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 _____	05/14/2020

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 and complaint survey for #2020008454 and #2020008704 was conducted through at Crystal Health and Rehab Center, LLC, a skilled nursing facility in Tavernier, Florida. Complaint #2020008454 was substantiated at F550, F585, and F921. Complaint #2020008704 was substantiated at F550, F558, F565, F585, F677, and F921. 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

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 _____	05/14/2020

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 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interviews and attempted calls, the facility failed to ensure a functional phone system to ensure communication between residents and families for 3 (Resident #1, #2, and #3) of 3 family members interviewed with a potential to affect all 77 residents. This issue has caused families to become . . . . , worried and frustrated with not being able to contact loved ones to provide support or facility staff for answers to questions. The findings included: In interview on . . . . . at 2:14 p.m., Resident	F 550	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. F.550 1. Residents had the potential to be	

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 _____	05/14/2020

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 550	Continued From page 2 #1's son said that his biggest issue was the communication with the facility and his mother. He said the phone system had been bad for over a year and he had put in grievances about this issue, but nothing was done. He said that when you call, no one answers or when you try to contact the correct person to leave a message, the call does not connect, is dropped, or goes to a busy signal. It was hard to call into his mother's room and he cannot get any information on what was happening in the facility or with his mother, which was making him very worried. In a telephone interview on at 2:33 p.m., Resident #2's family member said she was very upset with the facility because she could not get any information. She said that she had learned things in the newspaper. It made her so upset because she could not get through on the phone lines and could not go in and see her loved one. She said that she had been calling for two weeks to get her father-in-law's test results and could not get any answers. She said that the staff hardly ever answer the phones, "It is very frustrating." The family called repeatedly, we were so worried, and were not receiving answers from facility management. In interview on . . . . . at 12:15 p.m., Resident #3's son said the main problem was communication. He said his mother was very hard of hearing and she could not talk on the phone very well. He said the facility wasn't answering their phones and when messages were left for the Director of Nursing or Social Worker, they don't return calls. When the phone rings now it was forwarded to the Administrator where the recording says the mailbox was full. The son said the phones in the facility hadn't	F	affected by this deficient practice. 2. A new functional phone system was installed, while surveyors were still in the building. A hotline was also setup to provide COVID-19 general updates to family members and other callers, which will be monitored by the corporate office. 3. Staff was educated on the new phone system and were also re-educated on customer service and timely communication to residents and family members regarding both resident and family concerns; and for staff to check their messages daily, and return phone calls within 24 hours by the Administrator or designated staff. 4. Administrator will randomly make weekly phone calls and report to QAPI X3 months 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 _____	05/14/2020

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 550	Continued From page 3	F 550		

been working properly for 2 years and the families could not reach their loved ones.

In interview on at 12:30 p.m., Registered Nurse (RN) Staff M said she did feel short of staff at times because they had 37 residents sometimes and it was hard to do all the duties, plus secretary work, answer the phone, and talk with families. She said a lot of times she was unable to answer the phone when she was busy.

In interview on at 12:45 p.m., RN Staff N said the facility was sometimes short of staff, but it was within the numbers, but sometimes with the whole COVID thing going on, she did hear from a lot of families that they had trouble with the phone system. She said that after they reset the fax machine it messed with the phone system. She also said that sometimes the families were calling a lot, trying to get information about their loved one because of the COVID. She said when we were busy and did not have a desk person, it was hard to answer the phone.

In interview on at 12:58 p.m., the Assistant Director of Nursing said the facility now had a hot line number which was started on today (during the survey). When a family member called it would go to one of four phones that the management team carried on them to ensure that the family could always get a hold of someone to answer their questions or find a way they could communicate with their loved one.

In interview on at 1:52 p.m., the Maintenance/Housekeeping and Laundry Manager said he was aware of problems with the current phone system, and it was going to be replaced.

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 _____	05/14/2020

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 550	Continued From page 4 On at 12:36 p.m., a surveyor placed a telephone call to the facility during the survey. The phone rang until the communication was lost. The phone call was not directed to a voicemail before the line went . In interview on at 1:55 p.m., the Executive Director said the phone system for the entire facility including the resident rooms were being replaced as we spoke, the phone men were here installing the phones. On at 6:00 p.m., this surveyor attempted to call the facility from a phone located in town. There were many phone prompts to get through. After selection of the first-floor nurses' station, the phone continued to ring without an answer.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide equipment to accommodate the need for transfers for 1 (Resident #5) of 2 residents who require assistance from staff in the COVID unit to maintain independent functioning. The failure to provide a way for residents to get up in their chairs could negatively impact the health and social well-being of the residents.	F 558	1. Resident #5 on the COVID unit was identified, and residents on the unit had the potential to be affected by this deficient practice 2. The facility obtained a , for use only on the COVID unit, which enabled resident # 5 to get in and out of bed and sit up in his chair 3. Staff was educated that the ,	

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 _____	05/14/2020

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 558	Continued From page 5 The findings included: During a telephone interview on at 2:38 p.m., a friend Resident #5 said the resident has been in isolation since he tested positive for COVID-19 the week before. The friend reported Resident #5 had not been able to get out of bed into his power chair for a week, since he had been in isolation on the COVID unit. Resident #5 had his full mental faculties but suffered from , is unable to move on his own, and was wheelchair or bed bound. Review of Minimum Data Set (MDS) assessment records revealed Resident #5 required of two or more staff members for moving in bed and transferring to his power chair. He also needed of two or more staff for bathing and . The MDS recorded the resident's mobility on and off the unit was supervision and he only needed to be set up in his power chair for him to have full mobility. In an interview on at 11:15 a.m., the Director of Nursing (DON) said she was aware Resident #5 had been upset about not being taken out of bed since he was moved to the COVID unit. She also said Resident #5 was upset because he was not getting up in his chair for meals. She added he had to be lifted with a and the facility only had one for each floor. She explained the facility did not want to bring one into the COVID unit because then they could not take it out again, so he was not able to get out of bed. In an interview on at 1:15 p.m., COVID unit nurse on days, Registered Nurse (RN) Staff	F 558	should only be used on the COVID unit and proper techniques before and after use to prevent the spread of the Coronavirus. The DON rounds daily on the unit to ensure that the is not moved to another unit in the facility 4. This will be monitored and reported through monthly QAPI for compliance until the facility is COVID free	

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 _____	05/14/2020

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 558	Continued From page 6 F said Resident #5 got upset because he had to stay in his bed since he was moved to the COVID unit. RN Staff F said Resident #5 had to stay in bed because they did not have a , to get him up and into his power chair. He said the facility only had one lift for each floor, and they could not bring it into the COVID unit because they would have to leave it there. Therefore, they were unable to get Resident #5 out of bed. The resident liked to be up in the chair because he can be mobile and liked to eat in his chair because he could be positioned better. RN Staff F said the Resident had been frustrated and upset for those reasons.	F 558		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-( )(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. ( ) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 565		

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 _____	05/14/2020

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 565	Continued From page 7 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to consider the views of a group of family members congregated outside the facility on Mother's Day. The family group was concerned because the facility failed to provide alternative to visitation and communication for residents and family members regarding the health status of 2 (Resident #2 and #3) of 8 sampled residents. The findings included: In an interview on at 12:15 p.m., Resident #3's son said the facility wasn't answering their phones. He said the Director of Nursing (DON) and the Social Worker do not return the calls when he leaves messages. The son said now when the phone rings and it is forwarded to the Administrator where a recording reports the mailbox is full. The son said he and his wife went to the facility on Mother's Day to see if they could see Resident #3. The resident's room was on the first floor and her bed was by the window. The son said other families were there as well.	F 565	1. Family members of residents #2 and #3 reported they were not receiving information from the facility and were not able to speak with any staff from the facility regarding their loved ones on Mother□s Day.. Residents had the potential to be affected by this deficient practice. 2. The facility installed a hotline thereafter where family members and other callers to the facility could obtain daily updated COVID-19 information relating to the facility. A new phone system was being installed while surveyors were still in the building The facility administrator mailed COVID-19 information return receipts to family members, and designated staff was identified to make weekly calls to family members in efforts to boost communication between the facility and family members 3. The Executive Director was educated on the handling of delicate situations that	

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 _____	05/14/2020

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 565	Continued From page 8	F 565		

Everyone was wearing masks and standing six apart. The Business Office Manager came outside and told us to leave or law enforcement would be called. He said they noticed the nurses were going from room to room and closing the window blinds in the resident's rooms, even the rooms on the second floor. The son said local law enforcement came. The family members were told it was private property and they had to leave. Resident #3's son said the families just wanted answers and know if their loved ones were all right.

In an interview on at 12:26 p.m., the Business Office Manager said on Mother's Day someone from administration called her to go to the door. She said a family member was at the door. The families said they weren't getting information. The Business Office Manager said the administrator asked her to call the sheriff. She said she did not know what happened when the sheriff came. The sheriff told her the families were told to leave.

In a telephone interview on at 2:33 p.m., Resident #2's daughter-in-law she was very upset with the facility because she could not get any information on how her father-in-law was doing and if his COVID-19 test was positive or not. She said they tried to visit Resident #2 on Mother's Day ( ) from the outside but the facility called the police. She said there were four other families there as well. They were all ordered to leave the property. She said the family was very frustrated because they could not talk to anyone about Resident #2 who no longer understands how to use the phone. The daughter-in-law said the only information they got was from the newspaper and families needed to know what

required sensitivity and discretion during times of difficulty by the Regional Director of Operations
4. This will be brought to monthly QAPI for monitoring and compliance x 2months

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 _____	05/14/2020

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 565	Continued From page 9	F 565		

was going on with their loved ones. She voiced concern about communication and the COVID spreading within the facility even when they were all locked in with no visitors.

In an interview on at 3:41 p.m., the Director of Nursing (DON) said she heard on Mother's Day, a group of family members came to the facility wanting information. They were worried about the information in the paper. The DON said the sheriff had called the Executive Director (ED) to inform her there would be a peaceful protest at the facility on Sunday. The DON said the ED instructed the Business Office Manager to call the sheriff. The sheriff's officer came to the facility and the families were made to leave the property.

In an interview on 1:55 p.m., the ED she said the Business Office Manager was at the facility on Mother's Day and called her. The Manager said there were about 10 family members outside and a couple of them were loud. A couple of them had cards with things written on them. The Manager said it wasn't peaceful, they were loud. The ED said the Manager didn't tell her what they were saying. The ED told the Manager to call the police as it's private property. The Manager told her they were picketing but did not say they were yelling or banging on the door or anything. The ED said she did not believe the Manager went out and tried to talk to them or see what the people were doing. The police officer said they (the families) wanted results, communication, and to be told what was happening. The ED said she lived far away and did not think to ask the Manager to take the phone out to the families so she could talk to them. She said as she thinks of it now, she

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 _____	05/14/2020

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 565	Continued From page 10 should have done that. She added "We didn't handle it correctly." Review of grievance log for , failed to reveal formal grievances filed by family members wanting information about COVID test results, or ability to contact family member via the problem-prone phone system in the facility.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		

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 _____	05/14/2020

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 585	Continued From page 11	F 585		

include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
( ) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, , including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the

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 _____	05/14/2020

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 585	Continued From page 12 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to take steps to resolve grievances concerning alternative to visitation for 2 (Resident #2 and #3) of 8 sampled residents. The facility failed to document and initiate appropriate corrective actions to facilitate reasonable communication with family members regarding the health status of 2 (Resident #2 and #3) of 8 sampled residents. The findings included: In an interview on . . . . . at 12:15 p.m., Resident	F 585	1. Family members of residents #2 and #3 were identified who reported that they were not receiving information from the facility regarding their loved ones and that the DON nor Social Services Director were returning messages. Residents had the potential to be affected by this deficient practice. 2. DON was re-educated that phone call and messages must be checked and returned within 24 hours of receipt by the administrator to ensure prompt response to residents and family members. The	

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 _____	05/14/2020

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 585	Continued From page 13 #3's son said the facility wasn't answering their phones. He said the Director of Nursing (DON) and the Social Worker do not return the calls when he left messages. Resident #3's son said now when the phone rings, it is forwarded to the Administrator where a recording says the mailbox is full. The son said his wife and he went to the facility on Mother's Day to see if they could see Resident #3 whose room was on the first floor by the window. He said other families were there as well. Everyone was wearing masks and standing six apart. The Business Office Manager immediately came outside where the families were and told us to leave or law enforcement would be called. He said they noticed the nurses were going from room to room and closing the window blinds in the resident's rooms, even the rooms on the second floor. The son said ultimately the local law enforcement came. He said they were told it was private property and they had to leave. Resident #3's son said the families just wanted answers and know if their loved ones were all right. In an interview on at 12:26 p.m., the Business Office Manager said on Mother's Day someone from administration called her to go to the door. The Manager said a family member was at the door. The families said they weren't getting information. The Manager said the Administrator asked her to call the sheriff. She said she did not know what happened when the sheriff came, but the sheriff told her the families were told to leave. In a telephone interview on at 2:33 p.m., Resident #2's daughter-in-law she said she was very upset with the facility because she could not	F	Social Worker will be re-educated upon return to work by the Administrator. The Social Worker and all staff will be re-educated on the grievance process that all residents have the right to voice grievances, and that they should document the grievance and report it to their supervisor and administration immediately so that an investigation can be initiated. Signs and forms will be posted on both floors with the name of the grievance officer, telephone contact, email and physical address for residents and family members to know how and where to file their grievances. 3. The Administrator will discuss grievances daily at morning meetings to identify grievances that violate residents rights and require reporting to the State. The facility will take corrective action if alleged violation of residents rights is confirmed after completion of investigation. 4. A monthly audit of grievances will be conducted by the Administrator x3 months to ensure that prompt resolutions to grievances are completed within 72 hours. This will be brought to monthly QAPI X3 months 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 _____	05/14/2020

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 585	Continued From page 14	F 585		

get any information on how her father-in-law was doing and if his COVID-19 test was positive or not. She said they tried to visit Resident #2 on Mother's Day ( ) from the outside but the facility called the police on them. She said there were four other families out there as well. They were all ordered to leave the property. She said the family was very frustrated because they could not talk to anyone about her father-in-law who no longer understands how to use the phone. The daughter-in-law said the only information they got was from the newspaper and families needed to know what was going on with their loved ones. She voiced concern about communication and the COVID spreading in the facility even while they were all locked in with no visitors.

In an interview on at 3:41 p.m., the DON said she heard on Mother's Day ( ), a group of family members came to the facility wanting information. They were worried about the information they saw in the paper. The DON said the sheriff had called the Executive Director (ED) to inform her there would be a peaceful protest at the facility on Sunday. She said the ED instructed the Business Office Manager to call the sheriff. The sheriff's officer came to the facility and the families were made to leave the property.

In an interview on 1:55 p.m., the ED said the Business Office Manager was at the facility on Mother's Day and called her. The Business Office Manager said there were about 10 family members outside and a couple of them were loud. A couple of them had cards with things written on them. The Manager said it wasn't peaceful, they were loud. The ED said the Manager didn't tell her what they were saying.

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 _____	05/14/2020

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 585	Continued From page 15 She told the Manager to call the police as it's private property. The Manager told her they were picketing but did not say they were yelling or banging on the door or anything. The ED said she did not believe that the Manager went out and tried to talk to them or see what the people were doing. The police officer said they (the families) wanted results, communication and to be told what was happening. The ED said she lived far away and did not think to ask the Manager to take the phone out to the families so she could talk to them. She said as she thinks of it now, she should have done that. She added, "We didn't handle it correctly." Review of the , grievance log failed to reveal any documentation of the grievances related to the inability of family members to visit their loved ones. The log did not list any grievance filed by family members wanting information about COVID test results or ability to contact family member via the , phone system in the facility.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 (Resident #5) of 2 dependent residents on the COVID unit received the necessary assistance for bathing and shaving. The failure to assist with personal hygiene can result in both health and social consequences for	F 677	1. Resident #5 on the COVID unit was identified and other residents on the unit had the potential to be affected by this deficient practice 2. Resident # 5 was given a bath and shaved on the same day of surveyor	

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 _____	05/14/2020

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 677	Continued From page 16 the residents. The findings included: During a telephone interview on [redacted] at 2:38 p.m., a friend Resident #5 said the resident has been in isolation since he tested positive for COVID-19 the week before. Resident #5 had his full mental faculties but suffered from [redacted], was unable to move on his own, and was wheelchair or bed bound. The friend reported Resident #5 had not been able to get out of bed into his power chair for a week, since he had been in isolation on the COVID unit. Review of Minimum Data Set assessment record revealed Resident #5 required [redacted] of two or more staff for bathing and [redacted] moving in bed and transferring. Review of the Certified Nursing Assistant (CNA) point of care documentation failed to show Resident #5 received a shower or bath or was shaved from [redacted] through [redacted] (7 days). The documentation showed Resident #5 needed [redacted] of two or more staff to provide his care. In an interview on [redacted] at 11:15 a.m., the Director of Nursing (DON) said she was aware Resident #5 had been upset about not getting bathed or shaved since he was moved to the COVID unit. She said the COVID unit is only staffed with one nurse and one CNA for 11 residents and a shower schedule was not thought out. The DON acknowledged the care was missed. In an interview on [redacted] at 1:15 p.m.,	F 677	inquiry, other residents on the unit were also given a bath and other ADL care was provided 3. The DON re-educated staff that baths and other ADL care must be provided daily on the COVID unit and as per request by resident. Staff was also re-educated on proper documentation of ADL care 4. Daily audits will be conducted by the DON/Designee on the COVID unit. This will be brought to monthly QAPI for compliance or until the facility is COVID free	

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 _____	05/14/2020

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 677	Continued From page 17 Registered Nurse (RN) Staff F (the COVID unit nurse on days) said Resident #5 had not had a shower or bed bath since last Friday (. . . . .) and was upset. RN Staff F said only one nurse and one CNA worked in the COVID unit, and they did not have a schedule of who and when residents were to get baths. He said the COVID unit did not have a shower and all the residents would have to get bed baths.	F 677		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		

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 _____	05/14/2020

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 842	Continued From page 18 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; ( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; ( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, , and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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 _____	05/14/2020

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 842	Continued From page 19 Based on record review and interview, the facility failed to maintain accurate and complete medical records to verify 3 (Resident #1, #3, and #4) of 4 sampled residents received medications and treatments as per the physician ordered. The findings included: 1. Review on ... of Resident #1's electronic medical record showed a physician order for the ... medication ... 2.5 milligram (mg) by ... in the evening on Tuesdays, Thursdays, Saturdays, and Sundays. The Medication Administration Record (MAR) lacked documentation Resident #1 received the ... on Saturday , Sunday , and Thursday . Resident #1 also had a physician order for the ... medication ... 500 mg by ... twice a day at 6:00 a.m. and 5:00 p.m. The MAR lacked documentation Resident #1 received the medication at 5:00 p.m., on or . 2. Review on of Resident #4's electronic medical record showed a physician order for the ... Suspension give 2 teaspoons by ... four times a day for ... until 11:59 p.m. on . The start date was 6:00 p.m. on ... The medication was scheduled for 12 a.m., 6 a.m., 12 p.m., and 6 p.m. daily. The MAR lacked documentation the nurse administered the medication at 6:00 a.m. on ..., ... and ... There was no documentation the nurse administered the medication at 12:00 a.m. on ..., or at 6:00 p.m. on , ..., and ... . 3. Review on of Resident #3's electronic record showed a physician order to apply skin	F 842	1. Residents #1, #3 and #4 were identified and these residents were not adversely affected by this deficient practice. 2. Licensed staff will be reeducated by DON on the importance that each resident medical record should be complete, and accurately documented. 3. The DON will conduct a house audit on EMAR/ETAR. Thereafter 3x per week for one month, then weekly x2 months, or until substantial compliance is achieved. Newly hired employees will receive education on complete and accurate documentation of the EMAR/ETAR during orientation 4. This will be brought to QAPI x3 months for compliance	

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 _____	05/14/2020

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 842	Continued From page 20 prep to [redacted] and [redacted] area every morning and at bedtime for [redacted]. This treatment was not documented as being performed on [redacted] and [redacted]. Resident #3 had a physician order for [redacted] 2% to apply to the right arm [redacted] every shift. This treatment was not documented as being performed on [redacted] and [redacted] on the 7 p.m. to 7 a.m. shift. Resident #3 had a physician's order for [redacted] floor mats while in bed every shift for [redacted] risk. The Treatment Administration Record (TAR) lacked documentation the floor mats were in place while the resident was in bed on [redacted] and [redacted] during the 7 p.m., to 7 a.m., shift. The clinical record included a physician order for [redacted] medication [redacted] AF Cream 1% to be apply to under [redacted] every shift for [redacted]. This treatment was not documented as performed on [redacted] and [redacted] on the 7 p.m. to 7 a.m. shift. There was an order to not use latex diapers or latex gloves and use only pull-ups and latex-free gloves every shift for possible Latex [redacted]. The TAR lacked documentation the staff followed these physician's orders on [redacted] and [redacted] on the 7 p.m. to 7 a.m. shift. 4. Review of Resident #1, Resident #3, and Resident#4's electronic record did not show any nursing explanations for the missing documentation. The lack of documentation made it impossible to determine the residents received their medications or treatments as the physician ordered. During an interview on [redacted] at 11:15 a.m., the Director of Nursing said she did not know how	F 842		

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 _____	05/14/2020

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 842	Continued From page 21 this could happen. She said the screen went red if you forget medications or treatments.	F 842		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a safe, functional and sanitary environment in the laundry room. The facility failed to maintain a secured separation between the COVID unit and the rest of the facility. The findings included: 1.Observations on at 1:30 p.m. during a tour of the laundry room, the doors of the clean and the soiled sides of the laundry leading to the hallway were propped open. The large sliding door between the two sides was also open. Bins filled with soiled laundry were right by the door of the clean side and dryers. A box fan was positioned right above one of the soiled clothes bins. Observation of the folding room found Laundry Worker Staff L folding residents' clothes without a protective cover gown. There were 2 fans sitting near the wall and running to circulate the air. In an interview on at 1:38 p.m., Laundry Worker Staff L said she was the only one working in the laundry. She said she started 3 weeks ago and last week the laundry manager and one of	F 921	1. Residents in the facility have the potential to be affected by this deficient practice. No residents were identified 2. The doors to the laundry room were immediately closed and staff L was re-educated along with the other environmental and laundry staff to maintain closed doors to reduce the risk of cross contamination 3. NHA/Environmental Services Director/DON will conduct daily audits to ensure that the applicable laundry room doors remain closed to prevent the spread of 4. This will be brought to QAPI monthly for 3 months 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 _____	05/14/2020

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 921	Continued From page 22	F 921		

the workers quit and she was left. She said she did not know the doors to the laundry should be shut. She said she did not realize the door between the room could close. She said the facility just fixed the washing machine which was broken for a while.

On at 1:40 p.m., the Director of Nursing (DON) toured the laundry room with the surveyor and verified the doors were open, and the fans were moving the air across the dirty clothes. She acknowledged the doors should be closed and the door between the dirty and the clean side of the laundry should be closed. She said this was an control issue and needed to be corrected.

In an interview on at 1:52 p.m., the Maintenance/Housekeeping and Laundry Manager said he would correct the issue with the doors of the laundry room and instruct Staff L as to why the doors need to remain closed. He said one of the washing machines had been down for about a month and the laundry had gotten backed up over that past month. The Manager said he stepped into the position the week before, did not know if there was a maintenance log, and had not created one since getting the position.

On at 12:10 p.m., during a tour of the COVID wing on the first floor (-129) the following observations were made:
The COVID wing was separated from the rest of the first floor by a large plastic construction tarp with a large zipper in the middle. The tarp was tapped around all four sides. The tarp was blowing and forth with the air pressure and air-conditioning. The left side of the plastic tarp was pulling away from the side of the wall. A 2½

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 _____	05/14/2020

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 921	Continued From page 23 by 10 inch gap allowed the air from the COVID unit to go around the tarp into the rest of the first floor. Photographic Evidence Obtained. In an interview on at 12:30 p.m., the DON said she was aware of the gap on the side of the tarp containing the COVID unit. She said she will get a staple gun from the hardware store to secure the plastic tarp to the wall. She said the tarp blew and forth so much that it pulled away from the wall and they had to re-tape it daily. She said she was aware of the air from the unit was getting throughout the facility. In an interview on at 1:36 p.m., the Maintenance Director he said he was aware the partition between the COVID unit and the rest of the first floor was pulling away from the wall. He said the partition blew so much and forth that it pulled away from the wall and allowed the air to escape around it. He said the DON was getting a staple gun to staple the tarp to the wall and hopefully that would hold it.	F 921		

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 _____	05/14/2020

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 and complaint survey for #2020008454 and #2020008704 was conducted through at Crystal Health and Rehab Center, LLC, a skilled nursing facility in Tavernier, Florida. Complaint #2020008454 was substantiated at N110, N188, and N189. Complaint #2020008704 was substantiated at N054, N110, N188, N189, and Z814. The following is description of the deficiencies.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to record accurate and complete medical records to verify 3 (Resident #1, #3, and #4) of 4 sampled residents received medications and treatments as the physician ordered. The findings included: 1. Review on of Resident #1's electronic medical record showed a physician order for the medication 2.5 milligram (mg) by in the evening on	N 054	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.	

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 _____	05/14/2020

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 054	Continued From page 1 Tuesdays, Thursdays, Saturdays, and Sundays. The Medication Administration Record (MAR) lacked documentation Resident #1 received the on Saturday , Sunday , and Thursday . Resident #1 also had a physician order for the medication 500 mg by twice a day at 6:00 a.m. and 5:00 p.m. The MAR lacked documentation Resident #1 received the medication at 5:00 p.m., on or . 2. Review on of Resident #4's electronic medical record showed a physician order for the , Suspension give 2 teaspoons by four times a day for until 11:59 p.m. on . The start date was 6:00 p.m. on . The medication was scheduled for 12 a.m., 6 a.m., 12 p.m., and 6 p.m. daily. The MAR lacked documentation the nurse administered the medication at 6:00 a.m. on , and . There was no documentation the nurse administered the medication at 12:00 a.m. on , or at 6:00 p.m. on , , and . 3. Review on of Resident #3's electronic record showed a physician order to apply skin prep to and area every morning and at bedtime for . This treatment was not documented as being performed on and . Resident #3 had a physician order for 2% to apply to the right arm , every shift. This treatment was not documented as being performed on and on the 7 p.m. to 7 a.m. shift. Resident #3 had a physician's order for floor mats while in bed every shift for risk. The Treatment Administration Record (TAR) lacked documentation the floor mats were in	N 054	1. Residents #1, #3 and #4 were identified and these residents were not adversely affected by this deficient practice. 2. Licensed staff will be reeducated by DON on the importance that each resident medical record should be complete, and accurately documented. 3. The DON will conduct a house audit on EMAR/ETAR. Thereafter 3x per week for one month, then weekly x2 months, or until substantial compliance is achieved. Newly hired employees will receive education on complete and accurate documentation of the EMAR/ETAR during orientation 4. This will be brought to QAPI x3 months for compliance	

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 _____	05/14/2020

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 054	Continued From page 2 place while the resident was in bed on . . . and during the 7 p.m., to 7 a.m., shift. The clinical record included a physician order for . . medication . . AF Cream 1% to be apply to under , , every shift for . . . This treatment was not documented as performed on and on the 7 p.m. to 7 a.m. shift. There was an order to not use latex diapers or latex gloves and use only pull-ups and latex-free gloves every shift for possible Latex . . The TAR lacked documentation the staff followed these physician's orders on and on the 7 p.m. to 7 a.m. shift. 4. Review of Resident #1, Resident #3, and Resident#4's electronic record did not show any nursing explanations for the missing documentation. The lack of documentation made it impossible to determine the residents received their medications or treatments as the physician ordered. During an interview on . . . . at 11:15 a.m., the Director of Nursing said she did not know how this could happen. She said the screen went red if you forget medications or treatments. Class III	N 054		
N 110 SS=F	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.	N 110		

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 _____	05/14/2020

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 110	Continued From page 3 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a safe and sanitary environment in the laundry room. The facility failed to maintain a secured separation between the COVID unit and the rest of the facility. These deficient practices put all ressidents, staff, and visitors at risk. The findings included: 1.Observations on at 1:30 p.m. during a tour of the laundry room, the doors of the clean and the soiled sides of the laundry leading to the hallway were propped open. The large sliding door between the two sides was also open. Bins filled with soiled laundry were right by the door of the clean side and dryers. A box fan was positioned right above one of the soiled clothes bins. Observation of the folding room found Laundry Worker Staff L folding residents' clothes without a protective cover gown. There were 2 fans sitting near the wall and running to circulate the air. In an interview on at 1:38 p.m., Laundry Worker Staff L said she was the only one working in the laundry. She said she started 3 weeks ago and last week the laundry manager and one of the workers quit and she was left. She said she did not know the doors to the laundry should be shut. She said she did not realize the door between the room could close. She said the facility just fixed the washing machine which was	N 110	1. Residents in the facility had the potential to be affected by this deficient practice. No residents were identified 2. The doors to the laundry room were immediately closed and staff L was re-educated along with the other environmental and laundry staff why the doors need to be remained closed to prevent the spread of . 3. NHA/Environmental Services Director/DON will conduct daily audits to ensure that the applicable laundry room doors remain closed to prevent the spread of . 4. This will be brought to QAPI monthly for 3 months 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
	114403A	A. BUILDING: _____ B. WING _____	05/14/2020

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 110	Continued From page 4 broken for a while. On . . . . . at 1:40 p.m., the Director of Nursing (DON) toured the laundry room with the surveyor and verified the doors were open, and the fans were moving the air across the dirty clothes. She acknowledged the doors should be closed and the door between the dirty and the clean side of the laundry should be closed. She said this was an control issue and needed to be corrected. In an interview on . . . . at 1:52 p.m., the Maintenance/Housekeeping and Laundry Manager said he would correct the issue with the doors of the laundry room and instruct Staff L as to why the doors need to remain closed. He said one of the washing machines had been down for about a month and the laundry had gotten backed up over that past month. The Manager said he stepped into the position the week before, did not know if there was a maintenance log, and had not created one since getting the position. On . . . . . at 12:10 p.m., during a tour of the COVID wing on the first floor (-129) the following observations were made: The COVID wing was separated from the rest of the first floor by a large plastic construction tarp with a large zipper in the middle. The tarp was tapped around all four sides. The tarp was blowing and forth with the air pressure and air-conditioning. The left side of the plastic tarp was pulling away from the side of the wall. A 2½ by 10 inch gap allowed the air from the COVID unit to go around the tarp into the rest of the first floor. Photographic Evidence Obtained. In an interview on at 12:30 p.m., the DON	N 110		

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 _____	05/14/2020

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 110	Continued From page 5 said she was aware of the gap on the side of the tarp containing the COVID unit. She said she will get a staple gun from the hardware store to secure the plastic tarp to the wall. She said the tarp blew and forth so much that it pulled away from the wall and they had to re-tape it daily. She said she was aware of the air from the unit was getting throughout the facility. In an interview on at 1:36 p.m., the Maintenance Director he said he was aware the partition between the COVID unit and the rest of the first floor was pulling away from the wall. He said the partition blew so much and forth that it pulled away from the wall and allowed the air to escape around it. He said the DON was getting a staple gun to staple the tarp to the wall and hopefully that would hold it. Class III	N 110		
N 188 SS=D	400.022(1)(d), FS. Right to File Grievances The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other persons; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from , interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other	N 188		

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 _____	05/14/2020

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 188	Continued From page 6 residents. This Statute or Rule is not met as evidenced by: Based on record review, family and staff interviews the facility failed to take steps to resolve grievances concerning alternative to visitation for 2 (Resident #2 and #3) of 8 sampled residents. The facility failed to document and initiate appropriate corrective actions to facilitate reasonable communication with family members regarding the health status of 2 (Resident #2 and #3) of 8 sampled residents. The findings included: In an interview on at 12:15 p.m., Resident #3's son said the facility wasn't answering their phones. He said the Director of Nursing (DON) and the Social Worker do not return the calls when he left messages. Resident #3's son said now when the phone rings, it is forwarded to the Administrator where a recording says the mailbox is full. The son said his wife and he went to the facility on Mother's Day to see if they could see Resident #3 whose room was on the first floor by the window. He said other families were there as well. Everyone was wearing masks and standing six apart. The Business Office Manager immediately came outside where the families were and told us to leave or law enforcement would be called. He said they noticed the nurses were going from room to room and closing the window blinds in the resident's rooms, even the rooms on the second floor. The son said ultimately the local law enforcement came. He said they were told it was private property and they had to leave. Resident #3's son said the families just wanted answers and know if their loved ones were all right.	N 188	1. Family members of residents #2 and #3 were identified who reported that they were not receiving information from the facility regarding their loved ones and that the DON nor Social Services Director were returning messages. Residents had the potential to be affected by this deficient practice. 2. DON was re-educated that phone call and messages must be checked and returned within 24 hours of receipt by the administrator to ensure prompt response to residents and family members. The Social Worker will be re-educated upon return to work by the Administrator. The Social Worker and all staff will be re-educated on the grievance process that all residents have the right to voice grievances, and that they should document the grievance and report it to their supervisor and administration immediately so that an investigation can be initiated. Signs and forms will be posted on both floors with the name of the grievance officer, telephone contact, email and physical address for residents and family members to know how and where to file their grievances. 3. The Administrator will discuss grievances daily at morning meetings to identify grievances that violate residents rights and require reporting to the State. The facility will take corrective action if alleged violation of residents rights is confirmed after completion of	

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 _____	05/14/2020

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 188	Continued From page 7 In an interview on . . . . at 12:26 p.m., the Business Office Manager said on Mother's Day someone from administration called her to go to the door. The Manager said a family member was at the door. The families said they weren't getting information. The Manager said the Administrator asked her to call the sheriff. She said she did not know what happened when the sheriff came, but the sheriff told her the families were told to leave. In a telephone interview on . . . . . at 2:33 p.m., Resident #2's daughter-in-law she said she was very upset with the facility because she could not get any information on how her father-in-law was doing and if his COVID-19 test was positive or not. She said they tried to visit Resident #2 on Mother's Day (. . . . .) from the outside but the facility called the police on them. She said there were four other families out there as well. They were all ordered to leave the property. She said the family was very frustrated because they could not talk to anyone about her father-in-law who no longer understands how to use the phone. The daughter-in-law said the only information they got was from the newspaper and families needed to know what was going on with their loved ones. She voiced concern about communication and the COVID spreading in the facility even while they were all locked in with no visitors. In an interview on . . . . . at 3:41 p.m., the DON said she heard on Mother's Day ( ), a group of family members came to the facility wanting information. They were worried about the information they saw in the paper. The DON said the sheriff had called the Executive Director	N 188	investigation. 4. A monthly audit of grievances will be conducted by the Administrator x3 months to ensure that prompt resolutions to grievances are completed within 72 hours. This will be brought to monthly QAPI X3 months 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
	114403A	A. BUILDING: _____ B. WING _____	05/14/2020

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 188	Continued From page 8 (ED) to inform her there would be a peaceful protest at the facility on Sunday. She said the ED instructed the Business Office Manager to call the sheriff. The sheriff's officer came to the facility and the families were made to leave the property. In an interview on 1:55 p.m., the ED said the Business Office Manager was at the facility on Mother's Day and called her. The Business Office Manager said there were about 10 family members outside and a couple of them were loud. A couple of them had cards with things written on them. The Manager said it wasn't peaceful, they were loud. The ED said the Manager didn't tell her what they were saying. She told the Manager to call the police as it's private property. The Manager told her they were picketing but did not say they were yelling or banging on the door or anything. The ED said she did not believe that the Manager went out and tried to talk to them or see what the people were doing. The police officer said they (the families) wanted results, communication and to be told what was happening. The ED said she lived far away and did not think to ask the Manager to take the phone out to the families so she could talk to them. She said as she thinks of it now, she should have done that. She added, "We didn't handle it correctly." Review of the grievance log failed to reveal any documentation of the grievances related to the inability of family members to visit their loved ones. The log did not list any grievance filed by family members wanting information about COVID test results or ability to contact family member via the phone system in the facility. Class III	N 188		

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 _____	05/14/2020

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 189 SS=D	400.022(1)(e), FS Right to Organize Resident/ Family Groups The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents. This Statute or Rule is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to consider the views of a group of family members congregated outside the facility on Mother's Day. The family group was concerned because the facility failed to provide alternative to visitation and communication for residents and family members regarding the health status of 2 (Resident #2 and #3) of 8 sampled residents. The findings included: In an interview on at 12:15 p.m., Resident #3's son said the facility wasn't answering their phones. He said the Director of Nursing (DON) and the Social Worker do not return the calls when he leaves messages. The son said now when the phone rings and it is forwarded to the Administrator where a recording reports the mailbox is full. The son said he and his wife went to the facility on Mother's Day to see if they could see Resident #3. The resident's room was on the first floor and her bed was by the window. The son said other families were there as well. Everyone was wearing masks and standing six apart. The Business Office Manager came outside and told us to leave or law enforcement would be called. He said they noticed the nurses were going from room to room and closing the window blinds in the resident's rooms, even the rooms on the second floor. The son said local	N 189	1. Family members of residents #2 and #3 reported they were not receiving information from the facility and were not able to speak with any staff from the facility regarding their loved ones on Mother□s Day.. Residents had the potential to be affected by this deficient practice. 2. The facility installed a hotline thereafter where family members and other callers to the facility could obtain daily updated COVID-19 information relating to the facility. A new phone system was being installed while surveyors were still in the building The facility administrator mailed COVID-19 information return receipts to family members, and designated staff was identified to make weekly calls to family members in efforts to boost communication between the facility and family members. The ED will make random weekly calls to the facility to ensure that the new phone system works and that calls are being answered 3. The Executive Director was re-educated on the handling of delicate situations that required sensitivity and discretion during times of difficulty by the Regional Director of Operations	

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 _____	05/14/2020

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 189	Continued From page 10 law enforcement came. The family members were told it was private property and they had to leave. Resident #3's son said the families just wanted answers and know if their loved ones were all right. In an interview on at 12:26 p.m., the Business Office Manager said on Mother's Day someone from administration called her to go to the door. She said a family member was at the door. The families said they weren't getting information. The Business Office Manager said the administrator asked her to call the sheriff. She said she did not know what happened when the sheriff came. The sheriff told her the families were told to leave. In a telephone interview on at 2:33 p.m., Resident #2's daughter-in-law she was very upset with the facility because she could not get any information on how her father-in-law was doing and if his COVID-19 test was positive or not. She said they tried to visit Resident #2 on Mother's Day ( ) from the outside but the facility called the police. She said there were four other families there as well. They were all ordered to leave the property. She said the family was very frustrated because they could not talk to anyone about Resident #2 who no longer understands how to use the phone. The daughter-in-law said the only information they got was from the newspaper and families needed to know what was going on with their loved ones. She voiced concern about communication and the COVID spreading within the facility even when they were all locked in with no visitors. In an interview on at 3:41 p.m., the Director of Nursing (DON) said she heard on	N 189	4. This will be brought to monthly QAPI for monitoring and compliance x 2months	

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 _____	05/14/2020

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 189	Continued From page 11 Mother's Day, a group of family members came to the facility wanting information. They were worried about the information in the paper. The DON said the sheriff had called the Executive Director (ED) to inform her there would be a peaceful protest at the facility on Sunday. The DON said the ED instructed the Business Office Manager to call the sheriff. The sheriff's officer came to the facility and the families were made to leave the property. In an interview on 1:55 p.m., the ED she said the Business Office Manager was at the facility on Mother's Day and called her. The Manager said there were about 10 family members outside and a couple of them were loud. A couple of them had cards with things written on them. The Manager said it wasn't peaceful, they were loud. The ED said the Manager didn't tell her what they were saying. The ED told the Manager to call the police as it's private property. The Manager told her they were picketing but did not say they were yelling or banging on the door or anything. The ED said she did not believe the Manager went out and tried to talk to them or see what the people were doing. The police officer said they (the families) wanted results, communication, and to be told what was happening. The ED said she lived far away and did not think to ask the Manager to take the phone out to the families so she could talk to them. She said as she thinks of it now, she should have done that. She added "We didn't handle it correctly." Review of grievance log for , failed to reveal formal grievances filed by family members wanting information about COVID test results, or ability to contact family member via the problem-prone phone system in the facility.	N 189		

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 _____	05/14/2020

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 189	Continued From page 12 Class III	N 189		

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 _____	05/14/2020

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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to add 5 (Staff B, C, D, F, and N) of 10 staff reviewed to the Agency for Health Care Administration background screening clearinghouse within 10 days of employment. The facility failed to complete a new background screening for 1 (Staff E) of 10 staff reviewed with a gap of employment greater than 90 days.	CZ814	1. No residents were identified in this deficient practice. 2. Staff B, C, D, F and N were identified as not been added to the roster timely, Staff E was identified as not having a complete background screen after having a gap in employment for nearly 8 months. Staff E was removed from the roster. Quality audits were	

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 _____	05/14/2020

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
CZ814	Continued From page 1 The findings included: 1. Record review on showed Certified Nursing Assistant (CNA) Staff B with a hire date of . The facility added Staff B to the Agency for Health Care Administration Background Screening Clearinghouse on (more than a month later). This was outside of the 10 business-day window to add an employee. 2. Record review on showed CNA Staff C with a hire date of . The facility added Staff C to the Agency for Health Care Administration Background Screening Clearinghouse on (3 weeks later). This was outside of the 10 business-day window to add an employee. 3. Record review on showed CNA Staff D with a hire date of . The facility added Staff D to the Agency for Health Care Administration Background Screening Clearinghouse on (11 business days later). This was outside of the 10 business-day window to add an employee. 4. Record review on showed Registered Nurse (RN) Staff F with a hire date of . The facility added Staff F to the Agency for Health Care Administration Background Screening Clearinghouse on (more than 2 months later). This was outside of the 10 business-day window to add an employee. 5. Record review on showed RN Staff N with a hire date of . The facility added Staff N to the Agency for Health Care Administration Background Screening Clearinghouse on (more than 3 months later). This was outside of the 10 business-day window to add an employee.	CZ814	conducted of the facility's employee roster and updated to ensure that all employees status was current and maintained. The Human Resources Coordinator was reeducated on Background Screens to ensure that compliance with the Agency's requirements is maintained 3. The Human Resources Coordinator will conduct a quality review of employee background to ensure compliance weekly x4 weeks then every 2 weeks x2 months 4. Findings will be reported to monthly QAPI until committee determines that 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 _____	05/14/2020

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
CZ814	Continued From page 2 6. Record review on showed RN Staff E with an eligibility determination date was . The end date for her last employment was . Staff E's hire date was (nearly an 8-month break in service). There was more than a 90-day gap in service without evidence of qualified employment or rescreening. 7. During an interview n at 1:00 p.m., the Administrator said she does not understand how this could happen. She said she has reviewed this with the Business Office Manager and does not understand how this could happen. Unclassed	CZ814		