STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) for CI MS #20809 at the facility on 03/23/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F600 for abuse, F609 for failure to immediately report an allegation of verbal abuse, and also cited F610 for failure to thoroughly investigate allegations of verbal abuse. The census at the time of the complaint survey was 91 with a license for 95 bed capacity.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record reviews, the facility failed to protect a resident from an incident of verbal abuse for one (1) of four (4) residents reviewed.Resident #1	F 600	F600 Preparation and submission of this plan of correction by Cornerstone Rehabilitation and Healthcare Center, Corinth, MS does	4/28/23

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

Electronically Signed | 04/11/2023

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F 600	Continued From page 1 Findings Include: During an interview on 03/23/23 at 11:30 AM, an interview with Resident #1, revealed that on Saturday, February 18, 2023, around 1:00 PM, Registered Nurse (RN) #1 disrespected him by yelling at him and telling him that he was an asshole and that was probably why he had no legs. Resident then stated to this SA, "She was an asshole to me." At 11:45 AM on 03/23/23, an interview with Certified Nursing Assistant (CNA) #2, revealed that she was working the day shift on February 18, 2023, when the incident between the resident and nurse occurred. She revealed that after Resident #1 was assisted back towards his room, that she (CNA #2) overheard the resident say, "Screw all of you bitches." Then she overhead the RN #1 reply to resident, "No, screw you, Buddy." CNA #2 revealed that Resident #1 was difficult at times; but "You have to learn to bite your tongue and walk away." An interview on 03/23/23 at 12:00 PM, with CNA #1, revealed that on February 18, 2023, at approximately 1:00 PM, she was in the front bathroom near the conference room when she overheard RN #1 speaking loudly to Resident #1. CNA #1 walked out of the bathroom and heard RN #1 say, "You're just an asshole, you're really mean and it's probably why you have no legs." CNA #1 revealed that RN #1 looked around and saw her (CNA #1) and then RN #1 replied, "He's so mean, I don't know why and he's an ass." CNA #1 revealed that she knew this was verbal abuse and had to be reported immediately. She stated after the witnessed occurrence between Resident	F 600	not constitute an admission of agreement by provider of the truth, or the facts alleged, or the correctness of the conclusions set forth on the statement of deficiencies. They prepared solely pursuant to the requirements under the federal and state laws. F600 D Free from Abuse and Neglect 1. Resident #1 was interviewed by Administrator on 2/20/2023. Resident #1 stated that Registered Nurse # 1 called him an asshole. He also stated, "that's why you have no legs." Registered Nurse Supervisor #1 was suspended on 2/20/2023. Social Services interviewed resident #1 on 2/20/2023 to assure resident social well-being. 2. The facility has determined that each of the 92 residents have the potential to be affected. 3. All staff members including, Director of Nursing, Assistant Director of Nurses, Director of Admissions/Social Services, and Assistant Director of Admissions/Social Services were in-serviced by Administrator on 3/24/2023, on reporting Abuse/Neglect, Types of Abuse, Facility providing a safe resident environment and protect residents from abuse and providing a written statement after reporting the Abuse. All staff were in-serviced on 3/24/2023 by the Nurse Educator on reporting Abuse/Neglect, Types of Abuse, Facility providing a safe resident environment and protect	

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F 600	Continued From page 2 #1 and RN#1 was over, she reported to the Director of Nursing (DON) by phone. The DON confirmed on 03/23/23 at 3:00 PM, during a phone interview, that she was notified by phone of the altercation between Resident #1 and RN #1 on Saturday, February 18, 2023 after it occurred and revealed that she received the information verbally from CNA #1; but that she did not realize the extent of the situation until she read the witness statements on Monday 02/20/23, which were left under the door of the Administrator's office. The Administrator (ADM) stated on 03/23/23 at 4:00, during an interview that she really didn't realize the seriousness of the incident since Resident #1 exhibited behavioral issues frequently. Record review of Resident #1's Face Sheet revealed documented an original admit date of 04/14/2016 and readmission date of 04/03/20 with the following diagnoses to include: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Anxiety, Major Depressive Disorder, Acquired Absence of Left Leg Below Knee, Acquired Absence of Right Leg Above Knee. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference date of 03/13/23, documented Brief Interview for Mental Status Score of 15 which indicated that resident was cognitively intact. Record review of timecards dated 02/18/23 and 02/19/23, revealed that RN#1, CNA #1, and CNA #2 worked day shift on these dates.	F 600	residents from abuse and providing a written statement immediately after reporting Abuse. Staff in-services started on 2/20/2023 for Abuse/Neglect, Vulnerable Adults and Resident Rights. Beginning 3/30/2023, Abuse /Neglect Incidents were added to the daily stand up meeting for daily review by Interdisciplinary Team. 4. In-service provided per Region IV Mental Health Services by the Director of Intellectual and Development Disabilities of Elderly Services, on 4/11/2023 and 4/13/2023. In Service provided by Ombudsman for the Mississippi State Department of Health on 4/12/2023. On 4/10/2023, Audits to be conducted on three employees weekly for four (4) weeks and then monthly for three (3) months to assure Compliance with Reporting Allegations of Abuse/Neglect/Exploitation is understood according to Facility Policy and Procedure. Audits will be taken to Quality Assurance monthly for review for three (3) months by the Administrator to monitor compliance starting 4/27/2023. The Administrator will conduct an audit of five (5) residents weekly beginning 4/10/2023 for four (4) weeks and monthly for three (3) months to assess and interview residents to identified issues/complaints, proper investigation and reports to the appropriate people were made.	

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews, and facility policy review, the facility failed to report an allegation of verbal abuse for one (1) of four (4) residents reviewed and failed to report a substantiated verbal abuse allegation timely to the State Agency and report to the State Board of Nursing Licensure after it was validated	F 609	F 609 D Reporting of Alleged Violations 1.The facility reported to the State Agency for Alleged Abuse on 2/20/2023. 2.The facility has determined that 92	4/28/23

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F 609	Continued From page 4 for Resident #1. Findings include: Review of the Facility "Abuse Prohibition Policy" with revised date of 10/2022, revealed "1. Any allegation of abuse/neglect, made by residents/staff/visitors shall be reported to the Abuse Coordinator and investigated immediately... Reporting/Response:..3. The facility will report to the state board of nursing, nurse aide registry or other licensing authority any substantiated allegation..." On 03/23/23 at 11:30 AM, an interview with Resident #1, revealed that on Saturday, February 18, 2023, around 1:00 PM, that Registered Nurse (RN) #1 had disrespected him by yelling at him and had told him that he was an asshole and that was probably why he had no legs. Resident then stated to this SA, "She was an asshole to me." On 03/23/23 at 11:45 AM, an interview with Certified Nursing Assistant (CNA) #2, revealed that she was working the day shift on February 18, 2023, when the incident between the resident and nurse occurred. She revealed that after Resident #1 was assisted back towards his room, that she (CNA #2) overheard the resident say, "Screw all of you bitches." Then she overhead the RN #1 reply to resident, "No, screw you, Buddy." CNA #2 revealed that Resident #1 was difficult at times; but "You have to learn to bite your tongue and walk away." On 03/23/23 at 12:00 PM, an interview with CNA #1, revealed that on February 18, 2023, at approximately 1:00 PM, she was in the front bathroom near the conference room when she	F 609	residents have the potential to be affected. 3.All staff have been in-serviced on reporting Abuse/Neglect in a timely manner (no later than two (2) hours after the incident on 3/24/2023. Abuse Reporting Requirements and Resident Abuse Prevention and Reporting was conducted by Administrator with Director of Nursing, Assistant Director of Nursing, Director of Social Services and Assistant Director of Social Services on 3/24/2023. 4. The Quality Assurance Committee will review all reports of abuse and/or neglect to ensure reporting of abuse and/or neglect to reporting guidelines are followed for three months effective 4/27/2023. All findings will be reviewed monthly for 3 months to assure substantial compliance is met, effective 4/27/2023 for (3) months. All incidents reports will be reviewed daily in stand up starting 4/10/2023.	

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F 609	Continued From page 5	F 609		

overheard RN #1 speaking loudly to Resident #1. CNA #1 walked out of the bathroom and heard RN #1 say, "You're just an asshole, you're really mean and it's probably why you have no legs." CNA #1 revealed that RN #1 looked around and saw her (CNA #1) and then RN #1 replied, "He's so mean, I don't know why and he's an ass." CNA #1 revealed that she knew this was verbal abuse and had to be reported immediately.

On 03/23/23 at 12:10 PM, an interview with CNA #1, revealed that on 02/18/23 after the witnessed occurrence between Resident #1 and RN#1, she reported to the Director of Nursing (DON) by phone. CNA #1 revealed that she told the DON that she (CNA#1) was aware that this was abuse and it had to be reported immediately.

On 03/23/23 at 3:00 PM, a phone interview with Director of Nursing (DON) confirmed that she was notified by phone of the altercation between Resident #1 and RN #1 on Saturday, February 18, 2023 after it occurred and revealed that she received the information verbally from CNA #1; but that she did not realize the extent of the situation until she read the witness statements on Monday 02/20/23. The DON also revealed that she knew that this kind of verbal abuse should be reported and investigated immediately and had she known the extent of it then she would have handled it differently. The DON confirmed that the facility failed to report the allegation of verbal abuse within the required timeframe according to the federal regulations.

On 03/23/23 at 4:00, an interview with the Administrator, (ADM) revealed that she really didn't realize the seriousness of the incident since Resident #1 exhibited behavioral issues

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F 609	Continued From page 6 frequently. The Administrator confirmed that she did not notify the State Board of Nursing related to the confirmed verbal abuse by the RN and that she also failed to report the allegation to the State Agency within the required timeframe according to the federal requirements. Record review of Resident #1's Face Sheet revealed documented an original admit date of 04/14/2016 and readmission date of 04/03/20 with the following diagnoses to include: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Anxiety, Major Depressive Disorder, Acquired Absence of Left Leg Below Knee, Acquired Absence of Right Leg Above Knee. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference date of 03/13/23, documented Brief Interview for Mental Status Score of 15 which indicated that resident was cognitively intact.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		4/28/23

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F 610	Continued From page 7 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews, and facility policy review, the facility failed to complete an immediate investigation of a report of verbal abuse by staff for one (1) of four (4) residents reviewed. Resident #1. Review of the Facility "Abuse Prohibition Policy" with revised date of 10/2022, revealed "1. Any allegation of abuse/neglect, made by residents/staff/visitors shall be reported to the Abuse Coordinator and investigated immediately...Investigation ...5. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions" During an interview on 03/23/23 at 11:30 AM, an interview with Resident #1, revealed that on Saturday, February 18, 2023, around 1:00 PM, that Registered Nurse (RN) #1 had disrespected him by yelling at him and had told him that he was an asshole and that was probably why he had no legs. Resident then stated to this SA, "She was an asshole to me." At 11:45 AM on 03/23/23, an interview with Certified Nursing Assistant (CNA) #2, revealed that she was working the day shift on February 18, 2023, when the incident between the resident and nurse occurred. She revealed that after Resident #1 was assisted back towards his room, that she (CNA #2) overheard the resident say, "Screw all of you bitches." Then she overhead the	F 610	F610 D Investigate/Prevent/Correct Alleged Violation 1.Resident # 1 was interviewed by the Administrator on 2/20/2023 to verify the Verbal Abuse. Resident # 1 advised the Registered Nurse # 1 called him an asshole and told him that was why he did not have any legs. Registered Nurse # 1 was immediately suspended after the interview with the resident and investigation was initiated by the Administrator. On 2/20/2020, Social Services interviewed resident #1 to assure social well being. 2.The facility has determined that each of the 92 residents has the potential to be affected. 3.All staff were in-serviced on 3/24/2023 by Nurse Educator on reporting timely investigations. Abuse Reporting Requirements and Resident Abuse Prevention was in-serviced by Administrator to Director of Nurses, Assistant Director of Nursing, Director of Social Services and Assistant Director of Social Services. 4.The Administrator will conduct an audit	

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F 610	Continued From page 8 RN #1 reply to resident, "No, screw you, Buddy." CNA #2 revealed that Resident #1 was difficult at times; but "You have to learn to bite your tongue and walk away." In an inteview on 03/23/23 at 12:00 PM, with CNA #1, revealed that on February 18, 2023, at approximately 1:00PM, she was in the front bathroom near the conference room when she overheard RN #1 speaking loudly to Resident #1. CNA #1 walked out of the bathroom and heard RN #1 say, "You're just an asshole, you're really mean and it's probably why you have no legs." CNA #1 revealed that RN #1 looked around and saw her (CNA #1) and then RN #1 replied, "He's so mean, I don't know why and he's an ass." CNA #1 revealed that she knew this was verbal abuse and had to be reported immediately. She stated after the witnessed occurrence between Resident #1 and RN#1 was over, she reported to the Director of Nursing (DON) by phone. CNA #1 revealed that she told the DON that she (CNA#1) was aware that this was abuse and it had to be reported immediately. CNA #1 then revealed that the DON had instructed her (CNA #1) to go back to work, to write statements and slide them under the Administrator's door and that this situation would be addressed on Monday, February 20, 2023. During this interview, CNA #1 also revealed that RN#1 returned to work on 02/19/23 and worked the entire day shift. The DON confirmed on 03/23/23 at 3:00 PM, during a phone interview, that she was notified by phone of the altercation between Resident #1 and RN #1 on Saturday, February 18, 2023 after it occurred and revealed that she received the information verbally from CNA #1; but that she did not realize the extent of the situation. The DON	F 610	of five (5) residents weekly beginning 4/10/2023 for four (4) weeks and monthly for three (3) months to assess and interview residents to identified issues/complaints, proper investigation and reports to the appropriate people were made. Quality Assurance will review the audits monthly for compliance beginning 4/27/2023 for three months.	

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F 610	Continued From page 9	F 610		

revealed that if she had known the seriousness of this incident, she would have come in and investigated it immediately that day. The DON also revealed that she knew that this kind of verbal abuse should be investigated immediately and had she known the extent of it then she would have handled it differently.

The Administrator (ADM) stated on 03/23/23 at 4:00, during an interview that she really didn't realize the seriousness of the incident since Resident #1 exhibited behavioral issues frequently. The ADM confirmed that the alleged verbal abuse was not investigated immediately and that she took full responsibility for this incident not being investigated timely and would make sure this kind of situation never occurred again.

Record review of timecards dated 02/18/23 and 02/19/23, revealed that RN#1, CNA #1, and CNA #2 worked day shift on these dates.

Record review of Resident #1's Face Sheet revealed documented an original admit date of 04/14/2016 and readmission date of 04/03/20 with the following diagnoses to include: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Anxiety, Major Depressive Disorder, Acquired Absence of Left Leg Below Knee, Acquired Absence of Right Leg Above Knee.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference date of 03/13/23, documented Brief Interview for Mental Status Score of 15 which indicated that resident was cognitively intact.