PRINTED: 05/19/2020

		ID HUMAN SERVICES				APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	400 500 900	V 0011070110701		0.0938-0391
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		106092	B. WING		05/	02/2020
NAME OF P	ROVIDER OR SUPPLIER		· I	STREET ADDRESS, CITY, STATE, ZIP CODE		
ODVOTAL		FNTER 110		48 HIGH POINT ROAD		
CRISIAL	HEALTH AND REHAB C	ENTER, LLC		TAVERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00			
	Tavernier, Florida. Crystal Health and F compliance with Cod-	control focused survey at Crystal Health and skilled nursing facility in tehab Center LLC is not in e of Federal Regulations				
	for Long-Term Care F					
	The following is a de- noncompliance.	scription of the				
F 835	Administration		F 83			
SS≃F	CFR(s): 483.70		1 00			
	enables it to use its n efficiently to attain or practicable physical, well-being of each re-	ninistered in a manner that esources effectively and maintain the highest mental, and				
	Based on interview a failed to report suspe 2019 (COVID-19) case	se to the Department of dministration is responsible		This Plan of Correction is the facility credible allegation of compliance. Preparation and/or execution of this p of correction does not constitute admission or agreement by the provist the truth of the facts alleged or	olan	
	executive order, date Department of Health State's response to the	rnor of the State of Florida		conclusions sel forth in the statement deficiencies. The plan of correction in prepared and/or executed solely beci it is required by the provisions of fede and state law. 1. No residents were affected by the deficient practice	s ause eral	
	wiesiem of the tacitud	r aumissionruischarge rog	1	dencient practice		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

/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.

Electronically Signed

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS	PLE CONSTRUCTION G	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		106092	B. WING		05.	/02/2020	
	ROVIDER OR SUPPLIER HEALTH AND REHAB C	ENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 48 HIGH POINT ROAD TAVERNIER, FL 33070			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 835 F 880 SS=F	Seven of the deaths is COVID-19 In an interview on County DOH on tacility-based report of the county DOH of the county DOH of the county DOH of the county DOH Prepare told the facility to report old the facility to report old the facility to report old the facility to report of the channels. In an interview on Medical Director said had COVID-19 testing In an interview on Administrator confirm deaths. Prevention 8 Prevention 8 CFR(s): 483.80(a)(1) §483.80 Corthe facility must estate acility acility acility acility acili	the facility since were suspicious for at 1:10 p.m., the Monroe Nurse said they have tris of resident deaths since id the facility was advised as report deaths as there was a slitty during that time. at 1:12 p.m., the Monroe dness Planner said he has of the said he had aths through other at 1:30 p.m., the facility there were 7 deaths that gordered. at 1:32 p.m., the facility days of the said he had aths through other at 1:32 p.m., the facility ded she had not reported the said he had not reported the said he had not reported the said said said said said said said said	F-8:	The DOH (Department of He be notified of all deaths in the faz within 12 hours of the expiration Nursing staff will be re-educe the Director of Nursing that a that occur in the facility must be rothe to DOH and the administr documented in the medical reconduced to the Discharges including deaths audited by Administrator and representity OAPI until substantial co is achieved	ated by all deaths eported ator and d will be orted at		
	§483.80(a) program.	prevention and control					

The facility must establish an prevention

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CENTERS FOR MEDICARE & MEDICAID SERVICES							0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		106092	B. WING _			05/	02/2020
NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL HEALTH AND REHAB CENTER, LLC					HIGH POINT ROAD AVERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	a minimum, the follow §483.80(a)(1) A syste reporting, investigated and communicable staff, volunteers, visit and communicable staff, volunteers, visit providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the proture and infinited to: (i) A system of surveil possible communicable possible communicable possible communicable reported; (iii) Standard and trat to be followed to prev () When and how iscresident; including bu (A) The type and dura depending upon the involved, and (B) A requirement tha least restrictive possil circumstances, (v) The circumstances (v) The circumstances under the control of the	IPCP) that must include, at iring elements: im for preventing, identifying, g, and controlling for all residents, ors, and other individuals der a contractual pon the facility assessment to \$483.70(e) and following individuals and the second of the facility assessment to \$483.70(e) and following individuals. It is a second of the second	F8	180			

hygiene procedures to be followed

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DEFAIL	VIEW OF HEALTHAN	ID HOMAIN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		106092	B. WING		05	/02/2020
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				48 HIGH POINT ROAD		
CRYSTAL	HEALTH AND REHAB C	ENTER, LLC		TAVERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	Continued From page by staff involved in di	rect resident contact.	F 880			
	identified under the fa corrective actions tak					
		le, store, process, and to prevent the spread of				
	IPCP and update the This REQUIREMENT by:	riew. ct an annual review of its ir program, as necessary. is not met as evidenced n, interview, and record		. Residents #37, #38, #39, #40), #	
	Corona precautions for 19 (108, 110, 111, 113, 11 127, 128, 129, and 13 the first floor. The fac	ad to enact appropriate . 2019 (COVID-19) 		#42, #43 were identified not practi social distancing in the upstairs restorative dining room without we masks. Other residents were identified outside of the restorative room not wearing masks or k	earing e dining eeping	
	#39, #40, #41, #42, a the facility. Failure to	r (Resident #37, #38, #39, nd #43) of 78 residents in follow CDC aces all residents in the		#, #106, #107, #108, #110, #1 111, #113, #115, #117, #122, #123	licient # , 11, # 3, #124,	
	The findings included	:		#125, #127, #128, #129, #130 doc open to the common hallway: Re in those rooms were PUI for COV	sidents	
	Suspected or Confirm 2019 (COVID-19) in I Section 3 "Patient Pla	rim Prevention and ations for Patients with ned Corona Healthcare Settings".		and this practice had the potential to increase the spread or possible 2. The upstairs restorative dinin is now locked, and residents are rhaving meals and watching televis	f g room now sion in	
	admitted, place a pat	ient with known or		their rooms. Residents on the fire	SI ROOF	1

suspected COVID-19 in a single-person

were in serviced on the importance of

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CENTERS FOR MEDICARE & MEDICAID SERVICES (
D DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED					
	106092	B. WING	05/02/2020					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	A. BUILDING			COMPLETED	
		106092	B. WING _			05	02/2020
	NAME OF PROVIDER OR SUPPLIER CRYSTAL HEALTH AND REHAB CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48 HIGH POINT ROAD TAVERNIER, FL 33070			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	with the door closed." In an interview on Administrator said the considered a COVID-confirmed or suspect of Considered a COVID-confirmed or suspect of Conservation on Consideration of Conservation on Conservation Conserv	at 11:45 a.m. the entire first floor is 19 unit for residents with ad COVID-19 at 12:00 p.m., 7 residents with 4d COVID-19. at 12:00 p.m., 7 residents with 4d COVID-19 at 141, #42, and #43) were in rative dining watching a tained 5 tables and proper not in use. Observation on 2 residents (#44 and #45) es second floor corridor nasks. at 12:00 p.m., fl A confirmed there were the room and proper social ed. She said residents in accemasks. at 12:05 p.m. doors were Residents on the said residents of the said residents of the said residents of the said residents on the said residents of the	F8	80	social distancing and wearing mass to minimize the risk of spreading and specifically COVID-19 3. Staff was in serviced by the Direct of Nursing to ensure that residents on 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 ke their doors closed and wear mask Residents on the first floor were in serviced on the rationale for staying in their rooms with doors closed to minim the risk of exposure and the sprea of other 4. Dally rounds on both floors will be conducted by the DON/Designee to ensure compliance by both staff and residents X1 month, then 3X weekly ar reported to monthly QAPI until substan compliance is achieved	or he i eep s. ize d	

distance. No facemasks were observed in the

PRINTED: 05/19/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 106092 B. WING 05/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 48 HIGH POINT ROAD CRYSTAL HEALTH AND REHAB CENTER, LLC TAVERNIER, FL 33070 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 5 F 880 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

Agency fr	or Health Care Adminis	tration				.05/19/2020 APPROVED
STATEMENT	OF DEFICIENCES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		114403A	B. WING		05/0:	2/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CRYSTAL	HEALTH AND REHAB C	ENTER LLC	POINT ROAD IER, FL 33070			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	INITIAL COMMENTS		N 000			
N 201 SS=F	Rehab Center LLC, a Tavernier, Florida The following deficier of the visit. 400.022(1)(i), FS Rig Appropriate Health C: The right to receive a health care and prote including social servic if available; planned r therapeutic and rehat with the resident care recognized practice s	dequate and appropriate clive and support services, bes; mental health services, ecreational activities; and dilitative services consistent plan, with established and	N 201			
	Based on observation review the facility faile Corona precautions for 19 (108, 110, 111, 113, 11 127, 128, 129, and 13 the first floor. The fac social distancing for 7 #39, #40, #41, #42, a the facility. Failure to	15, 117, 122, 123, 124, 125, 0) of 31 resident rooms on liltly failed to observe proper (Resident #37, #38, #39, nd #43) of 78 residents in follow CDC acces all residents in the		1. Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restor dining room without wearing mother residents were identified outsid the restorative dining room not wearin masks or keeping social distance. Residents have the potential to be affected by this deficient practice. Resident # # # #107, #108, #110, #111, #111, #113, #115, #117, #122, #123, #124, #125, #127, #128, #129, #130 doors were to the common hallway. Residents in	ative ks. e of g c.	

(CDC) released "Interim AHCA Form 3020-0001

On

The Centers for LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Control

Prevention and

(X6) DATE TITLE Electronically Signed /20

those rooms were PUI for COVID-19

potential to increase the spread of

and this practice had the

Agency f	or Health Care Adminis	stration				05/19/2020 APPROVED
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
		114403A	B. WING		05/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE		
CRYSTAL	HEALTH AND REHAB C	ENTER LLC	POINT ROAD HER, FL 33070			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 201	Continued From page	e 1	N 201			
	Suspected or Confirm 2019 (COVID-19) in Section 3 "Patient Pla admitted, place a pat suspected COVID-19 with the door closed." In an interview on Administrator said the considered a COVID-19 confirmed or suspect Observation on (#37, #38, #39, #39, were in the second fit watching a movie. The and proper social discovered to the second fit of the covid for the covid fit of the c	-Healthcare Settings" accement indicates, "If lent with known or in a single-person room		possible 2. The upstairs restorative dining re now locked, and residents are now heals and watching television in their rooms. Residents on the first floor win serviced on the importance of sociotistancing and wearing masks to minimize the risk of spreading and specifically COVID-19 3. Staff was in serviced by the Direction of the following the	aving r r rere al o , ctor of ne ain it) keep sks. n mize ead	

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

Agency	for Health Care Adminis	tration			PRINTED: 05/19/2020 FORM APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		114403A	B. WING		05/02/2020	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE		
CRYSTAL	HEALTH AND REHAB C	ENTER, LLC TAVERNI	POINT ROAD ER, FL 33070			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
N 201	Observation on were sitting outside the restorative dining roo were wearing facema distance. No facema vicinity of the resident provided.	at 3:15 p.m., 10 residents to entrance to the m. None of the 10 residents sks or keeping social sks were observed in the ts or evidence of their being at 3:25 p.m., the ledged the doors to rooms	N 201			

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		ID HUMAN SERVICES				APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	400 500 900	V 0011070110701		0.0938-0391
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		106092	B. WING		05/	02/2020
NAME OF P	ROVIDER OR SUPPLIER		· I	STREET ADDRESS, CITY, STATE, ZIP CODE		
ODVOTAL		FNTER 110		48 HIGH POINT ROAD		
CRISIAL	HEALTH AND REHAB C	ENTER, LLC		TAVERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00			
	Tavernier, Florida. Crystal Health and F compliance with Cod-	control focused survey at Crystal Health and skilled nursing facility in tehab Center LLC is not in e of Federal Regulations				
	for Long-Term Care F					
	The following is a de- noncompliance.	scription of the				
F 835	Administration		F 83			
SS≃F	CFR(s): 483.70		1 00			
	enables it to use its n efficiently to attain or practicable physical, well-being of each re-	ninistered in a manner that esources effectively and maintain the highest mental, and				
	Based on interview a failed to report suspe 2019 (COVID-19) case	se to the Department of dministration is responsible		This Plan of Correction is the facility credible allegation of compliance. Preparation and/or execution of this p of correction does not constitute admission or agreement by the provist the truth of the facts alleged or	olan	
	executive order, date Department of Health State's response to the	rnor of the State of Florida		conclusions sel forth in the statement deficiencies. The plan of correction in prepared and/or executed solely beci it is required by the provisions of fede and state law. 1. No residents were affected by the deficient practice	s ause eral	
	wiesiem of the tacitud	r aumissionruischarge rog	1	dencient practice		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that /2020

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.

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		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		CONSTRUCTION	(X3) DATE COME	SURVEY
		106092	B. WING _			05.	02/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CDVSTAI	HEALTH AND REHAB C	ENTED IIC		48	HIGH POINT ROAD		
CKISIAL	HEACITI AND KEHAB C	ENTER, LEG		TA	WERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F835	Seven of the deaths is COVID-19 In an interview on County DOH , no facility-based repo . The nurse sa early as to routy BOH report outbreak at the fac In an interview on County DOH Prepare told the facility to rep	the facility since	F8		The DOH (Department of Health) be notified of all deaths in the facility within 12 hours of the expiration Nursing staff will be re-educated in the Director of Nursing that all detended that occur in the facility must be report to the DOH and the administrator to documented in the medical record Discharges including deaths will be audited by Administrator and reported monthly QAPI until substantial complicits achieved	by aths ed and e e at	
	program. The facility must esta	blish an prevention					

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CENTERS FOR MEDICARE & MEDICAID SERVICES							3 NO. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION		DATE SURVEY COMPLETED
		106092	B. WING				05/02/2020
NAME OF PE	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL	HEALTH AND REHAB C	ENTER, LLC			HIGH POINT ROAD PERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	a minimum, the follow §483.80(a)(1) A syste reporting, investigated and communicable staff, volunteers, visit and communicable staff, volunteers, visit providing services un arrangement based u conducted according accepted national sta \$483.80(a)(2) Writter procedures for the pott are not limited to: (i) A system of survei possible communicable possible communicable possible communicable possible communicable reported; (ii) When and to who communicable reported; (iii) Standard and trat to be followed to prev () When and how is resident; including bu (A) The type and duratepending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employunce of significance of the contract with residents contact with residents.	IPCP) that must include, at ing elements: ing elements: in more preventing, identifying, g, and controlling for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and oppram, which must include, lance designed to identify ele	F:	380			
		procedures to be followed					

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		ID HUMAN SERVICES				PPROVED	
		MEDICAID SERVICES	T		OMB NO. 0		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: 106092			A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		05/02/	2020		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE C	(X5) COMPLETION DATE	
F 880	Continued From page by staff involved in di		F8	80			
	§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, 126, 129, and 130) of 31 resident rooms on the first floor. The facility failed to observe proper social distancing for 7 (Resident #87, #38, #39, #39, #40, #41, #42, and #43) of 78 residents in the facility. Failed to observe proper social distancing for 7 (Resident #87, #38, #39, #49, #41, #41, #42, and #43) of 78 residents in the facility. Failed to observe proper social distancing for 7 (Resident #87, #38, #39, #49, #41, #41, #42, and #43) of 78 residents in the facility at risk. The findings included:			Residents #37, #38, #39, #40, #42, #43 were identified not practis social distancing in the upstairs restorative dining room without we	earing a dining eeping he icient # , 11, # 3, #124, pre-were sidents iD-19		
	Suspected or Confirm 2019 (COVID-19) in F	rim Prevention and ations for Patients with ned Corona Healthcare Settings".		and this practice had the potential to increase the spread of possible 2. The upstairs restorative dining is now locked, and residents are in having meals and watching televis their rooms. Residents on the fire	f g room now sion in		

admitted, place a patient with known or suspected COVID-19 in a single-person

were in serviced on the importance of

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
l		106092	B. WING	05/02/2020	
1	NAME OF BROWINGS OF SUBBLIED		STREET ADORSES CITY STATE 7ID CODE		

			7. 35/25/10				
	106092 B. WING			05/02/2020			
NAME OF P	ROVIDER OR SUPPLIER			S'	FREET ADDRESS, CITY, STATE, ZIP CODE		
CRYSTAL HEALTH AND REHAB CENTER, LLC				48	HIGH POINT ROAD		
OILIOIAL	TICACITI AND NEITAD O	Little, CLO		T	AVERNIER, FL 33070		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 880	Continued From page	4	F.	380			
	with the door closed."				social distancing and wearing mas	le l	
	with the door closed.				to minimize the risk of spreading	K3	
	In an interview on	at 11:45 a.m. the			and specifically COVID-19	,	
	Administrator said the				3. Staff was in serviced by the Directo	r	
	considered a COVID-	19 unit for residents with			of Nursing to ensure that residents on the	ne	
	confirmed or suspecte	ed COVID-19 .			second floor are supervised to maintain social distancing, and staff on the first		
	Observation on	at 12:00 p.m., 7 residents			floor was in serviced and reminded to		
	(#37, #38, #39, #40, #	#41, #42, and #43) were in			encourage the first floor residents to ke	ep	
		rative dining watching a			their doors closed and wear masks		
	movie. The room cont	tained 5 tables and proper			Residents on the first floor were in		
	social distancing was	not in use. Observation on			serviced on the rationale for staying in		
	at 12:02 p.m.,	2 residents (#44 and #45)			their rooms with doors closed to minimize	ze	
		e second floor corridor			the risk of exposure and the spread	i	
	without wearing facemasks.				of other 4. Daily rounds on both floors will be		
	In an interview on	at 12:00 p.m.,			conducted by the DON/Designee to		
	Registered Nurse Sta	ff A confirmed there were			ensure compliance by both staff and		
	too many residents in	the room and proper social			residents X1 month, then 3X weekly an	d	
		ed. She said residents in			reported to monthly QAPI until substant	ial	
	the hall should wear f	acemasks.			compliance is achieved		
	Observation on	at 12:05 p.m. doors were					
	open for	, Residents					
	were present in the ro	oms and were persons					
	under investigation (P	PUI) for COVID-19 .					
	Observation on floor.	at 3:10 p.m., on the first					
		3, 124, 125, 127, 128, and					
		o the common hallway. The					
		s were PUI for COVID-19					
	Observation on at 3:15 p.m., 10 residents						
	were sitting outside th						
		m. None of the 10 residents					
	were wearing facema						
	distance. No facema:	sks were observed in the					

PRINTED: 06/12/2020 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL(ER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 106092 B. WING 05/02/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 48 HIGH POINT ROAD CRYSTAL HEALTH AND REHAB CENTER, LLC TAVERNIER, FL 33070 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 5 F 880 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

PRINTED: 06/12/202 FORM APPROVE Agency for Health Care Administration							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1		COMPLE	TED	
		114403A	B. WING		05/0	2/2020	
			1		1 DOIGE EDED		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE			
CRYSTAL	HEALTH AND REHAB C	ENTER LLC	POINT ROAD				
			R, FL 33070				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
N 000	INITIAL COMMENTS		N 000				
N 201	Rehab Center LLC, a Tavernier, Florida.	control focused survey at Crystal Health and licensed nursing home in cies were found at the time	N 201				
SS=F	Appropriate Health Car The right to receive at health care and prote including social servic if available; planned in therapeutic and rehab with the resident care recognized practice si	dequate and appropriate clive and support services, ses; mental health services, secreational activities; and slittative services consistent plan, with established and					
	Based on observation review the facility faile Corona precautions for 19 (108, 110, 111, 113, 11 127, 128, 129, and 13 the first floor. The faci social distancing for 7 439, #40, #41, #42, a the facility. Failure to	s not met as evidenced by: , interview, and record d to enact appropriate 2019 (COVID-19), 106, 107, 5, 117, 122, 123, 124, 125, 10) of 31 resident rooms on lity failed to observe proper (Resident #37, #38, #39, nd #43) of 78 residents in follow CDC acces all residents in the		Residents #37, #38, #39, #40, # #42, #43 were identified not practicing social distancing in the upstairs restor dining room without wearing	ative ks. e of g o.		

On

The Centers for LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Control

Prevention and

The findings included:

(CDC) released "Interim

(X6) DATE TITLE Electronically Signed /20

to the common hallway: Residents in those rooms were PUI for COVID-19

potential to increase the spread of

and this practice had the

Agency f	or Health Care Adminis	stration			PRINTED: 06/ FORM APF	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		114403A	B. WING		05/02/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
CDVSTAI	HEALTH AND REHAB C	ENTER II.C 48 HIGH	POINT ROAD			
CKISIAL	TIERETTI AND KETIAD C	TAVERN	IER, FL 33070			
(X4) ID		ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		MPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RATE	DATE
				DEFIGEROT)		
N 201	Continued From page	1	N 201		Sur Paris	
	Control Recommenda	ations for Patients with		possible	E E	
	Suspected or Confirm	ned Corona		2. The upstairs restorative dining ro	om is	
	2019 (COVID-19) in I	lealthcare Settings".		now locked, and residents are now ha	are now having	
	Section 3 "Patient Pla	cement" indicates, "If		meals and watching television in their		
	admitted, place a pat	ient with known or		rooms. Residents on the first floor w	ere	
	suspected COVID-19	in a single-person room		in serviced on the importance of social		
	with the door closed."	,		distancing and wearing masks to	and the same of th	
				minimize the risk of spreading		
	In an interview on	at 11:45 a.m. the		and specifically COVID-19		
	Administrator said the	e entire first floor is		3. Staff was in serviced by the Direct	tor of	
	considered a COVID-	19 unit for residents with		Nursing to ensure that residents on th		
	confirmed or suspected COVID-19			second floor are supervised to mainta		
				social distancing, and staff on the first		
	Observation on	at 12:00 p.m., 7 residents		floor was in serviced and reminded to		
	(#37, #38, #39, #39, #	#40, #41, #42, and #43)		encourage the first floor residents to k	eep	
	were in the second flo	oor restorative dining		their doors closed and wear mas	ks.	
	watching a movie. Th	e room contained 5 tables		Residents on the first floor were in		
	and proper social dist	ancing was not in use.		serviced on the rationale for staying in	, !	
		at 12:02 p.m., 2 residents		their rooms with doors closed to minir	nize	
		noving about the second		the risk of exposure and the spre		
	floor corridor without wearing facemasks.			of other		
				4. Daily rounds on both floors will be		
	In an interview on .	at 12:00 p m		conducted by the DON/Designee to	-	
		off A confirmed there were		ensure compliance by both staff and		
		the room and proper social		residents X1 month, then 3X weekly a	ind	
		sed. She said residents in	1	reported to monthly QAPI until substa		
	the hall should wear t			compliance is achieved	· moi	
	non onodio wedi i	and the same of th				
	Observation on	at 12:05 p.m. doors were				
		, Residents				
		ooms and were persons				
	under investigation (F				-	
	,					
	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

STATE FORM 690 FSJU11 H continuation sheet 2 of 3

Agency f	or Health Care Adminis	stration				1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		114403A	B. WING		05/0	2/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CRYSTAL	HEALTH AND REHAB C		POINT ROAD ER, FL 33070			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 201	were sitting outside the restorative dining roo were wearing facema distance. No facema vicinity of the residen provided. In an interview on	at 3:15 p.m., 10 residents to entrance to the m. None of the 10 residents sisks or keeping social sks were observed in the ts or evidence of their being at 3:25 p.m., the ledged the doors to rooms	N 201			