

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 12/09/2025
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	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interviews, record review and facility policy review, the facility failed to ensure timely assessment, physician notification, and initiation of appropriate treatment for an identified pressure ulcer to prevent further deterioration and promote healing for one (1) of three (3) residents reviewed for pressure ulcers. Resident #1. Findings Include:Record review of facility policy The [Proper Name of Corporation] Skin Integrity Prevention and Treatment Program revealed .Weekly Skin Integrity Checks a. Weekly assessment looking for new wounds-completed by a licensed nurse; b.Document on/in Treatment Record; c. If new area found .Notify Medical Doctor (MD) -obtain treatment orders .Record review of a Progress Note dated 1/17/25 documented by Licensed Practical Nurse #1 (LPN #1) revealed Resident #1 was noted with an open wound to the left upper extremity below the elbow with sanguineous drainage present. The note indicated first aid treatment was initiated and that the oncoming nurse and treatment nurse would be notified; however, there was no documentation to support that a physician was notified or that treatment orders were obtained at that time. Interview with Resident #1 on 12/9/25 at 12:30 PM, revealed the resident was unable to recall when or how the wound to the left elbow occurred.Record review of the January 2025 Treatment Administration Record revealed no wound care treatment orders were obtained from 1/17/25 until 1/22/25.Record review of a Surgical Note dated 1/22/25, from the wound care physician revealed Resident #1 had a Stage IV Pressure Ulcer to the left elbow with pre-op measurements of 1.5 centimeters (cm) length by 1.0 cm width with depth undetermined. The wound presented with moderate serosanguineous drainage, unhealthy surrounding tissue, and slough present requiring surgical debridement of devitalized subcutaneous, muscle, fascia and tendon tissue. Post-op measurement was 1.5 cm length by 1 cm width by 0.3 cm depth. Interview with the Treatment Nurse on 12/9/25 at 12:45 PM, revealed she stated that when a wound is identified, the physician should be notified for treatment orders.Telephone interview with LPN #1 on 12/9/25 at 1:02 PM, revealed she verified the resident had an open wound to the left elbow and acknowledged she did not notify the physician for treatment orders. She agreed the physician should have been notified.Interview with the Director of Nursing (DON) on 12/9/25 at 1:30 PM, revealed there was no documentation to support that wound care treatment was initiated prior to the wound care physician's assessment on 1/22/25. The DON agreed treatment orders should have been obtained when the wound was identified.Record review of the admission Record revealed that the facility admitted Resident #1 on 10/15/21 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-dominant Side.Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.		

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
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