

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Cornerstone Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 302 Alcorn Drive Corinth, MS 38834	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>45598</p> <p>Based on observation, interview, record review and facility policy review the facility failed to ensure a comprehensive care plan was implemented when a Certified Nursing Assistant (CNA) did not check a resident every two hours for incontinence episodes for one (1) of three (3) residents reviewed. Resident #1.</p> <p>Findings Include:</p> <p>Record review of the facility policy, Care Plans, Comprehensive Person-Centered with reviewed date of January 2023 revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .</p> <p>Record review of Resident #1's Care Plan with an initiation date of 03/19/24, revealed Focus: I am incontinent of bladder .Interventions/Tasks .Check every two (2) hours and as required for incontinence</p> <p>On 04/15/24 at 10:50 AM, an observation revealed Resident #1 lying in his bed on his left side and there was a mild odor of urine noted in the room. His sheet was pulled down with his incontinent brief exposed. The brief was saggy and appeared to be wet.</p> <p>On 04/15/24 at 11:20 AM, an observation revealed Licensed Practical Nurse (LPN) #1 performed wound care to Resident #1's right trochanter. LPN #1 pulled down Resident #1's incontinent brief to prepare for wound care and she confirmed that his incontinent brief was soaked with urine. Resident #1 revealed that he had not been changed since before breakfast. She revealed that the CNAs were supposed to make rounds on the residents every two hours.</p> <p>On 04/15/24 at 11:25 AM, an interview with CNA #1 confirmed that Resident #1 had not been changed since the last shift left at 7 AM that morning.</p> <p>On 04/15/24 at 11:45 AM, an interview with Assistant Director of Nursing (ADON), revealed CNAs were supposed to round on residents every two hours and if the resident refused care, they were supposed to report this to the nurse. The ADON confirmed Resident #1 should be checked at least every two hours.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/24 at 2:00 PM, an interview with Minimum Data Set (MDS) Nurse, revealed that the purpose of the care plan was to identify the care that each resident needed so the staff would know essentially how to take care of the resident. She revealed that the care plan identified the problems and the conditions of the residents and put individualized interventions in place to follow for each resident. The MDS Nurse also revealed all residents should be checked on at least every two hours whether they were asleep or not and if they refused to be changed, they should be care planned for that as well. The MDS Nurse confirmed that if a resident was not checked on every two hours, the care plan was not followed.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</p> <p>Based on observation, interview, record review and facility policy review the facility failed to ensure Activities of Daily Living (ADL) care was completed on a dependent resident when a Certified Nursing Assistant (CNA) did not check a resident every two hours for incontinent episodes and the resident was left wet for an undetermined amount of time for one (1) of three (3) residents reviewed. Resident #1.</p> <p>Findings Include:</p> <p>Record review of the facility policy titled Activities of Daily Living (ADLs), Supporting revised March 2018 revealed, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>During an observation on 04/15/24 at 10:50 AM, revealed Resident #1 lying in bed and there was a mild odor noted. His bed sheet was pulled down with his incontinent brief exposed and it was sagging and appeared to be wet.</p> <p>During an observation and interview on 04/15/24 at 11:20 AM, revealed Licensed Practical Nurse (LPN) #1 gather supplies and perform wound care to Resident #1's right trochanter. There was a mild odor noted when LPN #1 unfastened the resident's incontinent brief. LPN #1 confirmed the mild odor, and stated, It smells like urine. LPN #1 pulled down Resident #1's incontinent brief to prepare for wound care and she confirmed that his brief was soaked with urine. Resident #1 stated that he had not been changed since before breakfast.</p> <p>During an interview on 04/15/24 at 11:25 AM, CNA #1 confirmed Resident #1 was assigned to her and she had not changed him yet because he was sleeping. CNA #1 confirmed that he had not been changed since the last shift left at 7 AM that morning. She revealed that she didn't get him up because he didn't like to be woken up.</p> <p>During an interview on 04/15/24 at 11:45 AM, the Assistant Director of Nursing (ADON), revealed that CNAs were supposed to round on residents every two hours and if the resident refused care, they were supposed to report this to the nurse. She revealed that leaving a resident wet for extended periods could cause the wounds to get worse and could cause infection. The ADON revealed that Resident #1 was normally up and on the move but he still should be checked at least every two hours. She revealed that even if residents were sleeping, they were required to check and see if they needed to be changed. She revealed that it was unacceptable for a CNA to leave a resident for hours without checking on them and changing their brief. She revealed that they would educate and in-service about this. She stated, They can't not change them. She revealed that it was unacceptable for a CNA to leave a resident over four hours without checking on them and changing their brief.</p> <p>During an interview on 04/15/24 at 11:55 AM, the Director of Nursing (DON) revealed CNAs are required to check on residents every two hours that are incontinent and see if they needed changing. She revealed that CNA #1 should have rounded on Resident #1 and changed him even if he was asleep.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/15/24 at 3:09 PM, CNA #2 revealed that they were supposed to round on all residents every two hours and change them whether they were asleep or not because residents could be at risk for skin breakdown.</p> <p>Record review of Resident #1's Admission Record revealed that he was admitted on [DATE] and had diagnoses that included Huntington's Disease, Spina Bifida, Stage 3 Pressure Ulcer of Right Hip, and Need for Assistance with Personal Care.</p> <p>Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/24, Section C revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated he had moderate cognitive deficits.</p>