/inhalers, for one (1) of 20 resident records reviewed for care plans, Resident #92. Findings include: Record review of the facility's "Care Plan Completion" policy, not dated, revealed after completing the Minimum Data Set (MDS) and the	F 656	1. On 3/7/19 Resident #92 was offered opportunity to rinse mouth after the use of the inhaler per care plan intervention by Licensed Practical Nurse (LPN)#1. The Director of Nurses did a visual assessment of the inside of the mouth of Resident #92. There were no signs or symptoms of irritation, redness, or thrush on 03/06/19. On 03/06/19, the inhaler was discarded and replacement obtained by the Assistant Director of Nurses. 2. Thirty six Residents, with inhaler	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 656	Continued From page 5 Care Area Assessment (CAA) portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the Interdisciplinary Team (IDT) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs. Record review of the comprehensive care plan, for Resident # 92, revealed the resident had altered respiratory status/difficulty breathing with the intervention that directs nursing to administer medications/puffers as ordered. Record review, of Resident #92's physician's orders, revealed an order for Fluticasone-Salmeterol Aerosol (Advair) Powder Breath Activated 500-50 MCG (microgram)/DOSE, initiated on 1/23/19. Instructions included: Give one (1) puff-inhale orally one (1) time a day for shortness of breath (sob). Rinse mouth with water after use. Do not swallow. On 03/06/19 at 8:15 AM, during an observation of medication administration, revealed Licensed Practical Nurse (LPN) #1 administered Advair inhaler to Resident #92. LPN #1 did not offer or instruct the resident to rinse her mouth and spit the water. Resident #92 did not rinse her mouth after use of the inhaler. On 3/7/19 at 10:36 AM an interview with Registered Nurse (RN) #1, the Minimum Data Set Coordinator,confirmed the nursing staff know they	F 656	orders, were evaluated for signs and symptoms of side effects of irritation, redness, or thrush by the Registered Nurse Supervisor, Director of Nursing, Assistant Director of Nursing, and the Staff Development Coordinator on 03/13/19. There were no negative findings. 3. Upon notification on 03/07/19, LPN#1 was immediately educated on offering residents that are administered inhalers to rinse mouth and spit the water by the Staff Development Coordinator. Beginning on 03/07/19, licensed nursing staff were educated on offering residents that are administered inhalers to rinse mouth and spit the water as indicated on their care plans to avoid the irritation of the oral cavity by the Staff Development Coordinator and the Assistant Director of Nursing. 4. Beginning the week of 03/11/19, observations of the administration of inhalers will be conducted by Staff Development Coordinator, Assistant Director of Nursing, and RN Supervisor in regards to observing licensed nurse offer residents to rinse and spit water following administration of inhalant. Observations will be conducted three (3) times per week for four (4) weeks, then once weekly for four (4) weeks, and monthly thereafter. Any negative findings will be reported to the Quality Assurance Performance Improvement Committee by Director of Nursing monthly for three (3) months for review and recommendation. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 656	Continued From page 6 are to follow the care plan, which states to follow the physicians orders and the Medication Administration Record (MAR). On 3/7/19 at 10:45 AM, an interview with Licensed Practical Nurse (LPN) #1 confirmed the care plan instructed the nurse to administer medication/puffers as ordered. On 03/07/19 at 01:30 PM, an interview with Resident #92 confirmed she had not been rinsing and spitting out water after inhaling the Advair.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, manufacturer recommendation, and facility policy review, the facility failed to follow professional standards of practice related to administration of an inhaler for one (1) of three (3) residents observed during medication pass, Resident #92. Findings include: Record review of Resident #92's physician's orders, initiated 1/23/19, revealed an order for Fluticasone-Salmeterol Aerosol Powder Breath Activated 500-50 MCG/DOSE (Advair); with instructions of one (1) inhaled orally one (1) time a day for shortness of breath (sob), rinse mouth	F 658	1. Licensed Practical Nurse (LPN)#1 was immediately educated on offering residents that are administered inhalers to rinse mouth and spit the water as indicated on the care plans to avoid the irritation of the oral cavity on 03/07/19 by the Staff Development Coordinator. 2.Thirty Six residents with inhaler orders have potential to be affected by this deficient practice. 3.Licensed nursing staff were educated on the administration of inhalants and the following the care plan for offering the resident to rinse and spit water following administration of inhalant on 3/7/19 by the Staff Development Coordinator.	4/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 658	Continued From page 7 with water after use, and Do not swallow. Review of the care plan revealed Resident #92 should rinse her mouth and spit the water after receiving the inhaled medication. Review of the Advair Manufacturers insert, under the instructions for use, revealed to rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow. Under the topic of "What are the possible side effects of Advair", the first side effect listed is fungal infections in the mouth or throat (thrush). Rinse your mouth with water without swallowing after using Advair to help reduce your chance of getting thrush. On 03/06/19 at 8:15 AM, an observation of Licensed Practical Nurse (LPN) #1 revealed she administered an Advair inhaler to Resident #92. LPN #1 did not offer or instruct the resident to rinse her mouth and spit the water. On 03/06/19 at 01:50 PM, an interview with LPN #1 confirmed she did not instruct or suggest Resident #92 rinse and spit after the inhaler administration. LPN #1 stated, after reading the manufacturer's insert, (which instructed after administering the inhaler the resident should rinse and spit out water to prevent fungal growth or possible thrush) that she did not know she should have the resident rinse and spit. On 03/06/19 at 2:05 PM, an interview with the Director of Nursing (DON) confirmed that after administering the Advair inhaler, the nurse should have instructed the resident to rinse their mouth and spit, to prevent the medication from irritating the resident's mucosa.	F 658	4. Beginning the week of 03/11/19, observations of the administration of inhalers will be conducted by Staff Development Coordinator, Assistant Director of Nursing, and Registered Nurse Supervisor in regards to observing licensed nurse offer residents to rinse and spit water following administration of inhalant. Observations will be conducted three (3) times per week for four (4) weeks, then once weekly for four (4) weeks, and monthly thereafter. Any negative findings will be reported to the Quality Assurance Performance Improvement Committee by Director of Nursing monthly for three (3) months for review and recommendation. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 658	Continued From page 8 On 03/07/19 at 01:30 PM, an interview with Resident #92 confirmed she had not been rinsing and spitting out water after inhaling the Advair. Resident #92 stated she does not have any sores in her mouth, but she should rinse her mouth out. She stated no one had told her to rinse and spit.	F 658		
F 880 SS=E	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, 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 §483.70(e) 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	F 880		4/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 880	Continued From page 9 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 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	F 880	1. The inhaler for Resident #92 was discarded and replaced on 03/06/19 by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 880	Continued From page 10 to prevent the possible spread of infection during medication pass, as evidenced by failure to properly clean multi-use patient equipment and failed to properly clean an inhaler container prior to placing it in the medication cart. This affected two (2) of three (3) residents observed during medication pass, Resident #92 and Resident #65. Findings include: On 3/7/19 at 11:45 AM, an interview with the Director of Nursing (DON) revealed the facility did not have a policy addressing infection control during medication administration. On 03/06/19 at 8:15 AM, an observation of Licensed Practical Nurse (LPN) #1 during medication pass to Resident #92, revealed after taking the Advair inhaler, which was inside the box, into the resident's room, LPN #1 laid the box on the resident's over bed table without a barrier. After administering the Advair inhaler to the resident, LPN #1 placed the inhaler in the box and then into her jacket pocket. LPN #1 then went to her medication cart in the hall and placed the box in the medication cart drawer without cleaning/disinfecting the box. On 03/06/19 at 8:40 AM, an observation of Licensed Practical Nurse #2 during medication pass to Resident #65, revealed she removed the pulse oximeter from the drawer of her medication cart, carried it into the resident's room, placed it on the resident's index finger on her right hand, and then returned the pulse oximeter to the medication cart drawer without cleaning/disinfecting the pulse oximeter. On 03/06/19 at 01:50 PM, an interview with	F 880	Assistant Director of Nursing. The pulse oximeter device used on resident #65 was cleaned and disinfected with a bleach wipe on 03/06/19 by Assistant Director of Nursing. Upon notification on 03/06/19, Licensed Practical Nurse#1 was educated on placing inhaler on a barrier and not to place items in jacket pocket by the Staff Development Coordinator. Licensed Practical Nurse (LPN)#2 was educated on cleaning the pulse oximeter device prior to and after the use with a bleach wipe on 03/06/19 by the Staff Development Coordinator. 2. Those residents that have orders for inhalers and those receiving treatment involving pulse oximeter device could be affected by this deficient practice. 3. Licensed Nursing Staff were educated beginning on 03/07/19 in regards to infection control practices including the use of barriers during inhaler administration and not to place items in jacket pockets by the Staff Development Coordinator and the Assistant Director of Nursing. The Licensed Nursing Staff were educated beginning on 3/07/19 on infection control practices of cleaning pulse oximeter devices with bleach wipe prior to and immediately after use by the Staff Development Coordinator. 4. Beginning the week of 03/11/19, observations of the administration of inhalers will be conducted by Staff Development Coordinator, Assistant Director of Nursing, and Registered Nurse Supervisor in regards to observing licensed nurse offer residents to rinse and spit water following administration of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 880	Continued From page 11 Licensed Practical Nurse (LPN) #1 confirmed she placed the box containing the inhaler on the over bed table without a barrier, in her pocket, and then back in the medication cart without cleaning, possibly contaminating other items in the medication cart, which could spread infection. On 03/06/19 at 1:55 PM, an interview with Licensed Practical Nurse (LPN) #2 confirmed she did not clean the pulse oximeter before or after use on Resident #65. LPN #2 revealed that was the first time she had used the pulse oximeter that day and she felt sure the last person that used it would have cleaned it, but she could not be sure. LPN #2 confirmed by placing the contaminated pulse oximeter in the medication cart, it could cause the spread of infection to items in the medication cart and to other residents. On 03/06/19 at 2:05 PM, an interview with the Director of Nursing (DON) confirmed the nurses should not place the box's containing inhalers on over bed tables without a barrier or in their pocket because the contaminated box could cause the spread of infection. The DON confirmed that a pulse oximeter should be cleaned before and after use on a resident to prevent the possible spread of infection to other residents. On 03/07/19 at 01:30 PM, an interview with Resident #92 confirmed she had not been rinsing and spitting out water after inhaling the Advair. Resident #92 stated she does not have any sores in her mouth, but she should rinse her mouth out; no one told her. Record review of an in-service provided to nursing on 1/16/19 addressed using barriers	F 880	inhalant. Observations will be conducted three (3) times per week for four (4) weeks, then once weekly for four (4) weeks, and monthly thereafter. Any negative findings will be reported to the Quality Assurance Performance Improvement Committee by Director of Nursing monthly for three (3) months for review and recommendation. The Director of Nursing is responsible for monitoring and compliance. Observations of two (2) licensed staff member regarding the use of pulse oximeter device and cleaning prior to and immediately after use will be conducted three (3) times per a week for four (4) weeks, then once weekly for four (4) weeks, and monthly thereafter. Any negative findings will be reported to the Quality Assurance Performance Improvement Committee by Director of Nursing monthly for three (3) months for review and recommendation. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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 880	Continued From page 12 during medication administration and guidelines when administering inhalers. Both LPN #1 and LPN #2 have signatures on the attendance sheet.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING **02 - CRYSTAL HEALTH & REHAB OF GREENWOOD** B. WING _____	**03/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	**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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 04/09/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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
E 000	Initial Comments Initial certification survey conducted 3/6/19 revealed the above facility does not meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039		4/5/19

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

Electronically Signed | 04/09/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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
E 039	Continued From page 1 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to conduct Emergency Prep Testing Requirements Annually of the 'Tabletop Exercise' and 'Community-Based Exercise' for 2018 emergency preparedness (EP) plan requirements of 42 CFR §483.73(a). Findings include: On 3/6/19 at 11:45 AM, the facility failed to	E 039	A table top exercise regarding tornado damage to part of the building was performed by staff and led by the Maintenance Supervisor on 03/14/19, The emergency scenario of tornado damage to the building was discussed, problem statements organized and discussed, and the after action of challenges encountered were discussed. 2. The table top exercise was added to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	03/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	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
E 039	Continued From page 2 provide the documentation for tabletop exercise and community-based exercises of the 2018 emergency preparedness (EP) plan. The facility was able to provide the tabletop and community-based exercises for the 2017 emergency preparedness (EP) plan. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 3/6/19.	E 039	the annual calendar along with the facility exercises. 3. The Maintenance Director and The Administrator was educated by the Regional Maintenance Director on 03/07/19 on the Table Top exercise of the Emergency Operations Plan. The Maintenance Director educated the staff on 03/14/19 regarding the requirement to conduct exercises and table top exercise regarding the preparedness of the facility and staff in the event of a possible disaster. 4. The table top exercise and the facility exercise for disaster preparedness calendar and events will be monitored by the Administrator on a monthly basis. The Administrator or designee will report to the Quality Assurance Performance Improvement Committee. The Administrator is responsible for monitoring and compliance.	