

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 12/21/2022
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, MS00019836 and MS00019772 from 12/20/2022 through 12/21/2022. The SA did not substantiate the complaints of Verbal Abuse, No Pressure Ulcer Precautions, Inadequate ADL Care, Not receiving ordered Therapy Services and determined the facility was in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The facility held a license for 95 beds, with a census of 90.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/29/22