MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02CI	A. BUILDING: _____ B. WING _____	03/24/2022

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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) determined during an annual re-certification survey along with complaints, MS #18507, MS #18508, MS #18506 and MS #18270 at the facility from 3/21/22 to 3/24/22 that the facilty was not in compliance with the Minimum Standards of Operation for Instituitions for the Aged or Infirm, state requirements at M. The SA did not substantiate MS #18507 related to abuse with no citations related to the complaint. The SA substantiated CI MS #18508 related to a nurse working with a suspended license and cited M180 related to qualified staff. The SA substantiated CI MS #18270 related to Activities of Daily Living (ADL) assistance and cited M610 and M225 was cited related to insufficient nursing staff. CI MS #18506 was substantiated and cited M610 related to ADL assistance. The SA also cited M 655, M650 and M815. The facility had a census of 72 at the time of the survey and 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:	M 610		4/29/22

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/15/22

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M 610	Continued From page 1 Level II Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide baths and transfers for a resident that is dependent on staff for their Activities of Daily Living (ADL) for one (1) of 19 residents observed. Resident #44. Findings include: Record review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" with a revision date of "March 2018" revealed under the policy statement, " Residents who are unable to carry out activities of daily living, independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene". On 03/21/22 at 07:33 AM, an interview and observation of Resident #44 revealed she was lying in bed alert, awake and oriented with disheveled, greasy hair. She revealed she was the last on the bath schedule due to having to be lifted with a lift and that she is suppose to have a bath on Mondays but sometimes it gets pushed to Tuesday or not at all. Resident #44 revealed she can't remember the last time she got up in the wheelchair. She has told the staff that she wants to get up, but they will tell me they are short staffed, and that they do not have anyone that is certified to use the lift. We've had days where the only CNA we had were ones that were in training. An interview with Certified Nurse Assistant (CNA) #1 on 3/23/22 at 8:45 AM, revealed that bath days are Monday, Wednesday, and Fridays for even rooms and if the resident is bed bound then they get a bed bath. She has some residents that	M 610	1. On 3/23/2022, Certified Nursing Assistant and Temporary Nurse Aide immediately performed shower with personal hygiene providing out of bed activities on resident #44. On 3/28/2022 and by Staff Development Coordinator staff were educated on providing personal hygiene and Activities of Daily Living (ADL) care according to plan of care. 2. 72 Residents had the potential to be affected in receiving Activity of Daily Living Care. 3. On 03/28/22 current nursing staff were in serviced by Assistant Director of Nurses on completion with documentation of ADL care to include any refusals. On 3/28/2022 and by Medical Records, Staff Development Coordinator and Assistant Director of Nurses current residents care plans and care cards were reviewed to ensure proper bathing and ADL care were reflected. Any residents that were found with concerns were corrected immediately. 4. Beginning 4/3/2022, Audits by Medical Records, Staff Development and Assistant Director of Nurses for review of ADL documentation using Point of care three (3) times a week to ensure compliance for four (4) weeks and then weekly for three (3) months. Beginning April 21, 2022, report of findings will be submitted to the Quality Assurance Performance Improvement for review and recommendation monthly for three(3)months. The (DON) Director of Nurses is responsible for monitoring and	

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M 610	Continued From page 2 refuse a bath but Resident #44 is not one of them. CNA #1 revealed the facility has been short staffed, so some things they do get put off due to not having enough people and confirmed this resident must be lifted with a 2 person assist lift. Record review of documented baths and transfers revealed Resident #44 has had two baths and two transfers between the dates of 3/11/22 through 3/21/22 with no refusals documented. According to the bath schedule for Resident #44 she should have received five baths during that time frame. Record review of the Admission Record revealed she was admitted to the facility on 12/27/21. Record review of the medical diagnoses revealed the following diagnoses: morbid obesity, fusion of spine cervical region and muscle weakness. Record review of Resident #44's most recent accepted Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/22, Section C revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicates the resident has moderate cognitive impairment.	M 610	compliance.	
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed	M 650	1. On 3/24/2022, Resident #6 was evaluated for signs and symptoms of dehydration by Licensed Practical Nurse due to facilities policy and procedure for	4/29/22

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M 650	Continued From page 3 to provide hydration to a resident as evidenced by no water observed in the resident's room for two (2) of four (4) days of survey observations. Resident #6 Findings Include: Review of the facility policy titled, "Hydration Management," with no revision date revealed under "Standard" that "All residents will be provided with sufficient fluid intake to maintain proper hydration and nutritional status." An observation on 03/21/22 at 09:53 AM, revealed Resident #6 was alert and pleasantly confused. Her eyes appeared sunken, and she asked for water twice while the State Agency (SA) was interviewing her roommate. During this observation, Resident # 6's roommate, Resident #44 revealed that Resident #6 asked for water a lot. This observation revealed there was a half empty cup of water sitting on Resident #6's night stand that appeared to be thickened water but was out of reach of the resident. An observation on 3/22/22 at 9:00 AM, revealed that Resident #6 did not have a glass of water in her room. An observation on 3/23/22 at 8:40 AM, revealed there was no glass of water in Resident #6's room. An interview on 3/23/22 at 8:45 AM, with Certified Nurse Assistant (CNA) #1 revealed that Resident #6 can feed herself, but she has to be assisted to sit up. CNA #1 revealed that when she works she usually feeds her. CNA #1 revealed that the staff try to leave her water on her table, because she can reach it and drink it by herself.	M 650	Hydration Management. No signs and symptoms of dehydration were noted. On 3/24/2022 the Nursing staff were verbally in serviced on Hydration Management following policy and procedure by Director of Nursing. 2. Three (3) current residents with thickened liquids had the potential to be affected. 3. Beginning 3/24/2022, Nursing staff were verbally in serviced that residents with thickened liquids have them at bedside within reach by the Director of Nurses. On 3/28/2022, a written in-service was completed with all staff on Hydration and Nutritional Needs by Director of Nurses. 4. Beginning 3/28/2022, Medical Records, Staff Development and Assistant Director of Nurses will perform visual checks to ensure thickened liquids are available and in reach to residents requiring thickened liquids, three (3) times weekly, and weekly for three (3) months. A report of findings will be submitted to the Quality Assurance Performance Improvement for review and any recommendations monthly for three months, starting April 21, 2022. The DON (Director of Nurses) is responsible for monitoring and compliance.	

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M 650	Continued From page 4 An interview on 3/23/22 at 9:05 AM, with Licensed Practical Nurse (LPN) #2 confirmed that monitoring for dry mouth is listed on Resident #6's orders. LPN #2 confirmed that Resident #6 has to have thickened liquids and she revealed that the staff leave her a big cup of thickened liquid on her bedside table for her in the morning, lunch and afternoon. LPN #2 confirmed that the resident can reach her own water and self drink. LPN #2 revealed everyone is responsible for putting water out for the residents, but the nurses are the ones that add the thickening liquid. LPN #2 revealed she put Resident #6 a glass of water in her room this morning. LPN #2 observed and confirmed that the resident did not have any water in her room at that time and stated, "I will take care of this, I'm not sure what is going on." Record review revealed that Resident #6 was admitted to hospice 11/19/21 and all labs and monthly weight monitoring were discontinued per Resident #6's physician. An observation on 3/24/22 at 9:10 AM of Resident #6 revealed there was a glass of thickened water on her bedside table, but the table was out of reach of the resident. An interview on 3/24/22 at 9:15 AM, with LPN #2 confirmed the water on the bedside table should always be within reach of the resident, so she can drink it when she wants to. LPN #2 revealed she would send a Hospitality Nurse Aide to push Resident #6's bedside table close enough to the resident so she can reach her water. An interview on 3/24/22 at 9:30, with the Registered Dietician (RD) revealed that Resident #6 has no limits on the amount of fluid intake she	M 650		

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M 650	Continued From page 5	M 650		

has daily. The RD revealed that for Resident #6's most current weight of 83.2 pounds, the resident should be receiving at least 1300 milliliters (ml) of water per day.

An interview on 3/24/22 at 2:08 PM, with the Administrator, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed the CNA's are not taught how to add thickener and the Administrator revealed that she does not recall CNA's ever adding thickener to liquids. The Administrator revealed that it is the responsibility of the nurses to provide Resident #6 with her thickened water.

Record review of the Admission Record revealed Resident #6 was admitted to the facility on 10/25/18 with the following diagnoses: Dysphagia, Constipation, Personal history of urinary tract infections and Senile Degeneration of the brain.

Record review of Resident #6's "Nutrition-fluids" for the past 30 days revealed that Resident #6's daily fluid intake ranged from 360 ml to 960 ml for a 24 hours period.

Record review of Resident #6's Electronic Medical Record (EMAR) and Electronic Treatment Record (ETAR) for the dates of 3/1/22 through 3/23/22 revealed there was a task titled, "Interventions Anti-Psychotic Every Shift #7 Give Fluid," and was initialed by nursing staff every day.

Record review of Resident #6's physicians order dated 12/17/21 revealed the following order; Regular diet Pureed texture, Honey Thickened consistency, Double portions (every) Q meal with no straws, sippy cup with each meal, Magic Cup

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M 650	Continued From page 6 three times a day (tid) with meals, provide fortified foods on each meal tray daily, Ice Cream on lunch & supper trays for 60 days. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/21, Section G, revealed the resident needed extensive assistance with drinking. Record review of Resident #6's MDS with an ARD of 12/29/21 revealed Resident #6's Brief Interview for Mental Status Score (BIMS) of 99, which indicates that the resident was unable to complete the interview.	M 650		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, facility policy review, and record review the facility failed to appropriately administer medications for one (1) of two (2) residents observed for percutaneous endoscopic gastrostomy (PEG) medication administration. Resident #178. Findings include: Review of the facility policy titled, "Administering	M 655	1. On 3/22/2022, Resident #178 was assessed by the (RN) Registered Supervisor for any adverse reactions due to failure to follow facilities policy and procedure for Administering Enteral Medications. No adverse reactions were found. On 3/24/2022, an Inservice was completed by RN #2 by Director of Nurses on Enteral Medication Administration following policy and procedure.	4/29/22

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M 655	Continued From page 7 Medications through an Enteral Tube" revised November 2018, revealed the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Steps in the procedure: #12. Administer medication by gravity flow. An observation on 03/22/22 at 9:30 AM, revealed Registered Nurse (RN) #2 administered PEG tube medications to Resident #178. RN #2 crushed and mixed each of the five (5) medications separately in medication cups with water. RN #2 did not administer the medications by gravity flow. She pulled up each medication separately in the 60 cc syringe and pushed the medications into the enteral tube. She pushed the water flushes with a syringe between each medication and after all medications were administered. An interview on 3/24/22 at 11:10 AM, with the Director of Nursing (DON) revealed that PEG medications and anything else given via PEG should be by gravity flow. The DON confirmed that RN # 2 did not follow the facility policy for medication administration by PEG tube. She stated the facility has provided inservice education on PEG medication administration and used the facility policy to conduct the in-service. A telephone interview on 3/24/22 at 12:15 PM, with RN #2 revealed that she was not aware that she was not supposed to push the medications when administering by a PEG. She stated that she has been a nurse for 13 years and did not know this. She stated that she had not had any in-service education concerning PEG medication administration. A telephone interview on 3/24/22 at 2:30 PM, with	M 655	2. Eight (8) current residents with Enteral Tubes have the potential to be affected. 3. Beginning 3/24/2022, Licensed nursing staff were in serviced by Staff Development Coordinator and Assistance Director of Nurses on proper Enteral Medication Administration following policy and procedure with return demonstration. On 4/6/2022 skill evaluation with return demonstration was initiated by Consultant Pharmacist, Staff Development Coordinator and Assistant Director of Nurses on all current licensed nursing staff. All Licensed nurses will be completed with skills evaluation on 4/21/2022. 4. Effective 3/24/2022, Staff Development Coordinator and Assistant Director of Nursing will conduct audits on three (3) nurses three (3) times weekly for two (2) weeks and weekly for three (3) months to ensure Enteral Medication Administration is completed following policy and procedure. The report of audit findings will be reviewed by the Administrator and bought to the Quality Assurance/Performance Improvement Committee for review and recommendations monthly for four (4) months starting on April 21, 2022. The Director of Nursing will be responsible for monitoring and compliance.	

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M 655	Continued From page 8 the Consultant Pharmacist revealed that gravity flow is preferable. He stated that pushing the medications could force the tube out of place, cause irritation or push air into the stomach. Record review revealed the facility provided an inservice education with a topic titled, "Check Placement of PEG tube and one medication at a time with flush. Administer each medication by gravity flow." The inservice attendance sheet dated 03/07/22 revealed RN #2 was in attendance at this inservice and signed the in-service sheet.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review the facility failed to properly store, label and date foods in the refrigerator and freezer for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled, "Food Storage: Cold Foods" revised 9/2017, revealed per policy statement, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) food code. Procedure #5 revealed all foods will be stored wrapped or in covered	M 815	1. On 3/21/2022 Dietary Staff/Manager immediately discarded the unlabeled foods and juices and cleaned the bottom of the refrigerator. On 3/21/2022, Dietary Manager in serviced dietary staff on proper procedure for labeling, dating and storage of foods and juices. 2. 72 residents had the potential to be affected. 3. Beginning 3/28/2022, Dietary Manager and Administrator in serviced all dietary staff on proper procedure for labeling, dating and storage of foods and juices.	4/29/22

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M 815	Continued From page 9 containers, labeled and dated, and arranged in a manner to prevent cross contamination. An observation of the standup freezer revealed an open, undated one fourth full bag of French fries. An observation of the refrigerator revealed nine (9) cups of fruit cocktail, 21 glasses of milk, six (6) serving bowls of lettuce, three (3) glasses of orange juice, one (1) glass of soy milk not dated or labeled and five and one half (5 1/2) boiled eggs in a bag opened, not dated and unlabeled. A large hunk of whitish colored meat wrapped in plastic wrap, unlabeled and undated. There was a ten-pound tube of ground beef on the second shelf from the bottom and a box of pork thawing on the bottom shelf of the refrigerator not in a container. Observed the bottom of the refrigerator covered with pink-red fluid. An interview on 3/21/22 at 8:35 AM, with the Dietary Manager (DM) revealed that any food in the freezer that has been opened should be labeled and all foods in the refrigerator should be labeled and dated. The DM stated that food should be labeled and dated to prevent the possibility of spoilage and causing illness. The DM stated that the meat should be in a container when thawing to prevent contaminating everything. The DM stated that the hunk of meat was turkey used the day before. She confirmed it should be labeled and dated. An interview, on 3/24/22 at 1:50 PM with the Administrator (ADM) confirmed that foods in the freezer and refrigerator should be labeled and dated. She stated that if they are not the food could be spoiled. She stated, as for the meat thawing, she could not imagine this. The ADM who also serves as the Infection Preventionist	M 815	4. Effective 3/28/2022, Dietary Manager and Infection Preventionist will conduct audits on kitchen sanitation, labeling and storage three (3) times weekly and weekly thereafter. The report of the audits will be reviewed by the Administrator and brought to the Quality Assurance Performance Improvement Committee for review and recommendations monthly for four (4) months starting on April 21, 2022.	

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M 815	Continued From page 10 stated they have not had any outbreaks related to gastrointestinal issues.	M 815		