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	06/26/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on record review, staff interview, and facility policy review, the facility failed to provide adequate supervision and monitoring to reduce the risk of accident and hazards for a cognitively impaired ambulatory resident for (1) one of (4) four residents reviewed for accidents. (Resident # 1) Findings include: Review of the facility policy titled, Safety and Supervision of Residents, dated July 2017 revealed Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Systems approach to safety: 2.) Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . 3.) The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment or if there is a change in the resident's condition . A record review of a facility reported incident revealed, on 6/12/24, around 6:35 AM, LPN (Licensed Practical Nurse) #2, who was assigned to Resident #2, observed Resident #1 exiting the room of Resident #2. LPN #2 then heard Resident #2 gasping for air, and upon entering her room, she saw a pillow and sheet covering Resident #2's face. The nurse yelled for help from CNA (Certified Nursing Assistant) #2 who was right outside the room. They immediately removed the sheet and the pillow, grabbed some wipes to dab her face to calm her down. RN (Registered Nurse) Supervisor #1 took vital signs and noted that Resident #2 had an increased respiratory rate and a reddened face. Both nurses continued to check all vitals, performed incontinent care, and positioned Resident #2 comfortably in bed before exiting the room. An interview with the Director of Nursing (DON) on 6/26/24 at 9:25 AM revealed on 6/11/24, the afternoon before the incident, Resident #1 had been moved to another room because of a minor leak in the bathroom. Resident was ambulatory, and they did not want her to be injured until the water leak could be fixed in the bathroom. She stated that Resident #2, her roommate, remained in the room because she is bed bound and would not need to utilize the bathroom. She stated that the move was temporary and was explained to Resident #1. She stated when Resident #1 asked why Resident #2 was not moved, staff explained to her that Resident #2 was not ambulatory and did not use that bathroom. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER: Crystal Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 902 Sgt John A Pittman Drive, Greenwood, MS 38930	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA #4 on 6/26/24 at 11:41 AM, she revealed she worked 7:00 AM -7:00 PM on 6/11/24 and was assigned to Resident #1's prior room. She stated she observed Resident #1 attempting to enter her previous room at least three times, and she had to be redirected not to go in the room because it was not safe for her. She stated Resident #1 kept stating she could not understand why Resident #2 got to stay in the room and she didn't. CNA #4 stated she was unaware if any increased monitoring was put in place to observe Resident #1 closer. An interview with Resident #1's Resident Representative on 6/26/24 at 11:00 AM, revealed for the most part Resident #1 is alert and oriented but has frequent bouts of confusion and is very forgetful and change is hard for her. He then stated his sister has made the statement several times to him that she was upset and could not understand why she had to move out of her room and Resident #2 did not have to move and that she was upset about it. A phone interview with LPN #2 on 6/26/24 at 12:30 PM revealed she worked 7:00 PM-7:00 AM on 6/11/24 and was assigned to Resident #1's prior room. She stated that before the incident in the early morning of 6/12/24, she had observed Resident #1 going into her prior room on two separate occasions, and she had to be redirected. She stated each time Resident #1 expressed that she did not understand why Resident #2 got to stay in the room and she didn't. She stated she explained the safety reason to Resident #1 but confirmed Resident #1 has some confusion at times. She stated on the morning of 6/12/24 at approximately 6:35 AM she was making her final rounds and observed Resident #1 exiting her prior room. LPN #2 stated she asked Resident #1 what she was doing, and Resident #1 aggressively stated, I have not been in there because the door is locked. She stated she then told Resident #1 she had to be careful there was a leak in that bathroom, and she was going to get hurt. LPN #2 then revealed she heard gasping sounds and coughing coming from the room and she and CNA #2 entered the room and observed Resident #2 with the top sheet and a pillow covering Resident #2's face and immediately removed it. She stated she and CNA #2 stayed with Resident #2 calming her down. LPN #2 was asked if she had increased monitoring of Resident #1 when she observed her on two previous occasions attempting to go into her prior room. She stated no she did not, she just redirected her to stop her from going into the room because she was going to get hurt. In a phone interview with CNA #2 on 6/26/24 at 1:36 PM, she revealed she was assigned to Resident #1's previous room on 6/11/24, 11:00 PM-7:00 AM. She stated she saw Resident #1 walking the halls on the morning of 06/12/24 but thought nothing of it because she often does that. She stated she was making rounds that morning at about 6:30 AM and heard LPN #2 hollering for help and entered the room and observed the top sheet and pillow over Resident #2's face. She stated she and LPN #2 immediately removed the pillow and began calming Resident #2 down. She stated the last time she had seen Resident #2 was at 4:15 AM, and she repositioned her and made sure she was dry. In an interview with the Licensed Social Worker (LSW) on 6/26/24 at 3:00 PM, she revealed she was unaware that Resident #1 had attempted on several occasions to go into her prior room or that she was upset about the room move. She then confirmed that staff should have put increased monitoring in place to reduce her risk of injury because she kept attempting to enter the room. Record review of the June 2024 progress notes and physician's orders revealed no increased monitoring for Resident #1 after the move on 6/11/24 until 6/12/24 at 7:00 AM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 6/26/24 at 3:00 PM, she revealed she was not made aware that Resident #1 had been attempting, on multiple occasions, to go back into her prior room or that she was upset about the move out of her room. In an interview with the Administrator on 6/26/24 at 4:00 PM, she verbalized that Resident #1 had been moved to different rooms in the past, and she had attempted to go back to those rooms too because that was the room she was used to. Record review of the Admission Record revealed the facility had admitted Resident #1 to the facility on [DATE] with diagnoses including Unspecified Convulsions and Seizure Disorder. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 5/6/24, revealed that Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated that she was severely cognitively impaired. Record review of the Admission Record revealed the facility admitted Resident #2 to the facility on [DATE] with diagnoses including Hydrocephalus, Aphasia, and Quadriplegia. Record review of the MDS, Section C with an ARD of 05/15/24, revealed that Resident #2 is rarely or never understood, which indicated severe cognitive impairment.