MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 02CI | A. BUILDING: _____ B. WING _____ | C 04/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CORNERSTONE REHABILITATION AND HEALTHCARI | 302 ALCORN DRIVE CORINTH, MS 38834 |

| (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 |
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| M 000 | Initial Comments<br><br>On 04/15/24 the State Agency (SA) conducted an on site Complaint Investigation (CI) MS#24344. The SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610 related to residents being left wet for extended periods. | M 000 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>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.<br><br>Findings Include:<br><br>Record review of the facility policy titled "Activities | M 610 | M610 Activities of Daily Living<br><br>1. The facility failed to ensure Activities of Daily Living (ADL) care was completed on a dependent resident, Resident #1, when a Certified Nursing Assistant (CNA) did not check the resident every two hours for incontinent episodes and the resident was left wet for an undetermined amount of time. On 4/15/24 Wound Nurse and Certified Nursing Assistant(CNA) performed incontinent on Resident #1. On 4/15/2024, the Director of Nurses and Assistant Director of Nurses in-serviced current Nursing Staff on ADL (Activity of | 5/20/24 |

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| M 610 | Continued From page 1<br>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."<br><br>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.<br><br>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."<br><br>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.<br><br>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 | M 610 | Daily Living) care according to the plan of care.<br><br>2. Each of the 77 residents in the facility has the potential to be affected in receiving Activity of Daily Living Care.<br><br>3. On 4/15/2024 current nursing staff were in-serviced by the Director of Nurses and Assistant Director of Nurses on completion with documentation of ADL (Activity of Daily Living). On 4/16/24, the Wound Care Nurse and Medical Records Nurse completed an audit on current resident ADL (Activity of Daily Living) care plans were reviewed to ensure proper incontinent and ADL (Activity of Daily Living) care were reflected with no concerns.<br><br>4. Beginning 4/16/2024, Incontinent checks on incontinent residents to be performed by Medical Records Nurse and Wound Care Nurse three (3) days a week, on ten (10) residents for eight (8) weeks, then once monthly for three (3) months. IDT (Interdisciplinary Team) will review daily for accuracy and will discuss in Monthly Quality Assurance (QA) meeting on 5/16/24 and continue for three (3) months. | |

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| M 610 | Continued From page 2 | M 610 | | |

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.

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.

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.

Record review of Resident #1's Admission Record revealed that he was admitted on 04/13/22 and had diagnoses that included Huntington's Disease, Spina Bifida, Stage 3 Pressure Ulcer of Right Hip, and Need for Assistance with Personal Care.

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

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| M 610 | Continued From page 3<br>Interview for Mental Status (BIMS) score of 09 which indicated he had moderate cognitive deficits. | M 610 | | |