STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL REHABILITATION AND HEALTHCARE CENTER	**902 SGT JOHN A PITTMAN DRIVE , GREENWOOD, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey at the facility from 10/12/26 through 10/14/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F638, F640, F644, F761 and F812. The facility had a census of 75 and was licensed for 100 beds.	F0000		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure a Quarterly Minimum Data Set (MDS) was completed within 14 days after the Assessment Reference Date (ARD) for one (1) of 18 MDS reviewed. Resident #46 Findings Include: Review of the statement provided by the facility, dated October 2026, revealed the facility followed the guidelines outlined in the 2026 RAI (Resident Assessment Instrument) manual for late assessments. Record review of Resident #46's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/04/26 revealed the assessment was not completed and closed by the required completion date of 9/18/26. The assessment remained open as of 10/13/26. During an interview on 10/13/26 at 10:22 AM, the MDS Coordinator stated she had started in the	F0638		

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 reverse for further 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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F0638 SS = D	Continued from page 1 position in June and was the only person working in the MDS department. She acknowledged she was behind on assessments because she was still learning the job. She confirmed Resident #46's MDS assessment had not been completed within the required timeframe and should have been completed by 9/18/26. She stated, "It was an oversight on my part." During an interview on 10/13/26 at 10:31 AM, the Director of Nursing (DON) stated she was aware that some MDS assessments had not been completed within the required timeframes. She stated the facility had only one person working in the MDS department and corporate staff had been trying to help. The DON stated she expected MDS data to be collected during the look-back period and assessments to be completed within the required timeframes. Record review of the “Admission Record” revealed the facility admitted Resident #46 on 3/24/19 with an initial admission date of 7/15/2011 with medical diagnoses that included schizophrenia. Record review of the MDS with an ARD of 9/4/26 revealed a Brief Interview for Mental Status (BIMS) summary score of 14 under Section C, which indicated Resident #46 was cognitively intact.	F0638		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F0640		

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F0640 SS = D	Continued from page 2 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to complete and transmit the required Minimum Data Set (MDS) Assessments for two (2) of 18 sampled residents reviewed. (Resident #63 and #84). Findings Include: Review of the statement provided by the facility dated October 2026 revealed, "(Proper name) policy for late assessments follows the guidelines outlined in the 2026 RAI (Resident Assessment Instrument)	F0640		

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F0640 SS = D	Continued from page 3 manual." Resident #63 An interview conducted on 10/13/26 at 10:00 AM with the MDS Coordinator revealed that Entry MDS Assessments were required to be completed within seven (7) days of admission to the facility. During the interview and concurrent record review, the MDS Coordinator confirmed that no Entry or Admission MDS Assessment was completed following Resident #63's Discharge MDS Assessment dated 05/13/26. She further verified that Resident #63 returned to the facility on 05/14/26 and that the next MDS Assessment completed was a Quarterly Assessment dated 06/05/26. An interview conducted on 10/13/26 at 10:25 AM with the Director of Nursing (DON) revealed that the MDS Coordinator was relatively new to the position and that corporate staff were assisting with MDS submissions. During the interview and concurrent review of Resident #63's electronic medical record (EMR), the DON confirmed that no Entry or Admission MDS Assessment was completed following the resident's return to the facility from the hospital on 05/14/26. The DON further stated that her expectation was for all MDS Assessments to be completed and submitted timely and acknowledged that Resident #63's Entry/Admission MDS Assessment had been missed. Record review of a Progress Note dated 05/12/26 documented that Resident #63 was transferred to the hospital due to bleeding from the tracheostomy (trach). Record review of a Progress Note dated 05/14/26 documented that Resident #63 returned to the facility with no new orders. Record review of Resident #63's MDS Assessments revealed that a Discharge MDS Assessment with an Assessment Reference Date (ARD) of 5/12/26 revealed that Section A0310 identified the assessment as a "Discharge assessment - return anticipated," and Section Z documented a completion date of 05/13/26. The next MDS Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 06/04/26, completed on 06/05/26. Record review of Resident #63's Record review revealed that no Entry or Admission MDS Assessment was completed following the resident's return to the facility on 05/14/26.	F0640		

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F0640 SS = D	Continued from page 4 Record review of Resident #63's Admission Record revealed that the resident was admitted to the facility on 09/11/25 with diagnoses that included Nontraumatic Intracerebral Hemorrhage in an Unspecified Hemisphere and Dysphagia. Resident #84 Record review of Resident #84's Progress Note Type: Transfer to Hospital Summary dated 7/7/2026 at 11:59 AM, revealed, "The resident departed the facility via (proper name) Emergency Medical Service (EMS) at 11:55 a.m. for transport to (proper name) hospital." Record review of the resident's MDS Discharge Assessment dated 7/7/2026 revealed Section A0310F was coded 11, Discharge – Return Anticipated, Section Z0500 was signed on 7/9/2026. Record review of Resident #84's Progress Note Type: General Nurses Notes – narrative dated 7/10/2026 at 4:00 PM (1600) revealed, "Resident return home via facility van…" Record review of Resident #84's "Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries" form revealed, "…The beneficiary has chosen to elect the Hospice…Election Date 7/10/2026…" Record review of the resident's MDS assessment history revealed no Reentry Tracking Record was completed or submitted for the resident's return to the facility on 7/10/2026. Record review of Resident #84's Progress Note Type: General Nurses Notes – narrative dated 7/16/2026 at 3:49 PM (1549), revealed, "…resident found lying in bed. No noted respiration. Unable to detect pulse. No vital signs. Time of Death (TOD) 3:33 PM (1533) …" Further review revealed a Death in Facility Tracking Record dated 7/16/2026 was completed following the resident's death and signed on 7/17/2026. During an interview on 10/13/2026 at 11:53 AM, the MDS Coordinator confirmed the reentry tracking record was not completed as it should have been. She stated that during that time, she was still in orientation, and the assessments were being completed by a regional nurse. Record review of Resident #84's Admission Record	F0640		

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F0640 SS = D	Continued from page 5 revealed the resident was admitted to the facility on 5/21/2026 with diagnoses that included Malignant Neoplasm of Esophagus, unspecified and Secondary Malignant Neoplasm of unspecified lung.	F0640		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to refer a resident to the State Mental Health Authority for a PASRR Level II evaluation after a new psychiatric diagnosis was identified for one (1) of two (2) residents reviewed for Preadmission Screening and Resident Review (PASRR). Resident #71 Findings include: Review of the facility policy titled “Preadmission Screening and Resident Review (PASRR),” revised 7/18/18, revealed, “A resident with MI (mental illness) or ID/DD (Intellectual Disability/Developmental Disability) must have a Resident Review (RR) conducted when there is a significant change in the resident’s physical or mental condition. Therefore, when a significant change in status assessment is completed for a resident with MI (mental illness) or ID/DD, the nursing home is required to notify the State Mental Health Authority, intellectual disability or developmental disability authority in order to notify them of the resident’s change in status.”	F0644		

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F0644 SS = D	Continued from page 6 Record review of the “Admission Record” revealed the facility admitted Resident #71 on 12/23/22 with a medical diagnosis that included Nontraumatic Intracerebral Hemorrhage. The record did not indicate a diagnosis of mental illness at admission. Record review of Resident #71’s Preadmission Screening and Resident Review (PASRR) dated 12/26/22 revealed the resident did not have a history of mental illness or take any psychotropic drugs. Record review of Resident #71’s “Nurses Notes” dated 9/25/25, revealed, “New orders received for Quetiapine Fumarate (Seroquel)(antipsychotic) 50 MG (milligram) tablet 1 (one) po (by mouth) bid (twice daily) for Depressive Disorder.” Record review of Resident #71’s “Psych Progress Note” dated 4/2/26 revealed the Quetiapine Fumarate had a start date of 9/25/25 and was modified on 4/1/26 to include a diagnosis of Psychotic Disorder with Delusions due to Known Physiological Condition. Further review of the “Admission Record” revealed a new psychiatric diagnosis of Psychotic Disorder with Delusions due to Known Physiological Condition was added to Resident #71’s diagnosis profile on 3/03/26. An interview with Social Services (SS) on 10/13/26 at 2:50 PM revealed she was responsible for submitting referrals to the State Mental Health Authority. SS stated she submitted a new referral when a resident went to a geriatric psychiatric unit or received a new mental illness diagnosis. She stated Resident #71 had been seen by the psychiatric nurse practitioner (NP), but she was unaware he had received a new diagnosis. She stated no new referral had been sent to the State Mental Health Authority. SS confirmed Psychotic Disorder had been added to the resident’s diagnosis profile on 3/03/26 and the referral should have been made for a Level II evaluation. An interview with the Director of Nursing (DON) on 10/14/26 at 11:42 AM revealed the NP had visited and added a new diagnosis for Resident #71 on 4/2/26. The DON stated the NP had not communicated the new diagnosis to staff; therefore, a referral to the State Mental Health Authority had not been completed. The DON explained that a staff member added the diagnosis to the Admission Record diagnosis list with a date of 3/03/26,	F0644		

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F0644 SS = D	Continued from page 7 although it was added on 4/03/26. She stated the date needed to be corrected. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/13/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #71 was cognitively intact. Review of section I revealed psychotic disorder was checked as an active diagnosis.	F0644		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to ensure medications were securely stored and administered under nursing supervision for one (1) of 75 residents observed during the initial tour. Resident #4 Findings include: Review of the facility policy titled “Storage of Medications” reviewed 6/24/25 revealed under,	F0761		

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F0761 SS = D	Continued from page 8 “Policy statement: The facility stores all drugs and biologics in a safe, secure, and orderly manner.” The policy also revealed under, “Policy interpretation and Implementation: 1. Drugs and biologics used in the facility are stored in locked compartments...” An observation during the initial tour on 10/12/26 at 10:50 AM revealed Resident #4’s room door was open. Resident #4 was lying in bed on her left side with her eyes closed. A clear medicine cup, half full of an assortment of pills (medication), was on her bedside table. Record review of the “Admission Record” revealed the facility admitted Resident #4 on 2/14/24 with medical diagnoses that included Schizophrenia and Bipolar Disorder. An interview with Licensed Practical Nurse (LPN) #1 on 10/12/26 at 2:20 PM revealed he was assigned to Resident #4 that day. LPN #1 confirmed he had prepared Resident #4’s morning medication and left it on her bedside table for her to take when she woke up. He stated Resident #4 did not have a physician’s order to self-administer her medications. LPN #1 stated he usually prepared Resident #4’s medication close to 8 AM. Because she liked to sleep late, she had asked him to leave the medication on the bedside table so she could take it later. LPN #1 confirmed Resident #4 had a mental health diagnosis. He acknowledged he should observe her swallow the medication to ensure she took it and did not throw it away or hoard it. He stated that taking the medication later than ordered by the physician could cause a conflict with the next scheduled dose. An interview with the Director of Nursing (DON) on 10/12/26 at 2:26 PM revealed medication should never be left at a resident’s bedside. The DON stated nurses should observe residents swallow their medication. The DON stated, "Anything could happen." She stated residents might not take the medication or might take it too close to the next scheduled dose. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/22/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated Resident #4 was cognitively intact.	F0761		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812		

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F0812 SS = D	Continued from page 9 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure the kitchen environment and food service equipment were maintained in a clean and sanitary condition. The facility failed to ensure the ventilation hood, return air vent, steam tables, and warmer doors were free from accumulated dust, grease, and food residue for one (1) of two (2) kitchen observations. Findings Include: Review of the facility's policy titled "Environment," revised May 2014, revealed, "It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition..." Review of the facility's policy titled "Equipment," revised May 2014, revealed, "It is the center policy that all foodservice equipment is clean, sanitary, and in proper working order..." On 10/12/2026 at 10:27 AM, during the initial tour observation of the kitchen with the Dietary Manager, an accumulation of dust was observed underneath the ventilation hood. The return air vent was observed to have a buildup of caked-on dust and grease covering the entire vent. Additionally, the	F0812		

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F0812 SS = D	Continued from page 10 steam tables and warmer doors were observed to have substantial amounts of splattered food residue and drip marks covering the surfaces of the equipment. During an interview and observation on 10/12/2026 at 10:35 AM, the Dietary Manager stated that a cleaning schedule was in place for dietary employees to follow. He acknowledged the observed conditions and stated that the kitchen equipment, ventilation hood, and return air vent needed to be thoroughly cleaned because this could be a fire hazard. During an interview on 10/13/2026 at 9:45 AM, the Director of Nursing stated that she had observed areas of the kitchen that needed to be cleaned and stated that it was the facility's expectation to maintain the kitchen in a clean condition, free from dust and food buildup. During an interview on 10/13/2026 at 2:30 PM, the Administrator stated that it was the facility's expectation for the kitchen to be maintained in a clean condition, free from dirt, dust, grease, and food buildup.	F0812		