STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106092	A. BUILDING _____ B. WING _____	**05/14/2020**

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

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** 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 anxious, 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 5/13/20 at 2:14 p.m., Resident #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 5/13/20 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 5/13/20 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 been working properly for 2 years and the families could not reach their loved ones. In interview on 5/13/20 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 5/13/20 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 5/13/20 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 5/13/20 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. On 5/13/20 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 dead. In interview on 5/14/20 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 5/14/20 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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. The findings included: During a telephone interview on 5/14/20 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 [MEDICAL CONDITION], 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 extensive assistance of two or more staff members for moving in bed and transferring to his power chair. He also needed extensive assistance of two or more staff for bathing and dressing. 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 5/14/20 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 Hoyer lift 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 back out again, so he was not able to get out of bed. In an interview on 5/14/20 at 1:15 p.m., COVID unit nurse on days, Registered Nurse (RN) Staff 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 Hoyer lift 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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to organize and participate in resident/family groups in the facility.** 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (Resident #2 and #3) of 8 sampled residents. The findings included: In an interview on 5/13/20 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 feet 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 5/13/20 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 5/13/20 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 (5/10/20) 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 5/13/20 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 5/14/20 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 May 2020 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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** 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 5/13/20 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 feet 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 5/13/20 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 5/13/20 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 (5/10/20) 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 5/13/20 at 3:41 p.m., the DON said she heard on Mother's Day (5/10/20), 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 5/14/20 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 May 2020 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 impaired phone system in the facility.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 the residents. The findings included: During a telephone interview on 5/14/20 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 [MEDICAL CONDITION], 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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) required extensive assistance of two or more staff for bathing and dressing, 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 5/8/20 through 5/13/30 (7 days). The documentation showed Resident #5 needed extensive assist of two or more staff to provide his care. In an interview on 5/14/20 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 5/14/20 at 1:15 p.m., 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 (5/8/20) 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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 5/14/20 of Resident #1's electronic medical record showed a physician order [REDACTED]. Resident #1 also had a physician order [REDACTED]. Review on 5/14/20 of Resident #4's electronic medical record showed a physician order [REDACTED]. The medication was scheduled for 12 a.m., 6 a.m., 12 p.m., and 6 p.m. daily. The MAR indicated [REDACTED]. There was no documentation the nurse administered the medication at 12:00 a.m. on 5/10/20, or at 6:00 p.m. on 5/5/20, 5/8/20, and 5/9/20. 3. Review on 5/14/20 of Resident #3's electronic record showed a physician order [REDACTED]. This treatment was not documented as being performed on 5/9/20 and 5/11/20. Resident #3 had a physician order [REDACTED]. Resident #3 had a physician's orders [REDACTED]. The Treatment Administration Record (TAR) lacked documentation the floor mats were in place while the resident was in bed on 5/9/20 and 5/11/20 during the 7 p.m., to 7 a.m., shift. The clinical record included a physician order [REDACTED]. 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 allergy. The TAR lacked documentation the staff followed these physician's orders [REDACTED]. 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 5/14/20 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.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** 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 5/13/20 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 5/13/20 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 broken for a while. On 5/13/20 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 infection control issue and needed to be corrected. In an interview on 5/13/20 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 5/13/20 at 12:10 p.m., during a tour of the COVID wing on the first floor (rooms 123-129) 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 back 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 2 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 5/13/20 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 back 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 5/13/20 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 back 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.