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 _____ | 03/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CRYSTAL REHABILITATION AND HEALTHCARE CEN1 | 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 |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted during an annual recertification survey, along with complaints CI MS #17598, CI MS #17516, CI MS #17464, CI MS #17318, CI MS #17431, CI MS #17240, CI MS #17055, CI MS #17036, CI MS #17005, CI MS #16890, CI MS #16895 from 3/22/21 through 3/25/21. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum for Institutions for Aged or Infirm with deficiencies cited at M0610 and M0625. The SA did not substantiate CI MS #17598 for not grooming, CI MS #17516 for Pressure ulcers and notification, CI MS #17464 for Pressure ulcers and neglect, CI MS #17318 for Pressure ulcers and notification, CI MS #17431 for assessment/ monitoring, abuse, transfer/discharge and falls, CI MS #17240 for assessment/monitoring, and quality of care, CI MS #17055 for abuse, CI MS #17036 for neglect, CI MS #17005 for grooming, assessment and neglect, CI MS #16890 for elopement, and CI MS #16895 for assessment/monitoring and notification. No deficiencies were cited related to the complaint investigations. The census at the time of the survey was 81. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and | M 500 | | 4/23/21 |

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| M 500 | Continued From page 1<br>private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his | M 500 | | |

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| M 500 | Continued From page 2<br>period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; | M 500 | | |

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| M 500 | Continued From page 3<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse | M 500 | | |

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| M 500 | Continued From page 4<br>practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, resident interview, record review and facility policy review the facility failed to provide phone access in a private location for one (1) of seven (7) residents interviewed, Resident #36.<br><br>Findings include:<br><br>Review of facility's "Telephones, Resident Use Of" policy, dated May 2017, revealed "residents shall have easy access to telephones. Designated telephones are available to residents to make and receive private telephone calls. The telephones at the nursing stations should ordinarily be reserved for staff use unless no other alternative is available. Residents should use telephones at the nursing stations for as brief a period as possible. Telephones will be in areas that offer privacy and accommodate the hearing impaired, and wheelchair bound residents. Resident telephones are located in the following areas: Garden Room, East Nurses Station, West Nurses Station".<br><br>Review of facility policy titled, "Resident Rights" dated December 2016, revealed "Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee | M 500 | Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal laws.<br><br>1. On 03/24/2021 phone cord was replaced by Maintenance for Resident phone use in garden room. Phone cord keeper secure to wall to prevent removal of cord. Phone cord keeper secure to wall to prevent removal of cord. On 03/24/2021 Resident #36 was able to use phone in private setting. On 03/24/2021 Resident #36 was educated by Social Services Director regarding communication devices that are available to be utilized in private and who to contact for assistance with the devices.<br><br>2. Current Residents with ability to communicate have the potential to be affected by this deficient practice.<br><br>3. Residents educated by Social Services Director on 03/24/2021 on how to access | |

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| M 500 | Continued From page 5<br>certain basic rights to all residents of this facility. These rights include the resident's right to: privacy and confidentiality; access to a telephone, mail and email; communicate in person and by mail, email and telephone with privacy".<br><br>An interview on 3/22/2021 at 11:45 AM, with Resident #36 revealed the facility did not provide a private location for the resident's personal phone calls. Resident #36 stated he does not have a personal phone and the phone for resident's use in the activity room/dayroom has been unplugged and the cord is gone. He stated the only phone he now has access to is the nurse's desk phone and the staff is there, and he does not have privacy. When the staff is not at the desk, he does not have access to the phone, and when access is available, the privacy he would like is not available. Resident stated the activity room phone cord was missing last week and the staff replaced it. It then went missing again and he has been unable to use it for days. He stated he talked to the staff about the phone cord missing, but nothing has been done.<br><br>On 3/22/2021 at 11:45 AM, Resident #36 requested to show State Agency (SA) the phone situation. An observation of the activity room phone on a small table without a cord from the wall jack to phone. Phone is not working at this time.<br><br>An observation on 3/23/2021 at 10:00 AM, revealed the activity room phone with cord. Phone is working at this time.<br><br>An interview with the Activity Director on 3/23/21, at 3:20 PM, revealed the cord on the activity room phone had been missing. She stated last Thursday, she noted the cord was missing and | M 500 | communication devices that can be utilized in private. Content of education included where to find cordless phones that can be used privately and the phone in the garden room. Resident educated to notify Social services, activities, or nurse if there is an issue with a phone.<br><br>4. Beginning 04/12/2021 Maintenance to monitor garden room phone and nurses' station cordless phones once a day Monday-Friday weekly for four weeks and then twice a week for six weeks and then once weekly thereafter to ensure phones are in working order. Nurses will notify maintenance if an issue occurs with a phone via maintenance electronic log on weekends. All Findings will be immediately addressed and will be submitted to the Quality Assurance Performance Improvement Committee 04/21/2021) for review and recommendations and will continue monthly for 3 months. Social Services is responsible for monitoring and compliance. | |

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| M 500 | Continued From page 6 | M 500 | | |

she notified the Maintenance Director. He came and replaced the cord. She is not sure what happened to the cord or how long it had been missing, but realizes the residents need access to this phone. She stated when the state surveyor came into the activity room with Resident #36 on Monday, 3/22/2020, and was looking at the phone and the lack of a cord, she realized it was missing again. She notified the Maintenance Director on Tuesday morning and he came to replace it again. He gave her an extra cord to use, if needed. She stated the residents that use this phone enjoy being able to have more privacy than the nurse's desk phone offers.

An interview with the Maintenance Director on 3/23/21, at 3:40 PM, revealed he was notified last week (he thinks on Thursday), that the phone cord was missing, and the residents were unable to use this device. This morning, he was notified by the Activity Director that the cord was missing, so he replaced it again. He gave the Activity Director an extra cord to keep in her office just in case it was needed. He revealed he is unaware of who removed the cord and why and he does not know where it is located. He stated the phone had been mounted on the wall, but it was not wheelchair accessible, so it was removed from the wall and a cord was run from the wall jack to the phone placed on the table. He stated the residents need access to this phone and area for more privacy.

An interview on 3/24/2021, at 3:25 PM, was conducted with the Administrator concerning the phone cord missing on the activity room phone. She was aware of the phone cord missing last week but is unsure of where it was located or who removed it. She stated the residents have access to a phone to use at the nurse's desk and

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| M 500 | Continued From page 7<br><br>I-pads are available to be checked out and used in the resident's rooms. Each nurse's desk has a cordless, portable phone for the residents to use. Residents have to ask the staff to use these devices.<br><br>An observation on 3/25/2021, at 8:00 AM, revealed the activity room phone with a cord in place and the cord is now secured to the wall under a covering.<br><br>An interview on 3/25/2021, at 8:45 AM, with Resident #36 revealed he has used the phone since the cord has been reattached. He stated a staff employee informed him this morning that there was a portable phone at the desk that he could use in his room, but he had never been given that information before today. He stated the staff would only give him the option of using the phone at the nurse's station when the staff would be available to assist. He had used the phone at the desk before, but he did not have privacy. He had rather not call than have everyone listen to him. He stated the workers use the nurse's desk phone and makes it more difficult to have access. He stated he is not familiar with computer I-pads, so those would not be helpful. He only wants privacy to talk to his family by phone.<br><br>An interview with Licensed Practical Nurse (LPN) #4 on 3/25/2021, at 9:55 AM, revealed the residents can use the portable phone or the desk phone. The phones are not always available, but the residents can use them when available. The desk phones are located at the nurse's desk and staff members are usually in that area and privacy is limited.<br><br>Interview with Administrator on 3/25/2021, at | M 500 | | |

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| M 500 | Continued From page 8<br><br>11:45 AM, confirmed the phone in the activity room was not working properly due to a missing cord and this interfered with the residents' ability to have privacy during phone conversations.<br><br>Record review of the Admission Record revealed Resident #36 was admitted to the facility on 5/14/2019 with diagnoses of Atherosclerotic Heart Disease, Epilepsy, and Hypertensive Heart Disease with Heart Failure. Review of the Minimum Data Set (MDS) Section C, dated 1/4/2021, revealed Resident #36 with a Brief Interview for Mental Status (BIMS) score of 14, indicating resident was cognitively intact. | M 500 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, resident interview, record review and facility policy review the facility failed to provide nail care to for four (4) of six (6) dependent residents. Resident #333, #24, #33 and #10 and failed to ensure a male resident was clean shaven and hair trimmed for | M 610 | Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under | 4/23/21 |

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| M 610 | Continued From page 9<br>(1) of 11 male residents observed for shaving and hair length.<br><br>Findings include:<br><br>Record review of the facility procedure titled, "Fingernails/Toenails, Care of," with a revised date of February 2018, revealed, "The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection...Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin."<br><br>An observation of Resident #24, on 03/22/21, at 11:08 AM, revealed long facial hair and scalp hair. Resident #24's fingernails were long and curved over the end of his fingers. Resident #24 stated that his fingernails needed to be taken care of. He stated that he does not always want to take a bath but does want to be shaved every other day and he has told staff that.<br><br>An observation, on 03/23/21 at 11:30 AM, revealed Resident #24 out in the hallway in his wheelchair. his fingernails continued to be long and he was not shaven.<br><br>An interview, on 03/24/21, at 4:50 PM, with the Director of Nursing (DON), confirmed staff should be providing care for the residents. The resident's nails and hair should not be so long.<br><br>An interview, on 03/25/21, at 9:30 AM, with Licensed Practical Nurse (LPN) #3 confirmed Resident #24's nails were long and curved over the end of his fingers and his beard and hair was long.<br><br>An interview, on 03/25/21, at 11:41 AM, with the | M 610 | state and federal laws.<br><br>1. Resident #333, #24, #33, and #10 offered nail care on 03/25/2021 RN Supervisors. Resident # 24 and #10 accepted nail care and care was provided by Director of Nursing, and Assistant Director of Nursing. Resident #333 and # 33 refused nail care. Resident #24 offered and provided facial shave by LPN. On 03/25/2021 Registered Nurse Supervisors evaluated nails of each resident and offered nail care to residents in need. Podiatrist consult scheduled for 04/07/2021 by Director of Nurses for residents in need of service.<br><br>2. All current residents have the potential to be affected by the deficient practice.<br><br>3. Residents and family members interviewed on 04/18/2021 by Activities staff regarding preference of facial hair. On 04/19/2021 Kardex and care plans were updated by MDS nurse to reflect residents preferences related to nail care and facial hair. Beginning on 04/13/2021, education was started with licensed and certified nursing staff DON on how to provide nail care and shave residents.<br><br>4. On 04/18/2021 social services to make dignity rounds weekly on 15 Residents then 30 Residents monthly for three months intergrating into routine nexion neighbor rounds to observe if facial hair is appropriate and if nail care has been provided. Identified issues will be reported to interim Director of Nursing or designee for immediate education and correction. | |

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| M 610 | Continued From page 10<br><br>DON revealed the Certified Nursing Assistant (CNA) care sheets let the CNA's know to check all nails and do nail care if the resident is not a diabetic. If the resident is a diabetic they are to report the need for nail care to the nurse. The DON confirmed there was not anywhere designated for the nurses to document the nail care.<br><br>Resident #33<br><br>An observation, on 03/22/21, at 12:03 PM, revealed the fingernails on Resident #33's left hand extremely long, approximately one (1)inch from the end of his fingers. His left index finger had yellowish colored material under the nail. Resident #33's toe nails on the right foot were approximately one-half inch from the end of his toes. The fourth toe nail was long and curved under the toe.<br><br>An observation and interview, on 03/23/21 at 04:20 PM, with Certified Nursing Assistant (CNA) #2 confirmed Resident #33's fingernails and toenails were too long. She stated the resident could scratch himself causing a sore or he could scratch the staff. CNA #2 stated that it is the nurses responsibility to cut the nails if the resident is a diabetic but, the CNA's can do the others.<br><br>An observation and interview, on 03/23/21, at 4:25 PM, with Registered Nurse (RN) #2 stated that the CNA's should be assessing the resident's nails and trimming them unless they are diabetic and then they should let the RN's know. RN #2 stated that she makes rounds every two (2) hours to check on the residents and confirmed that she should have noticed that his nails were extremely long. | M 610 | All Findings will be immediately addressed and will be submitted to the Quality Assurance Performance Improvement Committee 04/21/2021 for review and recommendations and will continue monthly for 3 months. Social Services 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 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CRYSTAL REHABILITATION AND HEALTHCARE CEN1 | 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 |
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| M 610 | Continued From page 11<br><br>An observation and interview, on 3/23/21, at 4:45 PM, with the Director of Nursing (DON) confirmed Resident 33's nails on his left hand and right foot were way too long. The DON stated that Resident #33 needed nail care. She stated that the nurses, RN's and LPN's are responsible for diabetic nail care and the CNA's are responsible for daily nail care including cleaning and cutting if not diabetic. The DON confirmed that nails that long could cause skin tears and wounds.<br><br>Record review, of the quarterly Minimum Data Set (MDS), dated 01-13-21, revealed under Section G that Resident #33 required extensive one person assist with personal hygiene.<br><br>Resident #333<br>On 03/22/21, at 02:23 PM, an observation of Resident #333 on her bed revealed a long-jagged fingernail to the left ring finger with all nails one (1) to 1/2 inches long with two (2) fingernails on the right hand with a yellow substance under the nail. Resident #333 nodded her head and smiled when asked if she would like to have her fingernails trimmed and cleaned.<br><br>On 03/23/21, at 3:45 PM, an observation of Resident #333 revealed a long-left ring fingernail with jagged edges and all nails are 1 half to 1 inch long.<br><br>On 03/23/21, at 3:50 PM, an observation and interview with Licensed Practical Nurse (LPN) #1 confirmed during an observation of Resident #333's fingernails looked rigid, could use straightening, could use smoothing, and they could use cleaning. LPN confirmed Resident #333's fingernails look long, and like they have not been trimmed in a long time. LPN reported nail care is provided sometimes by a Registered | M 610 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CRYSTAL REHABILITATION AND HEALTHCARE CENT | 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930 |

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| M 610 | Continued From page 12 | M 610 | | |

Nurse, LPN's, or Certified Nursing Assistants (CNA).

On 03/25/21, at 08:55 AM, an interview with the Director of Nursing (DON) revealed she did not know how bad the nail care was until it was brought to her attention and she performed an in service on 3/25/21 with her staff on nail care.

On 03/25/21, at 11:00 AM, an interview with CNA #1 revealed the CNAs are assigned to do nail care on resident's that are not diabetic residents and nurses are tasked with trimming the diabetic resident's fingernails. When a CNA notices a diabetic with fingernails that need trimming it is reported to the nurse.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/2/21 revealed in section G, under grooming, that Resident #333 requires extensive assistance of 1 person with personal hygiene.

Record review of the MDS with an ARD of 1/25/21 revealed a Brief Interview for Mental Status (BIMS) score of 99 which revealed resident was unable to complete an interview.

Record review of Resident #333's Face sheet revealed Resident #333's initial admission date was 12/10/20 with diagnoses which included Hemiplegia and Hemiparesis affecting the left non-dominant side, Dysphasia, Lack of Coordination and Cognitive Communication Deficit.

Record review of the CNA Activities of Daily Living (ADL) documentation sheet revealed after Resident returned to the facility from a Hospital stay on 3/12/21 documentation of personal

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| CRYSTAL REHABILITATION AND HEALTHCARE CENT | 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930 |

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| M 610 | Continued From page 13 | M 610 | | |

hygiene care was provided daily. Resident #333 On 03/22/21, at 02:23 PM, an observation of Resident #333 on her bed revealed a long-jagged fingernail to the left ring finger with all nails one (1) to 1/2 inches long with two (2) fingernails on the right hand with a yellow substance under the nail. Resident #333 nodded her head and smiled when asked if she would like to have her fingernails trimmed and cleaned.

On 03/23/21, at 3:45 PM, an observation of Resident #333 revealed a long-left ring fingernail with jagged edges and all nails are 1 half to 1 inch long.

On 03/23/21, at 3:50 PM, an observation and interview with Licensed Practical Nurse (LPN) #1 confirmed during an observation of Resident #333's fingernails looked rigid, could use straightening, could use smoothing, and they could use cleaning. LPN confirmed Resident #333's fingernails look long, and like they have not been trimmed in a long time. LPN reported nail care is provided sometimes by a Registered Nurse, LPN's, or Certified Nursing Assistants (CNA).

On 03/25/21, at 08:55 AM, an interview with the Director of Nursing (DON) revealed she did not know how bad the nail care was until it was brought to her attention and she performed an in service on 3/25/21 with her staff on nail care.

On 03/25/21, at 11:00 AM, an interview with CNA #1 revealed the CNAs are assigned to do nail care on resident's that are not diabetic residents and nurses are tasked with trimming the diabetic resident's fingernails. When a CNA notices a diabetic with fingernails that need trimming it is reported to the nurse.

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| CRYSTAL REHABILITATION AND HEALTHCARE CENT | 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930 |

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| M 610 | Continued From page 14<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/2/21 revealed in section G, under grooming, that Resident #333 requires extensive assistance of 1 person with personal hygiene.<br><br>Resident #10<br>On 03/22/21, at 10:45 AM, an observation of Resident #10's fingernails was observed with long unclipped nails and a dark substance noted under her nails.<br><br>An interview on 03/22/21, at 10:45 AM, with Resident #10 and she confirmed she did not want her nails that long She shook her head back and forth aggressively, side to side to indicate "No," that she did not want her nails that long.<br><br>On 03/23/21, at 03:40 PM, an interview and observation with Certified Nursing Assistance (CNA) #2 confirmed that Resident #10's fingernails are one inch long, her thumb nail is broken and jagged and noted with a dirty dark substance under all of her fingernails. CNA #2 confirmed that the CNA's trim the fingernails and clean them if they are not a diabetic. CNA #2 confirmed that she would look at the care card and see if she could trim the Resident #10's nails.<br><br>On 03/23/21, at 3:50 PM, an interview and observation with Licensed Practical Nurse (LPN) #2 confirmed that the Resident #10's fingernails are long, unclipped and dirty. LPN #2 stated that Resident #10's fingernails have not been cut in weeks.<br><br>An interview on 03/23/21, at 3:55 PM, with the Assistant Director of Nursing (ADON), confirmed | M 610 | | |

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| CRYSTAL REHABILITATION AND HEALTHCARE CEN1 | 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930 |

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| M 610 | Continued From page 15 | M 610 | | |

that Resident #10 is not a diabetic and that a CNA could trim the resident's fingernails. The ADON confirmed that the resident should have her nails trimmed weekly and she confirmed that the resident's long unclipped nails could cause a skin tear.

An interview with the Director of Nursing (DON) on 03/25/21, at 10:30 AM, confirmed that cleaning and trimming of resident's fingernails is on the "ADL sheet," for the CNAs to complete on each shift.

An interview at 9:20 AM, on 03/24/21, with Registered Nurse (RN) #1 Charge Nurse, stated she makes rounds every two hours during the 7-3 shift at 9:00 AM, 11:00 AM, 1:00 PM and 3:00 PM and completes the "Resident Care Checklist" and "Infection Control Observation Audit." RN #1 confirmed during the interview that Resident #1's fingernails were long, unclipped and dirty and that she had failed to identify that when she completed her every two-hour round while conducting her "Resident Care Checklist.".

Record review of the CNA "Activities of Daily Living (ADL)" sheet revealed, "ADL-Check Nails and Facial Hair, on bath days Monday, Wednesday, Friday." An intervention was listed to check nail length and trim and clean on bath day and as necessary.

Record review of the Admission Record revealed that Resident #10 was admitted to the facility on 05/13/20 with diagnoses of Cerebrovascular Accident (CVA), Hemiplegia and Attention to Tracheostomy. The most recent Brief Interview for Mental Status (BIMS) completed 12/21/20 revealed a BIMS score 14, indicating that the resident has full cognitive ability.

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| M 625 | 45.21.5 Range of motion<br><br>Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to apply splints as ordered for one (1) of five (5) residents observed with splints. Resident #48.<br><br>Findings include:<br><br>Review of the facility policy, titled, "Assistive Devices and Equipment", revised January 2020, revealed the facility maintains and supervises the use of assistive devices and equipment for residents.<br><br>An observation, on 03/22/21 at 11:22 AM, revealed Resident #48 in her chair. A contracture was noted to her right hand. Resident #48's splints were laying on the bed. Resident #48 stated that they do not put them on.<br><br>An observation, on 03/22/21 at 3:00 PM, revealed Resident #48's splints remain on the bed in the same place. Resident #48 confirmed the staff had not put her splints on today.<br><br>An observation, on 03/23/21 at 09:39 AM, revealed Resident #48 up in her recliner chair eating breakfast. Arm splints laying on bed. She stated that she sleeps in her chair. Resident #48 stated that no staff had offered to put her splints | M 625 | Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal laws.<br><br>1. On 03/24/2021, DON offered to apply splint to right and left hand on Resident #48 and Resident refused application of splints. Resident referred to therapy by Director of Nurses on 03/24/2021 to evaluate appropriateness of splints.<br><br>2. Twelve (12) residents with orders for splints had the potential to be affected by this deficient practice.<br><br>3. On 04/13/2021 and 12 residents with orders for splints were referred to therapy to determine appropriateness of devices currently in place. 04/13/2021 Orders, Kardex and care plans were updated by MDS Nurse to reflect changes. Interim Director of Nursing began education on 04/13/2021 with licensed nurses and certified staff on the utilization of Medication Administration Records and following Kardex to determine the | 4/23/21 |

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| M 625 | Continued From page 17<br>on.<br><br>An observation, on 03/24/21 at 09:08 AM, with the Director of Nursing (DON) confirmed the resident does not have her splints on. The DON stated that Resident #48 should have her splints on.<br><br>An interview, on 3/24/21 at 9:10 AM, with the DON, revealed that the floor staff, charge nurses, nurses, and Certified Nursing Assistants (CNA) are responsible for putting splints on. She confirmed the splints should be on now.<br><br>An interview on 3/25/21, at 10:55 AM, with Licensed Practical Nurse (LPN) #3 revealed she charted the splints because she thought they were on. She confirmed she should make sure before she charts.<br><br>Record review of the Order Summary Report revealed resident order to wear left palm guard 24 hours a day or as tolerated, can take off during hours of sleep. Nurse to remove palm guard every shift and check skin. Report changes. Patient to use right resting splint after a.m. bath. Patient to doff resting splint before bedtime.<br><br>Record review of the Order Summary Report revealed an order, dated 9/22/20, for Resident #48 to use right resting splint after AM bath. Patient to doff resting splint before bedtime. Nursing to provide skin check every shift, every morning and bedtime. An order, dated 7/22/20, revealed Resident #48 was to wear left palm guard 24 hours a day or as tolerated. Can take off during meals . Nurse to remove palm guard every shift and check skin. Report changes every shift for impaired mobility. | M 625 | appropriate application of splints devices are in place for the Residents.<br><br>4. On 04/18/2021, Medical Records, Staff Development Coordinator, and Interim Director of Nursing to ensure appropriate application of all splints in place as physician ordered. Beginning 04/18/2021, Medical Records, Staff Development Coordinator, and Interim Director of Nursing Six Residents with splint devices will be reviewed weekly for four weeks then monthly for three months and quarterly thereafter for appropriate applications and placement of splint devices. All Findings will be immediately addressed and will be submitted to the Quality Assurance Performance Improvement Committee on 04/21/2021 for review and recommendations and will continue monthly for 3 months. Interim Director of Nursing is responsible for monitoring and compliance. | |

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| M 625 | Continued From page 18<br><br>Record review of the Medication Record Review (MAR) for 3/22/21, 3/23/21, and 3/24/21 revealed documentation that Resident #48's splints were applied.<br><br>Record review of the Order Summary Report revealed Resident #48 had a diagnosis of Cerebral Infarction and Hemiplegia affecting the Right Dominate Side.<br><br>Review of the Quarterly Minimum Data Set (MDS), dated 1/25/21, revealed Resident #48's Brief Interview for Mental Status (BIMS) score of 15 , indicating the resident was cognitively intact. | M 625 | | |