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| | 255232 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual survey at the facility from 05/28/19 to 05/30/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatoriy deficiencies at F565, F679, F804, and F880.<br><br>The census at the time of the survey entrance was 83, and the facility was certified for 95 beds. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every | F 565 | | 6/27/19 |

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

Electronically Signed | 06/27/2019

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.

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| F 565 | Continued From page 1<br>request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, resident council interview and facility policy review, the facility failed to resolve grievances related to food concerns for three of three (3 of 3) residents interviewed with food concerns. Residents #5, #20 and #26.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Filing Grievances/Complaints", revised 11/2017, revealed, Policy Statement: Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made. Policy Interpretation and Implementation: 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.<br><br>Review of the facility policy titled, "Food: Quality and Palatability", revealed: Policy Statement-Food will be prepared by methods that conserve nutritive value, flavor and appearance. | F 565 | F565<br>1. The Administrator begin reviewing the facility grievances log weekly starting 06/24/19 to ensure Resident grievances are being addressed in a timely manner. The Certified Dietary Manager met with Resident Council on 06/06/19 to listen to Resident grievances related to Dietary Services. The Administrator, Director of Nursing, and District Manager for the contracted Dietary Services provider met with Residents #5, #20, and #26, on 06/24/19 to discuss the plan to follow up on grievances related to Dietary. All three Residents stated they can see that the Certified Dietary Manager is listening to their grievances, and addressing their grievances.<br><br>2. Residents who receive meals from dietary department have the potential to be affected.<br><br>3. The facility department heads were in-serviced on the documentation and resolution of grievances on 05/31/19 by the Administrator. Facility staff was | |

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| F 565 | Continued From page 2<br>Food will be palatable, attractive and served at a safe and appetizing temperature. Definitions: "Food attractiveness" refers to the appearance of the food when served to the residents. "Food palatability" refers to the taste and/or flavor of the food".<br><br>On 05/29/19, at 1:00 PM, a Resident Council meeting was held with Residents #26, #20, and #5 in attendance. Review of the Resident Council Minutes revealed the residents attended Resident Council meetings on three (3) of the last 3 months. They stated the food taste and quality was discussed at each of the meetings. During Resident Council, Resident #5 revealed she frequently goes to bed hungry because she couldn't eat the food. She stated the food was "not fit to eat" and she hoped something could be done about it. She stated she had talked to the administrator but he said he didn't have anything to do with it because it was Corporate. Resident #26 stated, "We've talked until we're blue in the face. They said they have to go by the menu that was made up North. We're Southern, we don't like some of that food. There is such a turnover in the kitchen, you never know who is going to cook".<br><br>In an interview on 05/29/19, at 3:45 PM, the Ombudsman, stated she had spoken with the Administrator several months ago regarding the food. She stated, on 02/13/19, then Vice President of the Resident Council, Resident #20, had given a report on the food and stated it was not good. She stated she had also spoken with Resident #5 and #26, who confirmed the food was bad. She stated the Administrator was very much aware of the problem. She stated, "We've been on them since the last survey." | F 565 | in-serviced by the local Ombudsman on 06/26/19 in regards to the requirement for the facility staff to report Resident grievances to the facility Social Services Director, who serves as the facility Grievance Officer, including the documenting and resolution of resident grievances.<br><br>4. Beginning the week of 06/24/19, the Administrator will audit the Grievance Log maintained by the Grievance Officer weekly for four (4) weeks, then monthly for three (3) months to ensure that grievances are being resolved. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator for three (3) months for review and recommendations. The Administrator is responsible for on-going monitoring and compliance. | |

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| F 565 | Continued From page 3<br><br>In an interview with the Administrator, on 05/29/19, at 4:30 PM, he stated he was aware of the problem with the food, that it was an ongoing issue since July 2018. He stated that food is absolutely important and the only thing some of the residents have to look forward to. He stated he had told the dietary staff that they can choose what they want to eat every night, but our residents get what you put in front of them. They don't have the ability to choose what they have. He stated there had been a lot of turnover in the dietary department. Healthcare Services is contracted for Dietary. He stated he did not eat from the kitchen, but agreed it would be a good idea to taste it every now and then. He confirmed he had spoken to the Ombudsman about the food issue a few months ago. The Administrator stated the issues with the food should have been documented in the Grievance Log, and that everybody in the building, management and the contracted dietary company, were aware there were issues. He said there was no excuse for not documenting the grievances, but believes it may be because it was an issue they were all discussing frequently. He stated that all grievances should be documented and followed up on per agency policy and that was not done.<br><br>Record Review of the Grievance Log for 07/2018 - 05/2019 revealed no food grievances listed. | F 565 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing | F 679 | | 6/27/19 |

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| F 679 | Continued From page 4<br>program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and record review, the facility failed to provide activities that meet the resident's interests and needs for one (1) of two (2) residents reviewed for activities. Resident #34.<br><br>Findings include:<br><br>On 5/28/19 at 10:25 AM, an observation of Resident #34 revealed the resident in his room and in his bed sleeping. Resident #34 had an tube feeding infusing via a tube feeding pump.<br><br>On 05/29/19 at 2:10 PM, an interview with the Activity Assistant (AA) revealed she stated, "he refuses to go to activities and when I go in his room to do an in room activity he refuses. But today when I went in his room he allowed my to do an in room activity." The AA revealed she does not have any documentation to show when she attempted to take Resident #34 to an activity, offered activities to the resident, or what activities she offered the resident and that he refused.<br><br>On 05/29/19 at 4:33 PM, an interview with Resident # 34 revealed he would like to attend more activities and have more visits in his room. Resident #34 revealed he would like to attend Bingo, Church, Special Parties, and music. Resident #34 revealed he is not asked to attend | F 679 | F679<br>1. Resident #34 was placed on one-to-one Activities program on 06/01/19. Resident #34 is being invited to activities seven days a week by his department head Neighbor or Activity personnel. Resident #34 is being offered individual activities by both the Activities Department and his Department Head Neighbor. The facility also hired a second Activity Assistant to cover the days the Activity Director is on intermittent FMLA two days per week.<br><br>2. Twelve (12) Residents receiving one-to-one activities have the potential to be affected.<br><br>3. The facility department heads were in-serviced on 05/31/19 to relay the activities of the day to the Residents in the department head Nexion Neighborhood (assigned area), when they do their daily Neighbor Rounds, by the Administrator. The department head also invite the Residents to activities Monday through Friday, and document that they invited the Residents. The Activity personnel that is on duty Saturday and Sunday invite the Residents to activities on those days. On 06/12/19, Daily Activities was added to our | |

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| F 679 | Continued From page 5<br>activities and activities staff do not visit him in his room. Resident #34 stated he "gets lonely". Resident #34 stated, "I have asked to go to activities and they will not take me." Resident #34 revealed he would attend activities if they would come and get him and ask him to go.<br><br>On 05/30/19 at 10:00 AM, an interview with Resident #34's mother revealed she visits her son two (2) days a week, and on those two days she arrives at 5:30 AM and does not leave until late in the afternoon, and she has not ever witnessed a staff member coming into the room and inviting the resident to an activity. Resident #34's mother stated only one time she has seen a staff member providing activities in the room to the resident. Resident #34's mother revealed that people from a church have come and visited the resident and she was so glad they did and she wished she could come more often but can only get a ride to the facility two days a week.<br><br>On 5/30/19 at 10:30 AM, an interview with the Activity Director (AD) confirmed she did not document any attempts to get Resident #34 to participate in activities, in room or group, and she knew she should have. The AD confirmed she had not spent enough time with Resident #34 and it was because of not having enough time. The AD revealed things are a little messed up right now in her department while she is on Family Medical Leave and there is usually only one person in activities.<br><br>Record review of the Activity Log for Resident #34 revealed he had attended one (1) activity since admission on 01/02/19.<br><br>Record review of the Comprehensive Care Plan, | F 679 | facility Morning Announcements that are made over the facility intercom system Monday through Friday. The Activity personal that is on duty Saturday and Sunday will announce the activities of the day over the intercom system. Facility staff was in-serviced by the local Ombudsman on 06/26/19 in regards to the requirement for the facility to provide one-on-one Activities for those residents who desire one-on-one Activities.<br><br>4. Beginning the week of 06/24/19, the Administrator will audit the one-on-one Activity Record weekly for four (4) residents who require one-on-one activity program weekly for four (4) weeks, then monthly for three (3) months, to ensure that 1:1 Activities are being offered. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator for three (3) months for review and recommendations. The Administrator is responsible for on-going monitoring and compliance. | |

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| F 679 | Continued From page 6<br>initiated on 02/28/19, for Resident # 34 revealed a Focus area was developed for participation in activities and is limited due to the resident's illness. The interventions included activities Resident #34 enjoyed were cards, games, spiritual activities, parties/social events, visiting with company and spending time outdoors.<br><br>Record review of Resident #34's Face Sheet revealed an original admission date of 01/02/19, and most recent admission date of 04/12/19. Resident #34 was transferred to the hospital twice since his initial admission and readmission to the facility. Resident #34 had diagnoses which included Unspecified Sequelae of Cerebral Infarction, Tracheotomy Status, Cognitive Communication Deficit, Malignant Neoplasm of Laryngeal Cartilage, Major Depressive Disorder, Recurrent, Hemiplegia and need for assistance with personal care.<br><br>Record review of the Minimum Data Set, with an Assessment Reference Date of 03/30/19, revealed a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment. | F 679 | | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. | F 804 | | 6/27/19 |

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| F 804 | Continued From page 7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, test tray sample and the facility policy review, the facility failed to ensure residents were served palatable and appetizing food for three (3) of 3 residents interviewed with food concerns.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Food: Quality and Palatability", revised 09/2017, revealed, "Policy Statement, Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Definitions, "Food attractiveness" refers to the appearance of the food when served to the residents. "Food palatability" refers to the taste and/or flavor of the food".<br><br>On 05/28/19 at 2:54 PM, in an interview with Resident #5, she revealed at lunch today, "They ran out of everything by the time they got to me. Only thing I ate was potato wedges. I asked for mayonnaise for my hamburger but they said they ran out. I didn't get any green beans. By the time they got to our table they had run out of green beans, and they gave me carrots. I don't eat carrots, so the only thing I ate was potato wedges. I have told them I don't eat carrots". She stated the Resident Council members had talked to the Administrator, and he said he doesn't have any thing to do with the kitchen. She revealed she had talked with the manager from corporate a month ago and she told me she was going to see about getting some improvement, but it hasn't been any improvement so far. They have a new Dietary Manager who started yesterday. When | F 804 | F804<br>1. The Certified Dietary Manager met with Resident #5 on 06/06/19 to address her concerns related to running out of food, mayonnaise, green beans, bread being served not toasted, and Resident #5 likes and dislikes related to food. The Certified Dietary Manager is having on-going conversation multiple time per week with Resident #5 related to her meal service. The Certified Dietary Manager also met with Resident Council on 06/06/19 to listen to Resident grievances related to Dietary Services. The Certified Dietary Manager began making changes to the menu on 06/07/19 to address the Resident s wishes to have certain items, or combinations of items changed on the menu; changes were reviewed by the Registered Dietician on 06/07/19. The Administrator, Director of Nursing, and District Manager for the contracted Dietary Services provider met with Residents #5, #20, and #26, on 06/24/19 to discuss the plan to follow up on issues related to Dietary. All three Residents voiced agreement with plans implemented to address the food quantity, quality, palatability, and attractiveness.<br><br>2. Residents receiving meals from the dietary department have the potential to be affected.<br><br>3. Beginning the week of 06/10/19, Meal Monitoring will be documented by the Nurse Supervising meals in the Dining | |

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| F 804 | Continued From page 8<br>they bring the food around on the carts at night, almost all the food goes back uneaten. Almost nobody eats it. I don't believe they wrote down my complaint on a grievance form. I do attend Resident Council Meetings in the dining room monthly. We voice our food concerns in Resident Council at every meeting.<br><br>During an observation and interview, on 05/29/19 at 8:24 AM, Resident #5 stated, "This is what they gave me, this toast has never seen a toaster and the omelette was cold and hard. If my husband didn't bring me butter and jelly I wouldn't have any." This surveyor observed that Resident #5 had a tub of margarine and a jar of jelly on her overbed table that she stated she kept in her in room refrigerator. Present on the tray was a folded cheese omelette, a bowl of Cheerios, one (1), eight (8) ounce carton of milk, 1 piece of white bread that does not appear to have been toasted, orange juice, one (1) biscuit and two (2) pieces of bacon.<br><br>On 05/29/19 at 11:11 AM, four of four surveyors sampled a test tray of the lunch meal. Foods on the tray included Chicken with Thyme, Noodles with Mushrooms, Capri Vegetables (Squash/Zucchini) , Rice, English Peas, Meatballs with Brown Gravy, Chocolate Pudding and a roll. The rice was mushy with no taste and had brown specks in it. The chicken was dry. Capri Vegetables and English peas had no seasoning. The noodles were dry and bland with no seasoning.<br><br>On 05/29/19 at 1:00 PM, a meeting with the Resident Council was held. Residents #26, #20, and #5 attended. Review of the Resident Council Minutes revealed that these residents had | F 804 | Room and on hallways. The facility Certified Dietary Manager was in-serviced by the contract Dietary Company District Manager on 06/17/19 on purchasing practices with regards to forecasting and procurement of food to ensure that the facility does not run out of food items during meal service. The Certified Dietary Manager in-serviced facility staff on 06/17/19 related to food temps, Food Temp Logs, the importance of following recipes, preparation of food, seasoning, and appearance of the food when served to residents. The Dietary Department has had a list of always available items for Residents to choose from for the lunch meal. On 06/17/19 the Certified Dietary Manager implemented the always available resident choice items to the dinner meal. The facility staff was in-serviced on 06/26/19 by the Head Educator from the local hospital related to the preparations and serving to palatable and attractive food. The Administrator/Director of Nursing/Meal Monitor will start sampling meal trays daily the week of 06/24/19 to ensure that food being offered is palatable and attractive<br><br>4. Beginning the week of 06/24/19, the Administrator will review findings of the Meal Monitor reports weekly for four (4) weeks to and follow up with Certified Dietary Manager on any negative findings at that time. Meal Monitor report findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator for three (3) months for review and recommendations. | |

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| F 804 | Continued From page 9<br>attended Resident Council meetings on three (3) of the last 3 months. They stated that food taste and quality was discussed at each of the meetings. During Resident Council, Resident #5 revealed she frequently goes to bed hungry because she couldn't eat the food. She stated the food was "not fit to eat", and that she hoped something could be done about it. She stated she had talked to the administrator but he said he didn't have anything to do with it because it was Corporate. She stated she had a refrigerator in her room that her husband had stocked with snacks and that she will get a snack around 10:00 PM because she's hungry. She stated the beans and peas are dry with no liquid and the corn bread is so hard you could knock a hole in the wall with it. She revealed she had ordered a Bacon, Lettuce, and Tomato sandwich Monday night, and that she got two (2) pieces of "light" bread with two (2) strips of bacon, no mayonnaise, lettuce or tomato. When she asked where it was, the staff member stated, "in the kitchen", and did not bring it back to her. Resident #20 revealed she also was hungry most nights "because we didn't get a good dinner. I can't wait for breakfast". She stated, "We are old. We've worked hard all our lives and want respect and to be treated right. They take our checks, all we have is 44 dollars a month left and we expect food fit to eat. Something needs to be done". She revealed she and her roommate, Resident # 26, keep peanut butter and jelly in their room and hope for two pieces of bread on their dinner tray so they can make a sandwich. All three residents stated they dreaded to lift the lid on their plates. She stated that lunch today was awful, the chicken was hard and the noodles were dry with some mushrooms in them. She stated the food had no seasoning and the green beans tasted as | F 804 | The Administrator is responsible for on-going monitoring and compliance. | |

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| | 255232 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

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

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| F 804 | Continued From page 10 | F 804 | | |

if they were just dumped out of the can. Resident # 26, President of the Resident Council, stated a lot of food goes back to the kitchen on the trays because no one eats it, and the staff should realize that something needed to be done about it. She stated a new Dietary Manager started this week, and she plans to ask her to attend a meeting to talk about the food. She stated, "We've talked until we're blue in the face. They said they have to go by the menu that was made up North. We're Southern, we don't like some of that food. There is such a turnover in the kitchen, you never know who is going to cook".

In an interview on 05/29/19 at 3:45 PM, the Ombudsman stated she had spoken with the Administrator several months ago regarding the food, and that she had been following that problem since the last survey. She stated on 02/13/19, then Vice President of the Resident Council, Resident #20, had given a report on the food and stated it was not good, and she had also spoken with Resident #5 and #26, who confirmed this report.

In an interview with the Administrator, on 05/29/19, at 4:30 PM, he confirmed he was aware of the problem with the food and it was an ongoing issue since July 2018. He stated food is absolutely important, and the only thing some of the residents have to look forward to. He stated he had told his dietary staff they can choose what they want to eat every night, but our residents get what you put in front of them. They don't have the ability to choose what they have. He stated there had been a lot of turnover in the dietary department. Healthcare Services is contracted for Dietary. He stated he did not eat from the kitchen, but agreed it would be a good idea to taste it

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| | 255232 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

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

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| F 804 | Continued From page 11<br>every now and then. He confirmed he had spoken to the Ombudsman about the food issue a few months ago. | F 804 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be | F 880 | | 6/27/19 |

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|---|---|---|---|
| | 255232 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

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

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| F 880 | Continued From page 12<br>reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff<br><br>Based on observation, staff interview, and facility policy review, the facility failed to prevent the | F 880 | F880<br>1. Resident # 26 was seen by her attending Physician on 06/01/19 who documented there were no signs or symptoms of a UTI present at this time. Certified Nursing Assistant # 1 was | |

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| CORNERSTONE REHABILITATION AND HEALTHCARE CENTER | 302 ALCORN DRIVE CORINTH, MS 38834 |

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| F 880 | Continued From page 13<br>possible spread of infection during one (1) of four (4) care observations. Resident #26.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Suprapubic Catheter Care", from the Nursing Services Policy and Procedure Manual for Long Term Care, 2001 MED-PASS, Inc. (Revised October 2010), revealed the purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract.<br><br>On 05/29/19 at 3:50 PM, Certified Nursing Assistant (CNA) #1 performed Resident #26's supra pubic catheter care. Certified Nursing Assistant (CNA) #1 went into Resident #26's bathroom washed her hands and applied gloves. She came out of the bathroom with gloves on and closed the resident's privacy curtain, closed the window blind, and then picked up the pack of wipes and handed it to the CNA assisting her. CNA #1 proceeded with catheter care without changing her gloves before she started the procedure.<br><br>On 05/29/19 at 4:08 PM, an interview with CNA #1 confirmed she entered the resident's room, washed her hands , put on gloves, closed the privacy curtain, the window blinds and picked up the wipes before starting the catheter care. CNA #1 stated her gloves were contaminated because she touched all those things in the room. CNA #1 confirmed she should have washed her hands and changed gloves before doing the catheter care. She stated this could cause infection and spread germs.<br><br>An interview with the Director of Nursing (DON), | F 880 | in-serviced by the facility Staff Development Nurse on 05/30/19 related to the proper usage of gloves to prevent contamination of the gloves, prior to performing supra pubic catheter care.<br><br>2. Three (3) Residents with orders for supra pubic catheters have the potential to be affected.<br><br>3. Facility nursing staff was in-serviced by the Staff Development Nurse on supra pubic care provided in a manner to decrease the risk of infection, with return demonstration beginning on 05/31/19. Facility Staff was in-serviced by the Head Educator from the local hospital on 06/26/19 in regards to decreasing risk of infection.<br><br>4. Beginning the week of 06/24/19, the Staff Development Nurse will observe supra pubic catheter care three (3) times weekly for four (4) weeks, then monthly to ensure infection control and prevention measures are followed. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Staff Development Nurse for three (3) months for review and recommendations. The Staff Development Nurse is responsible for on-going monitoring and compliance. | |

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| | 255232 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

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

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| F 880 | Continued From page 14<br>on 05/29/19 at 5:02 PM, confirmed CNA #1 should not have touched anything with her gloves on before doing the care. The DON stated CNA #1 did not follow proper procedure during the care. She stated this was an infection control issue, and could cause an infection.<br><br>On 05/30/19 at 12:50 PM, an interview with the Staff Development Nurse confirmed CNA #1 should have changed her gloves before she did the catheter care. She stated CNA # 1 contaminated her gloves by touching things in the room. She stated she had an inservice in February, but CNA #1 did not come.<br><br>Record review revealed an Infection Control inservice was done on 02/21/19, and CNA #1 was not in attendance. | F 880 | | |

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|---|---|---|---|
| | 255232 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **05/29/2019** |

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

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| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).<br><br>There were no LSC deficiencies cited during this survey. | K 000 | | |

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

Electronically Signed | 06/27/2019

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.

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| | 255232 | A. BUILDING **02 - BUILDING 2** B. WING _____ | **05/29/2019** |

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

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| E 000 | Initial Comments<br><br>*EMERGENCY PREPAREDNESS*<br><br>Survey conducted on 5/29/19 reveals the above facility does not meet all applicable Federal, State and local emergency preparedness requirements.<br><br>Deficiencies were identified. | E 000 | | |
| E 039 SS=E | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:<br><br>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]<br><br>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is | E 039 | | 6/27/19 |

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| E 039 | Continued From page 1<br>community-based or individual, facility-based.<br>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and interviews, the facility failed to conduct Emergency Prep Testing Requirements Annually of the 'Tabletop Exercise' and 'Community-Based Exercise' for current annual emergency preparedness (EP) plan requirements of 42 CFR §483.73(a).<br><br>Findings include: | E 039 | E039<br><br>1. On 06/13/19, he Administrator and Maintenance Director completed the After Action Report / Improvement Plan for the Alcorn County Community Based Full Scale Exercise the facility participated in on 09/24/2018. On 06/27/19 Table Top | |

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| | 255232 | A. BUILDING _____ B. WING _____ | 05/29/2019 |

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| CORNERSTONE REHABILITATION AND HEALTHCARE CENTER | 302 ALCORN DRIVE CORINTH, MS 38834 |

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| E 039 | Continued From page 2<br><br>On 5/29/19 at 12:35 AM, the facility failed to provide all portions of the annual emergency preparedness (EP) requirements. Documentation review revealed the facility was unable to provide an up-to-date tabletop exercise and community-based exercise of EP plan. The documentation shall include performance of tabletop exercise and community-based exercise within the last calendar year of 2018. | E 039 | Exercise related to tornado damage to part of the building was conducted by the Maintenance Director, Administrator and facility staff. The emergency scenario of tornado damage to the building was discussed, problem statements organized, and discussed, and the after action review of challenges encountered were discussed.<br><br>2. The table top exercise was added to the annual calendar along with the facility exercises.<br><br>3. The facility Administrator and Maintenance Director were in-serviced 06/25/19 by the Regional Maintenance Director on the requirements of E039, including the requirement to complete an After Action Review on the Community Based Event, and on the Table Top Exercise of the Emergency Operations Plan. The Maintenance Director educated the staff on 06/26/19 regarding the requirement to conduct exercises and a Table Top Exercise regarding the preparedness of the facility and staff in the event of a possible disaster.<br><br>4. Beginning the week of 06/24/19, the facility exercise for Disaster Preparedness Calendar and the Table Top Exercise will be monitored by the Administrator on a monthly basis. The Administrator or designee will report to the Quality Assurance Performance Improvement Committee monthly for three (3) months. The Administrator is responsible for monitoring and compliance. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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