STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 000	INITIAL COMMENTS An unannounced control focused survey was conducted on at Crystal Health and Rehab Center LLC, a skilled nursing facility in Tavernier, Florida. Crystal Health and Rehab Center LLC is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is a description of the noncompliance.	F 000		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and , well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report suspected Corona 2019 (COVID-19) case to the Department of Health as directed. Administration is responsible for the overall conduct of the facility. The findings included: A review of the Governor of the State of Florida executive order, dated , directed the Florida Department of Health (DOH) to coordinate the State's response to the COVID-19 pandemic. A review of the facility admission/discharge log	F 835	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. No residents were affected by this deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 835	Continued From page 1 revealed 13 deaths in the facility since . Seven of the deaths were suspicious for COVID-19 . In an interview on at 1:10 p.m., the Monroe County DOH , Nurse said they have no facility-based reports of resident deaths since . The nurse said the facility was advised as early as , to report deaths as there was a outbreak at the facility during that time. In an interview on at 1:12 p.m., the Monroe County DOH Preparedness Planner said he has told the facility to report deaths. He said he had learned of 4 of the deaths through other channels. In an interview on at 1:30 p.m., the facility Medical Director said there were 7 deaths that had COVID-19 testing ordered. In an interview on at 1:32 p.m., the facility Administrator confirmed she had not reported the deaths.	F 835	2. The DOH (Department of Health) will be notified of all deaths in the facility within 12 hours of the expiration 3. Nursing staff will be re-educated by the Director of Nursing that all deaths that occur in the facility must be reported to the DOH and the administrator and documented in the medical record 4. Discharges including deaths will be audited by Administrator and reported at monthly QAPI until substantial compliance is achieved	
F 880 SS=F	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 2 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 3 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to enact appropriate Corona 2019 (COVID-19) precautions for 19 (, 106, 107, 108, 110, 111, 113, 115, 117, 122, 123, 124, 125, 127, 128, 129, and 130) of 31 resident rooms on the first floor. The facility failed to observe proper social distancing for 7 (Resident #37, #38, #39, #39, #40, #41, #42, and #43) of 78 residents in the facility. Failure to follow CDC Recommendations places all residents in the facility at risk. The findings included: On The Centers for Control (CDC) released "Interim Prevention and Control Recommendations for Patients with Suspected or Confirmed Corona 2019 (COVID-19) in Healthcare Settings". Section 3 "Patient Placement" indicates, "If admitted, place a patient with known or suspected COVID-19 in a single-person	F 880	. Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restorative dining room without wearing masks. Other residents were identified outside of the restorative dining room not wearing masks or keeping social distance. Residents have the potential to be affected by this deficient practice. Resident # , # , # , #106, #107, #108, #110, #111, # 111, #113, #115, #117, #122, #123, #124, #125, #127, #128, #129, #130 doors were open to the common hallway: Residents in those rooms were PUI for COVID-19 and this practice had the potential to increase the spread of possible 2. The upstairs restorative dining room is now locked, and residents are now having meals and watching television in their rooms. Residents on the first floor were in serviced on the importance of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 4 with the door closed." In an interview on ..... at 11:45 a.m. the Administrator said the entire first floor is considered a COVID-19 unit for residents with confirmed or suspected COVID-19 . Observation on at 12:00 p.m., 7 residents (#37, #38, #39, #40, #41, #42, and #43) were in the second floor restorative dining watching a movie. The room contained 5 tables and proper social distancing was not in use. Observation on ..... at 12:02 p.m., 2 residents (#44 and #45) were moving about the second floor corridor without wearing facemasks. In an interview on ..... at 12:00 p.m., Registered Nurse Staff A confirmed there were too many residents in the room and proper social distancing was not used. She said residents in the hall should wear facemasks. Observation on ..... at 12:05 p.m. doors were open for , , . Residents were present in the rooms and were persons under investigation (PUI) for COVID-19 . Observation on at 3:10 p.m., on the first floor, , 106, 107, 108, 110, 111, 113, 115, 117, 123, 124, 125, 127, 128, and 129 had doors open to the common hallway. The residents in the rooms were PUI for COVID-19 ..... Observation on ..... at 3:15 p.m., 10 residents were sitting outside the entrance to the restorative dining room. None of the 10 residents were wearing facemasks or keeping social distance. No facemasks were observed in the	F 880	social distancing and wearing .... masks to minimize the risk of spreading , and specifically COVID-19 ..... 3. Staff was in serviced by the Director of Nursing to ensure that residents on the second floor are supervised to maintain social distancing, and staff on the first floor was in serviced and reminded to encourage the first floor residents to keep their doors closed and wear masks. Residents on the first floor were in serviced on the rationale for staying in their rooms with doors closed to minimize the risk of exposure and the spread of other ..... 4. Daily rounds on both floors will be conducted by the DON/Designee to ensure compliance by both staff and residents X1 month, then 3X weekly and reported to monthly QAPI until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 5 vicinity of the residents or evidence of their being provided. In an interview on at 3:25 p.m., the Administrator acknowledged the doors to rooms with PUI for COVID-19 should be closed.	F 880		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 000	INITIAL COMMENTS An unannounced control focused survey was conducted on at Crystal Health and Rehab Center LLC, a licensed nursing home in Tavernier, Florida. The following deficiencies were found at the time of the visit.	N 000		
N 201 SS=F	400.022(1)(i), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to enact appropriate Corona 2019 (COVID-19) precautions for 19 (, , , , 106, 107, 108, 110, 111, 113, 115, 117, 122, 123, 124, 125, 127, 128, 129, and 130) of 31 resident rooms on the first floor. The facility failed to observe proper social distancing for 7 (Resident #37, #38, #39, #39, #40, #41, #42, and #43) of 78 residents in the facility. Failure to follow CDC Recommendations places all residents in the facility at risk. The findings included: On The Centers for Control (CDC) released "Interim Prevention and	N 201	1. Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restorative dining room without wearing masks. Other residents were identified outside of the restorative dining room not wearing masks or keeping social distance. Residents have the potential to be affected by this deficient practice. Resident # , # , # , #106, #107, #108, #110, #111, # 111, #113, #115, #117, #122, #123, #124, #125, #127, #128, #129, #130 doors were open to the common hallway: Residents in those rooms were PUI for COVID-19 and this practice had the potential to increase the spread of	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/20

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 201	Continued From page 1 Control Recommendations for Patients with Suspected or Confirmed Corona 2019 (COVID-19) in Healthcare Settings". Section 3 "Patient Placement" indicates, "If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed." In an interview on . . . . . at 11:45 a.m. the Administrator said the entire first floor is considered a COVID-19 unit for residents with confirmed or suspected COVID-19 . Observation on at 12:00 p.m., 7 residents (#37, #38, #39, #39, #40, #41, #42, and #43) were in the second floor restorative dining watching a movie. The room contained 5 tables and proper social distancing was not in use. Observation on . . . . . at 12:02 p.m., 2 residents (#44 and #45) were moving about the second floor corridor without wearing facemasks. In an interview on . . . . at 12:00 p.m., Registered Nurse Staff A confirmed there were too many residents in the room and proper social distancing was not used. She said residents in the hall should wear facemasks. Observation on . . . . . at 12:05 p.m. doors were open for . . . . Residents were present in the rooms and were persons under investigation (PUI) for COVID-19 . Observation on at 3:10 p.m., on the first floor, ... , 106, 107, 108, 110, 111, 113, 115, 117, 123, 124, 125, 127, 128, and 129 had doors open to the common hallway. The residents in the rooms were PUI for COVID-19	N 201	possible . . . . . . 2. The upstairs restorative dining room is now locked, and residents are now having meals and watching television in their rooms. Residents on the first floor were in serviced on the importance of social distancing and wearing . . . masks to minimize the risk of spreading , and specifically COVID-19 . . . . . 3. Staff was in serviced by the Director of Nursing to ensure that residents on the second floor are supervised to maintain social distancing, and staff on the first floor was in serviced and reminded to encourage the first floor residents to keep their doors closed and wear masks. Residents on the first floor were in serviced on the rationale for staying in their rooms with doors closed to minimize the risk of exposure and the spread of other . . . . . 4. Daily rounds on both floors will be conducted by the DON/Designee to ensure compliance by both staff and residents X1 month, then 3X weekly and reported to monthly QAPI until substantial compliance is achieved	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 201	Continued From page 2 Observation on [redacted] at 3:15 p.m., 10 residents were sitting outside the entrance to the restorative dining room. None of the 10 residents were wearing facemasks or keeping social distance. No facemasks were observed in the vicinity of the residents or evidence of their being provided. In an interview on [redacted] at 3:25 p.m., the Administrator acknowledged the doors to rooms with PUI for COVID-19 should be closed. Class III	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 000	INITIAL COMMENTS An unannounced control focused survey was conducted on at Crystal Health and Rehab Center LLC, a skilled nursing facility in Tavernier, Florida. Crystal Health and Rehab Center LLC is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is a description of the noncompliance.	F 000		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and , well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report suspected Corona 2019 (COVID-19) case to the Department of Health as directed. Administration is responsible for the overall conduct of the facility. The findings included: A review of the Governor of the State of Florida executive order, dated , directed the Florida Department of Health (DOH) to coordinate the State's response to the COVID-19 pandemic. A review of the facility admission/discharge log	F 835	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. No residents were affected by this deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 835	Continued From page 1 revealed 13 deaths in the facility since . . . . Seven of the deaths were suspicious for COVID-19 . . . . . . In an interview on . . . . . at 1:10 p.m., the Monroe County DOH , , Nurse said they have no facility-based reports of resident deaths since . The nurse said the facility was advised as early as . . . . . , to report deaths as there was a outbreak at the facility during that time. In an interview on at 1:12 p.m., the Monroe County DOH Preparedness Planner said he has told the facility to report deaths. He said he had learned of 4 of the deaths through other channels. In an interview on at 1:30 p.m., the facility Medical Director said there were 7 deaths that had COVID-19 testing ordered. In an interview on at 1:32 p.m., the facility Administrator confirmed she had not reported the deaths.	F 835	2. The DOH (Department of Health) will be notified of all deaths in the facility within 12 hours of the expiration 3. Nursing staff will be re-educated by the Director of Nursing that all deaths that occur in the facility must be reported to the DOH and the administrator and documented in the medical record 4. Discharges including deaths will be audited by Administrator and reported at monthly QAPI until substantial compliance is achieved	
F 880 SS=F	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an . . . . prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable . . . . . and . . . . . . §483.80(a) . . . . prevention and control program. The facility must establish an . . . . prevention	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 2 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 3 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to enact appropriate Corona 2019 (COVID-19) precautions for 19 (, 106, 107, 108, 110, 111, 113, 115, 117, 122, 123, 124, 125, 127, 128, 129, and 130) of 31 resident rooms on the first floor. The facility failed to observe proper social distancing for 7 (Resident #37, #38, #39, #39, #40, #41, #42, and #43) of 78 residents in the facility. Failure to follow CDC Recommendations places all residents in the facility at risk. The findings included: On The Centers for Control (CDC) released "Interim Prevention and Control Recommendations for Patients with Suspected or Confirmed Corona 2019 (COVID-19) in Healthcare Settings". Section 3 "Patient Placement" indicates, "If admitted, place a patient with known or suspected COVID-19 in a single-person	F 880	. Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restorative dining room without wearing masks. Other residents were identified outside of the restorative dining room not wearing masks or keeping social distance. Residents have the potential to be affected by this deficient practice. Resident # , # , # , #106, #107, #108, #110, #111, # 111, #113, #115, #117, #122, #123, #124, #125, #127, #128, #129, #130 doors were open to the common hallway: Residents in those rooms were PUI for COVID-19 and this practice had the potential to increase the spread of possible 2. The upstairs restorative dining room is now locked, and residents are now having meals and watching television in their rooms. Residents on the first floor were in serviced on the importance of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 4 with the door closed." In an interview on ..... at 11:45 a.m. the Administrator said the entire first floor is considered a COVID-19 unit for residents with confirmed or suspected COVID-19 . Observation on at 12:00 p.m., 7 residents (#37, #38, #39, #40, #41, #42, and #43) were in the second floor restorative dining watching a movie. The room contained 5 tables and proper social distancing was not in use. Observation on ..... at 12:02 p.m., 2 residents (#44 and #45) were moving about the second floor corridor without wearing facemasks. In an interview on ..... at 12:00 p.m., Registered Nurse Staff A confirmed there were too many residents in the room and proper social distancing was not used. She said residents in the hall should wear facemasks. Observation on ..... at 12:05 p.m. doors were open for , , . Residents were present in the rooms and were persons under investigation (PUI) for COVID-19 . Observation on at 3:10 p.m., on the first floor, , 106, 107, 108, 110, 111, 113, 115, 117, 123, 124, 125, 127, 128, and 129 had doors open to the common hallway. The residents in the rooms were PUI for COVID-19 . Observation on ..... at 3:15 p.m., 10 residents were sitting outside the entrance to the restorative dining room. None of the 10 residents were wearing facemasks or keeping social distance. No facemasks were observed in the	F 880	social distancing and wearing .... masks to minimize the risk of spreading , and specifically COVID-19 ..... 3. Staff was in serviced by the Director of Nursing to ensure that residents on the second floor are supervised to maintain social distancing, and staff on the first floor was in serviced and reminded to encourage the first floor residents to keep their doors closed and wear masks. Residents on the first floor were in serviced on the rationale for staying in their rooms with doors closed to minimize the risk of exposure and the spread of other ..... 4. Daily rounds on both floors will be conducted by the DON/Designee to ensure compliance by both staff and residents X1 month, then 3X weekly and reported to monthly QAPI until substantial compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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
F 880	Continued From page 5 vicinity of the residents or evidence of their being provided. In an interview on at 3:25 p.m., the Administrator acknowledged the doors to rooms with PUI for COVID-19 should be closed.	F 880		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 000	INITIAL COMMENTS An unannounced control focused survey was conducted on at Crystal Health and Rehab Center LLC, a licensed nursing home in Tavernier, Florida. The following deficiencies were found at the time of the visit.	N 000		
N 201 SS=F	400.022(1)(i), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to enact appropriate Corona 2019 (COVID-19) precautions for 19 (, , , , , , 106, 107, 108, 110, 111, 113, 115, 117, 122, 123, 124, 125, 127, 128, 129, and 130) of 31 resident rooms on the first floor. The facility failed to observe proper social distancing for 7 (Resident #37, #38, #39, #39, #40, #41, #42, and #43) of 78 residents in the facility. Failure to follow CDC Recommendations places all residents in the facility at risk. The findings included: On The Centers for Control (CDC) released "Interim Prevention and	N 201	1. Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restorative dining room without wearing masks. Other residents were identified outside of the restorative dining room not wearing masks or keeping social distance. Residents have the potential to be affected by this deficient practice. Resident # , # , # , #106, #107, #108, #110, #111, # 111, #113, #115, #117, #122, #123, #124, #125, #127, #128, #129, #130 doors were open to the common hallway: Residents in those rooms were PUI for COVID-19 and this practice had the potential to increase the spread of	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 201	Continued From page 1 Control Recommendations for Patients with Suspected or Confirmed Corona 2019 (COVID-19) in Healthcare Settings". Section 3 "Patient Placement" indicates, "If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed." In an interview on . . . . . at 11:45 a.m. the Administrator said the entire first floor is considered a COVID-19 unit for residents with confirmed or suspected COVID-19 . Observation on at 12:00 p.m., 7 residents (#37, #38, #39, #39, #40, #41, #42, and #43) were in the second floor restorative dining watching a movie. The room contained 5 tables and proper social distancing was not in use. Observation on . . . . . at 12:02 p.m., 2 residents (#44 and #45) were moving about the second floor corridor without wearing facemasks. In an interview on . . . . at 12:00 p.m., Registered Nurse Staff A confirmed there were too many residents in the room and proper social distancing was not used. She said residents in the hall should wear facemasks. Observation on . . . . . at 12:05 p.m. doors were open for . . . . Residents were present in the rooms and were persons under investigation (PUI) for COVID-19 . Observation on at 3:10 p.m., on the first floor, ... , 106, 107, 108, 110, 111, 113, 115, 117, 123, 124, 125, 127, 128, and 129 had doors open to the common hallway. The residents in the rooms were PUI for COVID-19	N 201	possible . . . . . . 2. The upstairs restorative dining room is now locked, and residents are now having meals and watching television in their rooms. Residents on the first floor were in serviced on the importance of social distancing and wearing . . . masks to minimize the risk of spreading , and specifically COVID-19 . . . . . 3. Staff was in serviced by the Director of Nursing to ensure that residents on the second floor are supervised to maintain social distancing, and staff on the first floor was in serviced and reminded to encourage the first floor residents to keep their doors closed and wear masks. Residents on the first floor were in serviced on the rationale for staying in their rooms with doors closed to minimize the risk of exposure and the spread of other . . . . . 4. Daily rounds on both floors will be conducted by the DON/Designee to ensure compliance by both staff and residents X1 month, then 3X weekly and reported to monthly QAPI until substantial compliance is achieved	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	114403A	A. BUILDING: _____ B. WING _____	05/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL HEALTH AND REHAB CENTER, LLC	48 HIGH POINT ROAD TAVERNIER, FL 33070

(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) COMPLETE DATE
N 201	Continued From page 2 Observation on . . . . . at 3:15 p.m., 10 residents were sitting outside the entrance to the restorative dining room. None of the 10 residents were wearing facemasks or keeping social distance. No facemasks were observed in the vicinity of the residents or evidence of their being provided. In an interview on . . . . . at 3:25 p.m., the Administrator acknowledged the doors to rooms with PUI for COVID-19 should be closed. Class III	N 201		