STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	C 01/23/2025

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and two (2) Complaint Investigations (CI MS #26868 and CI MS #27040) at the facility from 01/21/25 through 01/23/25. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F644, F656, F677, F686, F761, and F851. The SA determined the facility was in compliance for CI MS#26868 related to abuse with no deficiencies cited and determined noncompliance for CI MS#27040 related to quality of care and cited F656 and F677. The census at the time of the survey was 78 and the facility held a license for 95 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		2/24/25

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

Electronically Signed | 02/05/2025

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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. Findings Include	F 656	-F656- Develop/Implement Comprehensive Care Plan- 1. The facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with person hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident # 55, Resident #67, and Resident #71.	

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F 656	Continued From page 2 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". Resident #15 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. 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. " 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. Record review of Resident #15's "Admission	F 656	Assistance with personal hygiene was performed immediately by wound care nurse and Certified Nursing Assistant for each listed Resident. On 1/23/2025 Resident #15's facial hair was trimmed, Resident #71's nails were trimmed, Resident #31's nails were trimmed and he was shaved, Resident #55's nails were trimmed, and Resident #67's nails were cleaned and trimmed. A 100% audit of all current residents was started on 1-24-25 and completed by the Medical Records Nurse and Wound Nurse and those issues found were fixed during the audit. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on appropriate personal hygiene to be performed for dependent residents and its frequency related to the Residents Plan of Care, which is followed to care for the resident. If any changes are noted to the Resident□s Care Plan report it to the Supervisor so the Care Plan can be updated. 4. On 1/24/2025 personal hygiene checks started and will be conducted by Nursing Administration on dependent residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure substantial compliance that Activity of Daily Living (ADL) care on residents is	

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F 656	Continued From page 3 Record" revealed an admission date of 12/23/24 and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease. 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. Resident #71 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. 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. 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. Record review of Resident #71's "Admission Record" revealed an admission date of 12/09/24	F 656	being followed according to Care Plan by staff. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	

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F 656	Continued From page 4	F 656		

and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.

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.

Resident #31

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.

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."

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.

A record review of Resident #31's Admission Record revealed the facility admitted the resident

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F 656	Continued From page 5	F 656		

on 09/25/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.

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.

Resident #55

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."

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.

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.

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.

Record review of the MDS with an ARD of 11/8/24, revealed Resident #55 had a BIMS score

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F 656	Continued From page 6 of 12, which indicated the resident had moderate cognitive impairment. Resident #67 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." 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. 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. Review of the "Admission Record" revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage. Record review of Resident #67's MDS with an ARD of 11/05/24, revealed GG0130: Self Care : Personal Hygiene: coded 01 Dependent.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		2/24/25

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F 677	Continued From page 7 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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. Findings Include 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...." Resident #15 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. 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	F 677	-F677- ADL Care Provided for Dependent Residents 1. The facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with person hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident # 55, Resident #67, and Resident #71. Assistance with personal hygiene was performed immediately by wound care nurse and Certified Nursing Assistant for each listed Resident. On 1/23/2025 Resident #15's facial hair was trimmed, Resident #71's nails were trimmed, Resident #31's nails were trimmed and he was shaved, Resident #55's nails were trimmed, and Resident #67's nails were cleaned and trimmed. A 100% audit of all current residents was started on 1-24-25 and completed by the Medical Records Nurse and Wound Nurse and those issues found were fixed during the audit. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on appropriate personal hygiene to be performed for dependent residents and its frequency.	

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F 677	Continued From page 8 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. 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. Record review of Resident #15's "Admission Record" revealed an admission date of 12/23/24 and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease. 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. Resident #71 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."	F 677	4. On 1/24/2025 personal hygiene checks started and will be conducted by Nursing Administration on dependent residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure substantial compliance that personal hygiene care on residents is being performed by staff. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	

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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.

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.

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.

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.

Record review of Resident #71's Admission Record revealed an admission date of 12/09/24 and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.

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.

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F 677	Continued From page 10 Resident #31 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 ½) 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." 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." 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. 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. 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	F 677		

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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.

A record review of Resident #31's Admission Record revealed the resident was admitted to the facility on 09/25/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.

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.

Resident #55

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.

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 677	Continued From page 12	F 677		

A record review of Resident #55's Admission record revealed the resident was admitted to the facility on 05/31/2023 with diagnoses that included Pneumonia, Essential (Primary) Hypertension, and Major Depressive Disorder.

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.
Resident #67

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.

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.

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.

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

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	255232	A. BUILDING _____ B. WING _____	C 01/23/2025

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F 677	Continued From page 13 made rounds on the resident and seen the condition of her nails this shift. 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. Review of the "Admission Record" revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage. 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.	F 677		