MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the	M 735		4/6/19

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 1 resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II 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 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,	M 735	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 orders were evaluated for signs and symptoms of side effects of irritation, redness, or thrush by the Register 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 2 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 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	M 735	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.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 3 and spitting out water after inhaling the Advair.	M 735		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the	M 735		4/6/19

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 1 resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II 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 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,	M 735	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 orders were evaluated for signs and symptoms of side effects of irritation, redness, or thrush by the Register 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 2 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 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	M 735	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.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42CG	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCAR	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 735	Continued From page 3 and spitting out water after inhaling the Advair.	M 735		