

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 01/23/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013</p> <p>Based on staff interviews, record review, and facility policy review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) status change for a resident following an inpatient psychiatric hospital stay for one (1) of three (3) PASARRs reviewed. Resident # 57.</p> <p>Findings include:</p> <p>A review of the facility policy titled PASRR Policy and Procedure with a revision date of 7/18/18 revealed, (Facility proper name) uses the most current version of PASRR Rules of the Mississippi Division of Medicaid: Administrative Code, Medicaid Title 23: Part 207, Chapter 1: Long Term Care Pre-Admission Screening as they pertain to the Level 1 (PAS) and Level 2 (PASRR) long term care processes and procedures.</p> <p>Record review of Resident #57's Admission Record revealed that she was admitted to the facility on [DATE] with diagnoses that included Parkinsonism, Anxiety Disorder, Bipolar II Disorder, and Major Depressive Disorder, Recurrent.</p> <p>Record review of Resident #57's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 2, 2024, revealed under Section A2105. Discharge Status 07. Inpatient Psychiatric Facility (psychiatric hospital or unit)</p> <p>In an interview on 1/22/25 at 2:45 PM, the former Social Services Director revealed when Resident #57 went out for inpatient psychiatric treatment, she was responsible for completing the PASARRs. She confirmed she did not submit a new change of status form for a Level 2 PASARR because she thought that since the resident had a negative Level I Preadmission Screening (PAS), they were exempt from sending anything further for the resident.</p> <p>During an interview on 1/22/25 at 3:15 PM, the Administrator revealed that the purpose of the Level 2 evaluation is to ensure the residents get the proper psychiatric care they need. He revealed he was unaware that a change in status form was not completed for Resident #57 after her psychiatric hospital stay but confirmed that it should have been.</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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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</p> <p>Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with personal hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident #55, Resident #67, and Resident #71.</p> <p>Findings Include</p> <p>Review of the facility policy titled, Care Plans, Comprehensive, Person Centered with a revision date of 10/2022 revealed under, Policy Statement .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>Resident #15</p> <p>Record review of Resident #15's Care Plan date initiated 12/27/24 revealed that she had an ADL self-care performance deficit related to weakness and impaired mobility. Resident #15's interventions included that she required partial to moderate assistance by staff for personal hygiene and to offer assistance with any shaving needs.</p> <p>On 01/21/25 at 10:30 AM an observation and interview revealed Resident #15 with numerous scattered facial hairs that were approximately one-half inch long on her chin and upper lip. She stated she use to could take care of it herself, but not anymore. She admitted that no one had offered to shave or remove her facial hair since she had been there and stated, I've been here about a month.</p> <p>On 01/22/25 at 10:38 AM an interview with Registered Nurse (RN) Supervisor #1, confirmed the facial hair on Resident #15's chin and upper lip needed to be removed. She confirmed that shaving is part of grooming during their bath and since it was not done then her ADL care plan was not followed.</p> <p>Record review of Resident #15's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease.</p> <p>Record review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated that she had moderate cognitive deficits.</p> <p>Resident #71</p> <p>Record review of Resident #71's Care Plan date initiated 12/11/24 revealed that he had an ADL self-care performance deficit related to weakness and poor balance. Resident #71's interventions included that he required partial to moderate assistance with personal hygiene and to check nail length and trim and clean on bath day and as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/21/25 at 10:00 AM an observation and interview with Resident #71 revealed long, jagged fingernails that were approximately one-half to three-fourths inch long bilaterally. Resident #71 stated that his fingernails were too long.</p> <p>On 1/22/25 at 10:34 AM, an observation and interview with RN Supervisor #1 confirmed that Resident #71 had long jagged fingernails on both hands. She confirmed that the staff were supposed to take care of their fingernails on bath day and revealed that the residents' ADL care plan was not followed.</p> <p>Record review of Resident #71's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.</p> <p>Record review of Resident #71's MDS with ARD of 12/16/24 under Section C revealed a BIMS Score of 11 which indicated that he had moderate cognitive deficits.</p> <p>Resident #31</p> <p>Record review of Resident #31's Care plans revealed, Focus: I have an ADL self-care performance deficit r/t (related to) Cerebral infarction, weakness, need for assistance with personal care .with interventions initiated on 03/11/2020 that included, Perform AM/PM care including oral care, peri-care, bathing, dressing, hygiene, shaving and nail care.</p> <p>On 1/21/25 at 10:05 AM an observation and interview revealed Resident #31's fingernails were long and jagged with a brown substance under every nail. The resident had facial hair that was approximately one inch long on his cheeks, chin, and above the resident's lip and admitted that he had tried to get someone to shave him, but they still have not. Resident #31 stated, I've been trying to get shaved, and I want it all shaved off.</p> <p>On 1/22/25 at 9:15 AM, an interview and observation CNA #1 confirmed that Resident #31 needed to be shaved, and his fingernails needed trimming. She admitted that nail care and shaving is part of grooming.</p> <p>A record review of Resident #31's Admission Record revealed the facility admitted the resident on 09/25/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.</p> <p>Record review of the MDS with an ARD of 11/29/24 revealed Resident #31 had a BIMS score of 06, which indicated the resident had severe cognitive impairment.</p> <p>Resident #55</p> <p>Record review of Resident #55's Care plans revealed, Focus: I have an ADL self-care performance deficit r/t weakness, impaired mobility .with interventions initiated on 06/01/2023 that included Bathing/Showering: Check nail length and trim and clean on bath day and as necessary.</p> <p>On 1/21/25 at 10:25 AM an observation and interview with Resident #55's, he stated he likes his fingernails short. An observation at this time revealed the resident's fingernails were all long and jagged.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 at 9:20 AM, an observation and interview CNA #2 confirmed that Resident #55's fingernails on both hands were too long. She revealed his fingernails should be taken care of when he gets his baths.</p> <p>A record review of Resident #55's Admission Record revealed the facility admitted the resident on 05/31/2023 with diagnoses that included Pneumonia, Essential (Primary) Hypertension, and Major Depressive Disorder.</p> <p>Record review of the MDS with an ARD of 11/8/24, revealed Resident #55 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #67</p> <p>Record review of a care plan for Resident #67 titled, I have an ADL self-care performance deficit r/t (related to) impaired mobility, revealed Interventions: personal hygiene: I am totally dependent on staff for personal hygiene.</p> <p>On 11/21/25 at 9:25 AM, an observation of Resident # 67 revealed the resident had a brown substance on every fingernail on the resident's right hand.</p> <p>On 1/22/25 at 9:40 AM, in an observation and interview with Licensed Practical Nurse (LPN) #2 she confirmed there was a dried brown substance on each fingernail on Resident #67's right hand. She confirmed that Resident #67 had not received nail care and the resident's care plan had not been implemented.</p> <p>Review of the Admission Record revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage.</p> <p>Record review of Resident #67's MDS with an ARD of 11/05/24, revealed GG0130: Self Care : Personal Hygiene: coded 01 Dependent.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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, staff, resident, and resident representative interview, record review and facility policy review the facility failed to provide personal hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident #55, Resident #67, and Resident #71.</p> <p>Findings Include</p> <p>Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, revised March 2018, revealed, Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming and hygiene needs</p> <p>Resident #15</p> <p>An observation and interview on 01/21/25 at 10:30 AM, revealed Resident #15 sitting up on the side of her bed with facial hairs scatted over her chin and upper lip that was approximately one-half inch long. She stated that she use to be able to use tweezers when she was at home and kept her facial hair plucked. She revealed that her hair needed to be removed but she didn't have a way to do it, and no one had offered to shave or remove her facial hair since she had been there. She stated that she knew they get busy and probably forget about her but she didn't like to have hair on her face.</p> <p>An observation and interview on 01/22/25 at 10:30 AM with Certified Nursing Assistant (CNA) #3, revealed that facial hair was supposed to be addressed during a resident's bath or shower time and as needed and confirmed that Resident #15 had scattered facial hair on her chin and upper lip. She admitted that most ladies do not want facial hair, and it should be removed unless they refuse.</p> <p>An interview on 01/22/25 at 10:38 AM with Registered Nurse (RN) Supervisor #1, confirmed the facial hair on Resident #15's chin and upper lip. She revealed that most ladies were concerned about their appearance and would want it removed. She confirmed that facial hair should be addressed and removed during the resident's bath or shower and as needed.</p> <p>Record review of Resident #15's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease.</p> <p>Record review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 11 which indicated that she had moderate cognitive deficits.</p> <p>Resident #71</p> <p>An observation and interview with Resident #71 on 01/21/25 at 10:00 AM revealed him lying in bed with long, jagged fingernails on his bilateral hands and was approximately one-half to three-fourths long. Resident #71 stated that his fingernails were too long, and they had started to split and crack. He revealed that no one had offered to trim his fingernails since he came there and stated, I need them cut.</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 - Some</p>	<p>An observation and interview with Resident #71 on 01/22/25 at 9:38 AM, revealed no change in the appearance of the resident's fingernails. He stated that he used to be able to take care of his own nails when he was home, but not anymore and he liked to keep his nails a lot shorter than they are now.</p> <p>An observation and interview on 01/22/25 at 10:24 AM with CNA #3, revealed that nail care was part of personal hygiene and should be looked at and taken care of every day and as needed. CNA #3 revealed that Resident #71's fingernails appeared like they had not been clipped in a while.</p> <p>An observation and interview with RN Supervisor #1 on 1/22/25 at 10:34 AM confirmed Resident #71's nails needed to be trimmed and stated that long jagged fingernails could cause scratches, skin tears and possible spread of infection.</p> <p>An interview with Director of Nursing (DON) on 01/22/25 at 10:50 AM revealed that fingernails should be cleaned every day and facial hair should be addressed with the resident's bath or as needed.</p> <p>Record review of Resident #71's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.</p> <p>Record review of Resident #71's MDS with an ARD of 12/16/24 under Section C revealed a BIMS score of 11 which indicated that he had moderate cognitive deficits.</p> <p>46013</p> <p>Resident #31</p> <p>An observation and interview on 1/21/25 at 10:05 AM revealed Resident #31's bilateral fingernails were approximately one and one-half (1 1/2) inches long and jagged past the tip of fingers; a brown substance was under each nail. Resident #31 revealed they need to be cut; they are too long. Facial hair was approximately one inch long and was noted on the cheeks, chin, and above the resident's lip. Resident #31 stated, I've been trying to get shaved, and I want it all shaved off.</p> <p>During a phone interview on 1/21/25 at 2:57 PM, Resident #31's Representative (RR) stated We had visited before and found him to have long fingernails and not be shaved. We have brought it to the staff's attention before.</p> <p>An observation and interview on 1/22/25 at 9:05 AM revealed that Resident #31 was lying in bed with no change in appearance from the prior day. Resident #31 again confirmed that he wants to be shaved, and his nails cut.</p> <p>In an interview and observation on 1/22/25 at 9:15 AM, CNA #1 confirmed Resident #31's nails were very long, and that he needed to be shaved and stated, I'm not sure when his nails or shaving has last been. She revealed the resident had refused to have his nails cut in the past, so she doesn't ask him anymore if he wants them to be done.</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 - Some</p>	<p>During an observation and interview on 1/22/25 at 9:25 AM, the DON confirmed Resident #31's fingernails were long and jagged, with a brown substance under them and that he needed shaving. She stated that this is not how we operate. Regardless, if he has refused in the past, he should still be offered to have his nails cleaned and cut and his facial hair shaven, which is part of his daily grooming.</p> <p>A record review of Resident #31's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.</p> <p>Record review of the MDS with an ARD of 11/29/24 revealed Resident #31 had a BIMS score of 06, which indicated the resident had severe cognitive impairment.</p> <p>Resident #55</p> <p>An observation and interview on 1/21/25 at 10:25 AM revealed Resident #55's bilateral fingernails were approximately one-half (1/2) inch long and jagged past the tip of his fingers. Resident #55 revealed he likes them to be cut shorter and neater.</p> <p>An observation on 1/22/25 at 8:45 AM revealed Resident #55's fingernails remain one-half inch long and jagged past the tip of his fingers.</p> <p>An observation and interview on 1/22/25 at 9:20 AM, CNA #2 revealed she was assigned to Resident #55 today and confirmed that his fingernails on bilateral hands were long and jagged. She revealed his fingernails should be looked at every day when he gets either a bed bath or a shower and that they should be kept trimmed to prevent him from scratching himself and causing a skin tear.</p> <p>A record review of Resident #55's Admission record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Pneumonia, Essential (Primary) Hypertension, and Major Depressive Disorder.</p> <p>Record review of the MDS with an ARD of 11/8/24, revealed Resident #55 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>47157</p> <p>Resident #67</p> <p>An observation of Resident # 67 on 11/21/25 at 9:25 AM, revealed all the resident's fingernails on the right hand to have a dried dark brown substance surrounding the nail cuticles and under the nail beds.</p> <p>An observation on 11/21/25 at 1:45 PM, revealed Resident #67's fingernails to the right hand were still observed to have a dried dark brown substance surrounding the nail cuticles and under the nail beds.</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 - Some</p>	<p>In an observation and interview with Licensed Practical Nurse (LPN) #2 on 1/22/25 at 9:40 AM confirmed that Resident # 67's fingernails on the right hand had a dried dark brown substance around the nail cuticles and under the nail beds and it appeared to be feces. She then stated that Resident #67 had not received nail care or hand hygiene lately and confirmed that failing to perform hand hygiene and nail care could lead to infections.</p> <p>In an interview with CNA #4 on 1/22/25 at 9:45 AM, she revealed that Resident #67 was prone to playing in her stool and confirmed she had not made rounds on the resident and seen the condition of her nails this shift.</p> <p>In an interview with the DON on 1/22/25 at 9:49 AM, she confirmed that not performing nail care was an infection control concern.</p> <p>Review of the Admission Record revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage.</p> <p>Record review of Resident #67's MDS with an ARD of 11/5/24 revealed a BIMS score of 99 indicating the resident was unable to complete the interview. Section GG revealed that Resident #67 was dependent on staff for personal hygiene.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47157</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to provide necessary services, to promote healing, and prevention of developing new pressure ulcers for (1) one of (3) three residents with wounds reviewed. (Resident #49)</p> <p>Findings include:</p> <p>Review of the facility policy titled, (Proper Name) Pressure Injury Prevention Program, with a revision date of 09/2024 revealed all residents will be assessed for the risk of pressure injury . specific interventions will be implemented to prevent the development of avoidable pressure injuries, or to treat new/existing pressure injuries.</p> <p>An observation on 1/21/25 at 9:15 AM revealed Resident #49 lying asleep in bed, an air-mattress control box was attached to the foot of the bed, with no lights on indicating the mattress was not on. An observation of the mattress revealed the resident was lying in the middle of the bed, with the mattress completely deflated and sunken in the middle.</p> <p>Review of the Order Summary Report for Resident #49 revealed an active order dated 7/12/23 for a low air loss mattress for pressure redistribution.</p> <p>An observation of Resident #49 on 1/21/25 at 11:20 AM, revealed the mattress remained sunken in the middle, with Resident #49 lying in the sunken area. Certified Nurse Assistant (CNA) #4 was in the room preparing to get the resident out of bed. She revealed the air-mattress was sunken in the middle earlier in the morning before breakfast when she provided care to Resident #49 and admitted that she had not reported that to anyone.</p> <p>An observation and interview on 1/21/25 at 11:25 AM with Licensed Practical Nurse (LPN) #1 revealed Resident #49's air-mattress control box was not on. LPN #1 pushed the buttons on the top of the air-mattress control box and stated she could not get the box to come on. LPN #1 touched the mattress and confirmed that it was deflated. She stated that the resident could develop worsening wounds or skin breakdown from lying on a deflated air mattress.</p> <p>In an observation and interview on 1/21/25 at 11:27 AM with the Maintenance Director, he confirmed Resident #49's air-mattress was deflated because the control box was cut off. He turned the box on, and it immediately came on and inflated the mattress. He then confirmed staff should check the air-mattress often to ensure it is on and functioning and report any concerns.</p> <p>In an interview with the Director of Nursing (DON) on 1/22/25 at 9:48 AM confirmed that Resident #49 could develop worsening of wounds because of his small stature and lead to more skin breakdown from lying on a deflated air mattress. She then confirmed CNA #4 should have reported the mattress being deflated immediately when it was observed.</p> <p>Review of the Admission Record revealed the facility admitted Resident # 49 on 4/13/22 with a diagnosis of Huntington's Disease.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 49's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/01/24, revealed Section M: 0300: Number of Stage 4 pressure ulcers coded as (1) one. Item M:1200 was coded as having a pressure reducing device for bed.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</p> <p>Based on observation, resident and staff interview, record review and facility policy review, the facility failed to ensure medications were safely and securely stored for one (1) of three (3) survey days.</p> <p>Findings Include:</p> <p>Record review of the facility policy, Storage of Medications with a reviewed date of July 2024, revealed, The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>An observation and interview with Resident #72 on 01/21/25 at 9:35 AM, revealed him lying on his bed in his room and there were ten pills inside a medication cup placed on the top of his over bed table. Resident #72 revealed that the nurse brought his medicine in about five minutes ago and he asked her to leave it there, and he planned to take it in a few minutes. He revealed that the nurse had set the medicine down and left it and a cup of water for him to take it with.</p> <p>An observation and interview on 01/21/25 at 9:40 AM with Licensed Practical Nurse (LPN) #3 confirmed that there were ten pills in a medicine cup on Resident #72's over bed table. She revealed that she had just prepared his 9:00 AM medications and brought them to him. LPN #3 confirmed that she should have stayed in the room and watched him take the medications and not left them with him. She revealed that by leaving medications at the bedside, she would not know what medication the resident took and someone else could come in and take them. LPN #3 confirmed that she was supposed to watch the residents take their medicine and not leave them at the bedside. LPN #3 validated with the Medication Administration Record (MAR) that those medications in the cup were the ones she had just prepared and brought in for Resident #72 to take.</p> <p>An observation and interview with Registered Nurse (RN) Supervisor #2 on 01/21/25 at 9:50 AM confirmed that it was against the facility policy to leave medications at a resident's bedside. She confirmed that there were ten pills in the medication cup left at Resident #72's bedside and that the nurses were supposed to watch the residents swallow the medications before they left the room. RN Supervisor #2 revealed that by leaving medications at the bedside, there was a risk of another resident taking the medications which could possibly be something they were not supposed to have.</p> <p>An interview on 01/22/25 at 2:00 PM with the Director of Nursing (DON), revealed that medications should never be left at a resident's bedside. She revealed that someone else could have rolled in there and taken the medications while the resident was asleep. She went on to say that Resident #72 could have also put off taking them until later when other medications were due and received too much. The DON confirmed that LPN #3 should have watched the resident swallow the pills prior to leaving the room.</p> <p>Record review of Resident #72's Medication Administration Record (MAR) revealed that on 01/21/25 at 9:00 AM, LPN #3 signed out ten medications for administration to Resident #72.</p> <p>(continued on next page)</p>

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 01/23/2025
NAME OF PROVIDER OR SUPPLIER Cornerstone Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 302 Alcorn Drive Corinth, MS 38834	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #72's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Major Depressive Disorder, Unspecified Mood Disorder, Anxiety Disorder, and Need for Assistance with Personal Care.</p> <p>Record review of Resident #72's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was cognitively intact.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>47157</p> <p>Based on record review, staff interview, and facility policy review, the facility failed to accurately submit the Payroll-Based Journal (PBJ) for the 4th quarter (July 1 - September 30) in the fiscal year (FY) 2024.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Reporting Direct-Care Information (Payroll-Based Journal), last reviewed 3/2023, revealed Policy Statement: Staffing and census information will be reported electronically to CMS (Centers for Medicare and Medicaid Services) through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act .2. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees .10. Staffing data includes the number of hours worked each day by each staff member .</p> <p>Record review of the PBJ Staffing Data Report revealed that the facility triggered for low weekend staffing for the fourth quarter of 2024.</p> <p>In an interview with the Director of Nursing (DON) and the Administrator on 1/22/25 at 3:12 PM, they revealed during the timeframe the facility triggered for low weekend staffing, the facility was having to use a lot of agency nursing staff. The DON and the Administrator both confirmed that some agency staff hours were not accurately submitted to the PBJ, resulting in the low weekend staffing being triggered.</p>		