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CORNERSTONE REHABILITATION AND HEALTHCARI	302 ALCORN DRIVE CORINTH, MS 38834

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (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 the Minimum Standards for Institutions for the Aged or Infirm, and cited deficiencies at M 610, M 615 and M 705. 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 M 610. The census at the time of the survey was 78 and the facility held a license for 95 beds.	M 000		
M 610	45.21.2 Activities of daily living 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: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern 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,	M 610	-M610- Activities of daily living 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	2/24/25

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M 610	Continued From page 1 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 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	M 610	(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. 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	

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M 610	Continued From page 2 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." 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	M 610	monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	

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M 610	Continued From page 3	M 610		

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.

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

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M 610	Continued From page 4	M 610		

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 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.

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M 610	Continued From page 5 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. 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.	M 610		

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M 610	Continued From page 6 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 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.	M 610		

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M 610	Continued From page 7 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.	M 610		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II 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) Findings include: 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. ... An observation on 1/21/25 at 9:15 AM revealed Resident #49 lying asleep in bed, an air-mattress	M 615	-M615- Pressure sores 1. The facility failed to provide necessary services, to promote healing, and prevention of developing new pressure ulcers for one (1) of three (3) residents with wounds reviewed. Resident was Resident #49. Upon discovery of the deflated air mattress under this resident on 1-21-25 the Maintenance Supervisor checked and turned the mattress□ power on immediately. 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 checking of air-mattresses to ensure they are functioning properly and	2/24/25

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M 615	Continued From page 8 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. 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. 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. 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. 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	M 615	letting Maintenance know immediately if they are not. 4. On 1/24/2025 air mattress checks started and will be conducted by Nursing Administration on residents with air mattresses three (3) days a week, on each resident, for eight (8) weeks then once monthly for three (3) months to assure that mattresses remain functional and aired up properly. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-2025 and continue for three (3) months.	

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M 615	Continued From page 9 should check the air-mattress often to ensure it is on and functioning and report any concerns. 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. Review of the "Admission Record" revealed the facility admitted Resident # 49 on 4/13/22 with a diagnosis of Huntington's Disease. 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.	M 615		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by:	M 705		2/24/25

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M 705	Continued From page 10 Level II 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. Findings Include: 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." 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. 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	M 705	-M705- Policies and procedures 1. The facility failed to ensure medications were safely and securely stored for one (1) of three (3) survey days. On this day the LPN Cart nurse left pills laying on resident #72's overbed table for him to take and exited the room. Upon notification on 1-21-2025 that the resident hadn't taken the medications the LPN then returned to the room and observed the resident take those medications immediately. An 100% audit of all residents rooms was started on 1-24-25 and completed by the Administrator with no new findings. 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 med passes and how appropriately perform a med pass as well as the appropriate ways to store medications. 4. On 1/24/2025 Med Pass checks started and will be conducted by Nursing Administration on residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure residents are being given their meds properly and medications aren□t being stored incorrectly. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA)	

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M 705	Continued From page 11 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. 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. 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. 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. Record review of Resident #72's "Admission Record" revealed an admission date of 12/18/24	M 705	Meeting on 2-24-25 and continue for three (3) months.	

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 _____	01/23/2025

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
M 705	Continued From page 12 and that he had diagnoses that included Major Depressive Disorder, Unspecified Mood Disorder, Anxiety Disorder, and Need for Assistance with Personal Care. 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.	M 705		