

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  |                                                                                                            |                                                                                                                          |                                                                    |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255154</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/13/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL REHABILITATION AND HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>902 SGT JOHN A PITTMAN DRIVE</b><br><b>GREENWOOD, MS 38930</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                  |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| E 000                                                                                   | <p>Initial Comments</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the State Agency (SA) 4/11/23 through 4/13/23. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>At the time of the survey the facility census was 84 and the facility is licensed for 100 beds.</p> |                                                                            |  | E 000                                                                                                      |                                                                                                                          |                                                                    |                            |

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

TITLE

(X6) DATE

Electronically Signed

04/21/2023

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.