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 _____	**09/09/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on observation, record review and interview, the facility failed to notify the residents physician of a significant change in a residents' physical health for 1 (Resident #3) of 1 resident reviewed for physician notification. This has the potential to delay treatment or decision making for end of life care. The findings included: On 9/8/20 at 12:22 p.m., Resident #3's son-in-law said they had been notified the evening prior that the facility staff had to put a tube in Resident #3's throat because she wasn't swallowing and had to be suctioned twice. He said she had a problem with swallowing and choking on things, and it goes places it shouldn't be. He said he and his wife had been trying to get Hospice involved. On 9/8/20 at 12:35 p.m., Resident #3 was observed lying in bed. She appeared cachectic (very frail, thin, wasting, lacking muscle). She did not respond or make eye contact when spoken to. Her mouth was wide open and appeared whitish and very dry inside. Suctioning equipment was noted at bedside with secretions in the container. On 9/8/20 at 12:40 p.m., Staff A Registered Nurse (RN) said she was the nurse caring for Resident #3. She said Resident #3 had been in that condition for 2 days and they had started suctioning her the day prior. Record review of Resident #3's progress notes for 9/7/20 at 21:35 revealed Resident #3 was unable to receive prescribed medications due to difficulty swallowing, however, there was no documentation that Resident #3 had experienced any distress or that she had needed to be suctioned. There was no documentation that anyone had spoken with the family or the doctor had been notified of any change in condition. On 9/9/20 at 9:39 a.m. Staff B (RN) said the nurse caring for Resident #3 asked her to look in on her as she wasn't doing well. Staff B said Resident #3 didn't look herself and she discussed this with Staff C Licensed Practical Nurse (LPN) who also came to see Resident #3. They decided Resident #3 needed to be suctioned. Staff B said she did notify the daughter and in that conversation the daughter discussed a desire for hospice and asked to have the doctor notified. Staff B said in the course of all that, documentation and notification to the doctor just did not happen. On 9/9/20 at 10:05 a.m., Staff C (LPN) said on 9/7/20 at approximately 6:45 p.m., Staff B asked if I could come look at Resident #3 because she didn't look good. Staff C said when she observed Resident #3 she looked like she was in distress and she heard a thick gurgle. Staff C said she did a finger sweep of Resident #3's mouth and pulled out two large pieces of food. Staff C said they got swabs and suction and they suctioned more contents from Resident #3's mouth and throat. Staff C said she does not know if anyone notified the doctor. On 9/9/20 at 11:30 a.m., Resident #3's doctor said she had received no communication about these events from the facility staff and knew nothing about it until 9/8/20 at approximately 2:00 p.m. The doctor said she had not been notified about the gurgling or suctioning and said if she had been notified maybe she could have averted some of the problems. On 9/8/20 at 3:28 p.m., the Director of Nursing (DON) said she had spoken with the doctor who said she was never notified of the change of condition and agreed there was no documentation that anyone had notified the doctor.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide needed care and services in accordance with residents or resident representative preferences for 1 (Resident #3) of 4 residents reviewed for provision of care and services. This has the potential to delay treatment or deprive terminally ill patients and/or family members of services to maintain physical, psychosocial, spiritual and emotional needs. The findings included: On [DATE] at 12:22 p.m., Resident #3's son-in-law said he was concerned about her as she had been losing weight, in the past week had a fall that resulted in a broken collar bone, and the evening prior, had been notified that the staff had to put a tube in her throat because she wasn't swallowing, and they had to suction her twice. He said he and his wife had wanted to have her placed on hospice but was told by the facility staff that they can't. Review of Resident #3's record on [DATE] revealed [DIAGNOSES REDACTED]. On [DATE] her weight was recorded at 90 pounds and she had a body mass index (BMI) of 14.1 (BMI is a screening method for weight category, underweight, healthy weight, overweight or obesity. Per the Centers for Disease Control normal or healthy weight BMI for adults is between 18XXX,[DATE].9). Resident 3 had sustained a fractured clavicle from an unwitnessed fall on [DATE]. No documentation was found in the nursing progress notes that she had recently required suctioning or that the family had inquired about hospice. A Physician note was found in the chart dated [DATE] indicating the doctor had spoken with the daughter and informed the daughter her husband had called about hospice which the patient was discharged from at least 6 months ago. MD wrote she didn't understand why husband had called as she wasn't a hospice patient at the time. Note said Resident #3 has had no decline in her dementia and from that point was stable. Review of Resident #3's file revealed she had not been enrolled in hospice since 2018. On [DATE] at 12:30 p.m., the Administrator said he was under the impression, due to COVID restrictions hospice was not allowed in unless a resident was actively dying. Administrator said he wasn't aware of Resident #3's condition, nor was he aware the family had been requesting a hospice consult. On [DATE] at 12:35 p.m., Resident #3 was observed lying in bed. She appeared cachectic (very frail, thin, wasting, lacking muscle) and did not respond or make eye contact when spoken to. Her mouth was wide open and appeared whitish and very dry inside. Suctioning equipment was noted at bedside with secretions in the container. On [DATE] at 12:40 p.m., Staff A Registered Nurse (RN) said she was the nurse caring for Resident #3. She said Resident #3 had been in that condition for 2 days and they had started suctioning her the day prior ([DATE]). Record review of Resident #3's progress notes for [DATE] timed 21:35 revealed Resident #3 was unable to receive prescribed medications due to difficulty swallowing, however, there was no documentation that Resident #3 had experienced any distress or that she had needed to be suctioned. There was no documentation anyone had spoken with the family, that the family was requesting hospice or that the doctor had been notified of any change in condition. On [DATE] at 1:20 p.m., the Director of Nursing (DON) said she was aware of the change of condition with Resident #3. DON said the nurse had spoken with the daughter the night prior and the daughter requested the nurse to call the doctor to try to get her back on hospice. On [DATE] at 3:28 p.m., the DON returned and said she spoke to the doctor who said she was never notified by the nurse. The DON agreed there was no documentation about the change of condition, the suctioning, that the family was notified, that the family was requesting hospice or that the doctor had been contacted about any of it. On [DATE] at 9:39 a.m., Staff B (RN) said on [DATE], the nurse caring for Resident #3 asked her to look in on her as she wasn't doing well. Staff B said Resident #3 didn't look herself and she discussed this with Staff C Licensed Practical Nurse (LPN) who also came to see Resident #3. They decided Resident #3 needed to be suctioned. Staff B said she notified Resident #3's daughter and said the daughter said she had asked for hospice from the doctor and that the doctor had refused it. Staff B said she explained to the daughter that hospice nurses and aides weren't allowed in anyway

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

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) due to COVID and they had to call in by phone to ask about their patients. Staff B said in the course of all that, documentation and notification to the doctor just did not happen. On [DATE] at 10:05 a.m., Staff C (LPN) said on [DATE] at approximately 6:45 p.m., Staff B asked her to come look at Resident #3 because she didn't look good. Staff C said when she observed Resident #3 she looked to be in distress and she could hear a thick gurgle. Staff C said she did a finger sweep of Resident #3's mouth and pulled out two large pieces of food. Staff C said they got swabs and suction and they suctioned more contents from Resident #3's mouth and throat. Staff C said she does not know if anyone documented or notified the doctor. On [DATE] at 9:22 a.m., the DON said Resident #3's doctor had come in the prior evening. The doctor agreed the patient was declining and had aspiration pneumonia. The doctor said no one had called her about the change in the residents' condition. After speaking to the doctor, the daughter decided to transfer care to another physician. DON said Resident #3 died later that evening. On [DATE] at 11:30 a.m., the doctor said Resident #3 had died the previous evening. The doctor said she came to the facility that evening and told the daughter she had aspiration pneumonia. The daughter said she did not want the doctor to treat her anymore and she was transferring care to a different physician. The doctor said she had no communication from the facility that there had been a change in condition and knew nothing about it until the next afternoon at 2:00 p.m. The doctor said she had not been notified about the gurgling and suctioning and said if she had maybe she could have averted some of the problems. On [DATE] at 9:50 a.m., the Administrator provided the policy titled COVID-19 Pandemic Plan, updated [DATE]. On page 3, Under the title Visitors & Non-Essential Healthcare Providers, bullet 5 it states: Non-essential physicians, providers, marketers, and vendors are not allowed in the facility until further notice. There was nothing listing what or who is considered a non-essential physician or provider. The Administrator said it was a corporate decision regarding Hospice. He said you wouldn't know if they were tested , or what they were doing on the outside.