

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02CI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/29/2019
NAME OF PROVIDER OR SUPPLIER CORNERSTONE REHABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments The State Agency (SA) conducted a complaint survey investigating CI MS# 16194 and CI MS#16332 on 10/28/19-10/29/19. Concerns identified in the complaint were related to possible quality of care and staffing regarding Resident #1 and Resident #2. These concerns were not substantiated, and no deficiencies were cited. During the survey the SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 85 at the time of the complaint survey, with a license for 95 bed capacity.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE