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 _____	C 09/14/2023

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CRYSTAL REHABILITATION AND HEALTHCARE CENTER	**902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation CI MS# 22670 at the facility from 9/12/23 through 9/14/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F600. The census at the time of the survey was 82 with a bed capacity of 110 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, facility policy review, and record review, the facility failed to ensure residents were free from abuse/neglect, as evidenced by a Certified Nursing Assistant (CNA) not performing needed hygiene care, being rough during care and cursing around residents, for four (4) of 10	F 600	Preparation and Submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truths of the facts alleged or the correctness of the conclusion set forth on this statement of deficiencies. The plan of	10/16/23

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

Electronically Signed | 09/29/2023

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F 600	Continued From page 1 residents that were provided care by CNA #5. Resident #1, Resident #2, Resident #3, and Resident #4. Findings include: Review of the facility policy titled "Abuse Prohibition Policy," with a review date of 3-2023, revealed "INTENT: This protocol was intended to assist in the prevention of abuse, neglect ... Each resident has the right to be free from abuse, mistreatment, neglect ... POLICY: 1. The facility will prohibit neglect, mental or physical abuse..." Record review of the "Investigation Summary" revealed "This is a written investigation summary to follow up on an allegation reported 08/27/2023 ...Resident Statement of Events &/or Timeline of Events: On 08/27/2023, LPN #1 (Formal Name) alleged that she witnessed (Formal Name) CNA #5 being aggressive and rude to (Formal Name) Resident #3 while providing care. LPN #1 also alleged that CNA #5 failed to provide incontinent care to Resident #2 (Formal Name) as directed. CNA #5 has been suspended pending investigation ...LPN #1 alleged an altercation between Resident #1 and CNA #5 ...Upon investigation (Formal Name) CNA #2 alleged that she witnessed CNA #5 use profanity and speak demanding to Resident (Formal Name) #4 ... In conclusion, the center is able to substantiate the allegations of Abuse/Neglect. CNA (Formal Name) #5 employment was terminated ..." An interview on 9/12/23 at 03:09 PM, with CNA #1 revealed on 8/23/23 one (1) of the nurses kept sending for CNA #5 to come and clean Resident #2 because he was constantly having loose stools, that had spilled over his bed, the floor, and	F 600	correction is prepared and submitted solely pursuant to the requirements under state and federal laws. The following measures for impacted residents were implemented: Residents #1, #2, #3 and #4 were immediately assessed on 08/27/2023 by Registered Nurse. Assessments revealed no injuries or adverse effects. On 08/27/2023, CNA 5 was called for interview and statement of incident by Director of Nursing. CNA 5 was suspended at this time pending investigation and ultimately terminated on 08/27/2023. 82 residents had the potential to be affected by this deficient practice. On 08/27/2023, Staffing Development Coordinator initiated education for all staff regarding Abuse, Neglect, Resident Rights and Vulnerable Adult Act. On 09/01/2023, Assistant Director of Nursing initiated abuse testing to ensure competency. Beginning 09/29/2023, the facility will conduct a monthly abuse drill for 3 months and then quarterly to ensure staff capability and comprehension. After the incident, beginning 09/01/2023,	

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F 600	Continued From page 2 his wheelchair. CNA #1 also revealed CNA #5 was exhibiting behaviors of being very frustrated and angrily voicing, "I just cleaned him up." CNA #1 noted she was in the breakroom with CNA #5 and revealed she heard CNA #5 mention that Resident #1 had called on the call light requesting for his brief to be changed, but CNA #5 revealed she told Resident #1 he had to wait until she came back from lunch. CNA #5 revealed she had attended Abuse/Neglect in-services and had been told what suspected abuse/neglect was, and that residents are not to be abused/neglected. An interview on 9/12/23 at 03:21 PM, with CNA #2 revealed CNA #5 appeared to be very upset and appeared to be very frustrated on the evening of 8/26/23. She noted she assisted CNA #5 with incontinent care for Resident #4. CNA #2 revealed she asked CNA #5 to roll Resident #4 over so another pad could be placed under him, when CNA #5 quickly grabbed Resident #4 under his upper back and the bend of his knees, and aggressively snatched him up off the bed, forcing him in a cradled, fetal position, in her arms. CNA #2 revealed the action of CNA #5 alarmed her and she was scared the action could be harmful to Resident #4. She revealed she did ask CNA #5, "What the hell are you doing picking the resident up and being that rough?" She noted she could not recall word for word what CNA #5 said but did remember the first part of her statement was "He need to bring his ugly ass." CNA #2 revealed she had attended Abuse/Neglect in-services and was aware the staff were to keep the residents free from abuse/neglect. An interview on 9/12/23 at 03:48 PM with CNA #4 revealed she helped CNA #5 provide incontinent care on 8/26/23 for Resident #2 who had several	F 600	the Nursing Home Administrator, Director of Nursing and Social Services Director began audit grievance and incident reports weekly time 4 weeks, biweekly twice a month and monthly x 2 months to ensure compliance. Any negative findings will be submitted to the Quality Assurance and Performance Committee (QAPI). Beginning 09/29/2023, QAPI Committee will review potential trends, patterns and provide recommendations X 4 months.	

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loose stools, during the shift and had gotten it on several surfaces in the room and himself each time. She revealed she noticed CNA #5 was very upset and cursing in the room with Resident #2 and Resident #3 saying, "I am sick of this shit. This shit don't make no sense." CNA #4 shared that CNA #5 appeared to be upset and came back into the room with Resident #2 and Resident #3 each time saying, "I am sick of the shit," and both residents were awake. CNA #4 revealed she left CNA #5 in Resident #2's and Resident #3's room to clean up the bowel that had spilled on the floor and Resident #2's wheelchair. CNA #4 noted she was trying to help CNA #5 to not get in trouble, and she knew cursing around the residents was considered mistreatment of the residents. CNA #4 also revealed she had attended in-services on Abuse/Neglect, knew the residents were to be free of abuse/neglect.

An interview on 9/12/23 at 04:04 PM with Licensed Practical Nurse (LPN) #2, revealed she was informed by LPN #1, near the end of 3-11 shift for the CNAs, that CNA #5 had been told two (2) times, by LPN #1, to go back and provide additional incontinent care to Resident #2 and to clean the bowel up off his floor and wheelchair. LPN #2 revealed she went to Resident #2's room and observed him in the wheelchair with bowel running out of one of the leg holes of his brief, onto the wheelchair and the floor. LPN #2 noted she did ask CNA #5 to go back to provide incontinent care and to clean the bowel off the floor and wheelchair for Resident #2, before she ended her shift. She instructed CNA #5 that it was neglectful to leave the bowel on Resident #2, and that it was neglectful to not clean the bowel from his floor and wheelchair. LPN #2 noted CNA #5 revealed she had just checked him at the end of

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shift rounds, that he was not soiled, that she had been busy all night, and was not going back to clean him up. She also noted that CNA #5 clocked out and left the nursing facility. She revealed she had attended Abuse/Neglect in-services and knew the residents had the right to be free of abuse/neglect.

A telephone interview on 9/12/23 at 04:12 PM, with LPN #1 revealed CNA #5 asked her to assist with the care for Resident #3, because he grabs a hold of whoever assisted with his care or held onto the bed rails often during care. LPN #1 noted Resident #3 was turned facing her holding onto the bedrail, and CNA #5 snatched his arms to make Resident #3 release the bed rail as she jerked him towards her to turn him over to face her. She further shared CNA #5 was moving fast with providing Resident #3's care and did not appear to be gentle when she was pulling on him to move him around in the bed. LPN #1 revealed she did not say anything to CNA #5 about being aggressive with moving Resident #3, was not sure if it was abusive behavior towards Resident #3 from CNA #5 but shared that it made her feel uncomfortable. She noted she observed bowel on the floor and on the wheelchair for Resident #2, and asked CNA #5 who was responsible to clean it up. She revealed CNA #5 told her she did not know who was supposed to clean it up, but she was not going to be the one to clean it up. LPN #1 also shared that she did tell LPN #2 about CNA #5's behavior towards Resident #3, and about CNA #5 needing to clean the bowel up from Resident #2's and Resident #3's floor. LPN #1 noted she did attend an Abuse/Neglect in-service but could not remember all what was said in the in-services about abuse. She shared that she did not feel the incident between CNA #5 and

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Resident #3 was suspected abuse because Resident #2 was not punched by CNA #5.

An interview on 9/12/23 at 4:20 PM, with Resident #1 revealed he had called over the call system one night for the assistance to have his brief changed because he had a bowel movement. He also revealed his CNA did come to his room that night, told him he had to sit and wait until she came off lunch break, and revealed the CNA never came back to his room to clean him up. He noted he could not remember her name or how long he waited for her. Resident #1 also noted he had to wait to be changed by one of the CNAs that came to work on the next shift. Resident #1 voiced, "Being treated that way made me feel shitty and made me feel bad."

An interview on 9/14/23 at 10:10 AM, with the Director of Nursing (DON), confirmed the nurses and the CNAs, including CNA #5, had been in-serviced on the Abuse/Neglect policy and were aware that residents of the nursing facility were to be kept free of abuse and neglect. She confirmed that Resident #1, Resident #2, Resident #3, and Resident #4 were not kept free of abuse/neglect by the nursing facility staff.

An interview on 9/14/23 at 10:30 AM, with the Administrator confirmed the nursing facility failed to keep Resident #1, Resident #2, Resident #3, and Resident #4 free from abuse/neglect. The Administrator also confirmed, through facility investigation, the nursing facility was not in compliance with the allegations of abuse/neglect by a CNA on 8/26/23 for Resident #1, Resident #2, Resident #3, and Resident #4.

Record review of the nursing facility in-services

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revealed "Abuse and Neglect," dated 07/12/23; "Abuse Neglect Vulnerable Adult Patient Rights," dated 7/13/23; "Elderly Care Acts/Abuse and Neglect," dated 7/20/23; "Abuse and Neglect, Reporting Abuse," date 8/9/2023; "Abuse Neglect, Patient Rights," dated 8/11/23; and "Abuse Neglect, Resident Rights," dated 8/28/23.

Record review of the Personnel Record for the CNA#5 revealed the last day worked was 8/26/23, the date of the alleged incident of abuse and neglect and was terminated on 9/1/23.

Record review of the Admission Record for Resident #1 revealed an admission date of 07/08/2023 with diagnoses of Functional Quadriplegia and Unspecified Focal Trauma Brain Injury Without Loss of Consciousness, Sequela.

Record review of a Minimum Data Set (MDS) with an Assessment Reference Date of 9/1/23 with a Brief Interview For Mental Status (BIMS), for Resident #1, revealed a score of 7, indicating Resident #1 is moderately cognitively impaired.

Record review of the Admission Record for Resident #2 revealed an admission date of 03/03/2023 with diagnoses of Hemiplegia and Hemiparesis Following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Dysphagia Following Cerebral Infarction, and Aphasia Following Cerebral Infarction.

Record review of Section C of a Minimum Data Set (MDS) Admission Assessment, with an Assessment Reference Date (ARD) of August 28, 2023, for Resident #2, revealed a BIMS score of

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99, indicating Resident #2 is severely cognitively impaired.

Record review of the Admission Record for Resident #3 revealed an admission date of 05/25/2022 with diagnoses of Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Other Sequelae of Cerebral Infarction, and Transient Cerebral Ischemic Attack, Unspecified.

Record review of Section C of a Quarterly MDS Assessment, with an ARD of August 23, 2023, for Resident #3, revealed a BIMS score of 03, indicating Resident #3 is severely cognitively impaired.

Record review of the Admission Record for Resident #4 revealed an admission date of 08/15/2023 with diagnoses of Acute and Chronic Respiratory Failure, Unspecified Whether With Hypoxia or Hypercapnia, Encounter for Attention to Tracheostomy, Dysphagia Following Cerebral Infarction, and Unspecified Sequelae of Cerebral Infarction.

Record review of Section C of a 5-Day MDS Assessment, with an ARD of August 22, 2023, for Resident #4, revealed "C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? ... Enter Code: 0; 0. No (resident is rarely/never understood). The record review did not reveal a BIMS score.