| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a complaint investigation (CI) survey for CI MS #21948, CI MS #22024, CI MS #22026, CI MS #22027, CI MS #22028, CI MS #22029, CI MS #22030, and CI MS #22031) at the facility from 07/17/23 through 07/19/23. The SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA identified non-compliance and cited M 815 for CI MS #21948 for failure to clean kitchen equipment used to prepare food. The SA investigated CI MS #22024, CI MS #22026, and CI MS #22028 for leaving medications in residents room and not administering medications according to plan of care and there were no deficiencies cited. The SA investigated CI MS #22030 and CI MS #22031 for Staff to Resident Altercation, investigated CI MS #22027 related to injury of unknown origin and there were no deficiencies cited. The SA also investigated CI MS # 22026 and CI MS #22029 for resident not groomed adequately and cited M 610, along with M 225 for insufficient staffing.<br><br>The census at the time of the survey was 81 with a bed capacity of 95 beds. | M 000 | | |
| M 225 | 45.4.1 Nursing Facility<br><br>Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements:<br><br>1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the | M 225 | | 8/25/23 |

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| M 225 | Continued From page 1<br>physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio.<br><br>2. Each facility shall have the following licensed personnel as a minimum:<br><br>a. Seven (7) day coverage on the day shift by a registered nurse.<br><br>b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.<br><br>c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.<br><br>d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse.<br><br>e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse.<br><br>f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. | M 225 | | |

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| M 225 | Continued From page 2<br><br>3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements.<br><br>4. There shall be at least two (2) employees in the facility at all times in the event of an emergency.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observations, staff interviews, record review, and facility policy review, the facility failed to maintain adequate staffing numbers to assist the residents in getting the care they needed to maintain good grooming, bathing and personal hygiene needs for one (1) of three (3) days of survey.<br><br>Findings include:<br><br>The Administrator revealed that they had no policy on Nursing Assistant staffing; but provided the following typed statement on Company Letterhead: "After completing the Certified Nursing Assistant (CNA) class, The Nurse Assistant is scheduled on the unit teamed with a Certified Nursing Assistant. They are overseen by the Nurse working the cart and Registered Nurse (RN) Supervisor." This letter was typed up, dated 7/18/2023 and signed by Administrator.<br><br>On 07/18/23 at 10:05 AM, observed Resident #2 lying in bed with eyes open. She was non-verbal and unable to make her needs known. State Agent (SA) observed a white crusty substance to the right side of her mouth and right chin area and a mild body odor was noted. Resident's hair was observed as disheveled and matted. | M 225 | M0225<br><br>Sufficient Nursing Staff<br>1. On 7/21/2023, Facility will ensure sufficient staffing to ensure provision of resident care. The Director of Nurses, Assistant Director of Nurses, and Staff Development Coordinator will ensure that the Nurses Assistants working on the floor provide care with the supervision of a Certified Nursing Assistant or Licensed Nurse.<br>2. The facility determined that each of the 81 residents could be affected.<br>3. On 7/20/2023, the Nursing Assistants and Certified Nursing Assistant were in-serviced by Director of Nurses and Nurse Educator that they must work together to provide care for residents. Nursing Assistants must not be left unattended during care. Audit will be completed by 8/4/2023 on acuity of residents on A/A plus Hall by Medical Records. On August 7,2023, an extra slot will be added to the A and A plus Hall for a Certified Nursing Assistant or Licensed Nurse to provide compliance.<br>4. Beginning 7/24/2023, the Director of Nurses and Administrator will review for sufficient staffing daily to ensure | |

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| M 225 | Continued From page 3<br><br>On 07/18/23 at 10:25 AM, an interview with Nursing Aide (NA), revealed that she had completed the Certified Nursing Assistant Program, had passed her written Certification Test on 06/13/23, had failed her skills test and was scheduled to retake her skills test in August to get her certification. She revealed that she gave baths/showers on A plus hall to all residents in even numbered rooms yesterday which was Monday, July 17, 2023. This NA revealed that she gave the showers first and when this was completed, she completed the bed baths. NA stated, "I do bed baths and showers all by myself." She also revealed that someone was supposed to always be with her when taking care of residents, but they were not because there wasn't enough staff. This NA confirmed that Resident #2's hair was unbrushed and matted up and confirmed that Resident #2 had a mild body odor. NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her.<br><br>On 07/18/23 at 10:30 AM, an interview with CNA #1, revealed that there was supposed to be a Certified Nursing Assistant working alongside Nursing Assistants until they received their certification. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was matted and unbrushed. CNA also revealed that there should always be two (2) people bathing Resident #2; and stated, "We don't always have enough staff." CNA #1 revealed that Resident #2 was frequently resistant to care and often slapped them back with her hands blocking them from giving the care she needed.<br><br>On 07/18/23 at 10:45 AM, an interview with | M 225 | compliance of provision of resident care. Sufficient staffing will be reviewed daily in the Morning Meeting to ensure Nursing Assistants are teamed with Certified Nursing Assistants to provide | |

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| M 225 | Continued From page 4<br><br>Administrator (ADM), revealed that the Nursing Assistants who had not received their certification were required to be overseen by Certified Nursing Assistants (CNAs) or Licensed Practical Nurses (LPNs). ADM stated, "They were supposed to work together." Administrator revealed that Nursing Assistant (NA) had passed the written certification test; but had failed her first skills test and was rescheduled to take it again.<br><br>On 07/18/23 at 11:15 AM, an interview with Registered Nurse (RN) #1 in Resident #2's room, revealed that she was working on A-Hall this shift. She confirmed that Resident #2 had disheveled, matted hair, and a mild body odor. RN #1 stated, "It doesn't appear that she had a bath yesterday based on the smell."<br><br>An interview on 07/19/23 at 9:45 AM, with Director of Nursing (DON), revealed that the Nursing Assistants (NAs) were supposed to be supervised by Certified Nursing Assistants (CNAs) and she confirmed that the NA was not supposed to be giving Resident #2 a bed bath by herself since her needs were documented for two persons assist. She confirmed that there was no way the resident could be thoroughly cleaned if she completed the bed-bath by herself. The DON revealed that this would require two people to turn and really get her clean.<br><br>On 07/20/23 at 4:00 PM, an interview with CNA #2, revealed that when the NAs completed their classes, they were paired with a CNA. She revealed that the NAs who had not passed the CNA classes were not supposed to give baths or showers without a CNA or Nurse with them; but the NAs were providing care without supervision at this time due to staffing issues. CNA #2 revealed that if they were fully staffed for the day, | M 225 | | |

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| M 225 | Continued From page 5<br>then the NAs could be paired with a CNA.<br><br>Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, Difficulty in Walking, and Need for Assistance with Personal Care. | M 225 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>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:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADLs) received services by qualified staff to maintain good grooming, bathing and personal hygiene needs for one (1) of six (6) residents sampled. Resident #2. | M 610 | M0610<br>Activity Daily Living Care Provided for Dependent Resident<br>1. Resident # 2 received a shower from a Certified Nursing Assistant and Nursing Assistant on 7/19/2023. On observation after care by Director of Nurses and Staff Development Coordinator resident #2 had no odor and hair was not matted. On 7/19/2023, the Nursing Assistant was verbally counseled that she could not provide care to residents independently by | 8/25/23 |

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| M 610 | Continued From page 6<br>Findings include:<br><br>Record review of the facility policy with revision date of March 2018 entitled, "Activities of Daily Living (ADLs), Supporting", revealed, "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."<br><br>On 07/18/23 at 10:05 AM, observed Resident #2 lying in bed with eyes open. She was non-verbal and unable to make her needs known. State Agent (SA) observed a white crusty substance to the right side of her mouth and right chin area and a mild body odor was noted. Resident's hair was observed as disheveled and matted.<br><br>On 07/18/23 at 10:20 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed that residents in even numbered rooms received baths every Monday, Wednesday, and Friday and residents in odd numbered rooms received their baths on Tuesday, Thursday, and Saturday.<br><br>On 07/18/23 at 10:25 AM, an interview with Nursing Aide (NA), revealed that she had completed the Certified Nursing Assistant Program, had passed her written Certification Test on 06/13/23, had failed her skills test and was scheduled to retake her skills test in August to get her certification. She revealed that she gave baths/showers on A plus hall to all residents in even numbered rooms yesterday which was Monday, July 17, 2023. This NA revealed that she gave the showers first and when this was completed, she completed the bed baths. NA stated, "I do bed baths and showers all by myself." She also revealed that someone was | M 610 | Director of Nurses.<br>2. The facility determined that each of the 81 residents could be affected.<br>3. On 7/21/2023, Nursing Staff were educated by Nurse Educator on providing personal hygiene, activities of daily living according to the Care Plan and documentation of care to include any refusals. On 7/19/2023, the Licensed Nursing Staff and Interdisciplinary Team began visual observation to assure the Nursing Assistants do not work independently.<br>4. Beginning 7/24/2023, audits will be conducted by Assistant Director of Nurses on five (5) residents for completion of care for Activities of Daily Living by observation weekly to ensure compliance for four (4) weeks and monthly for three (3) months. On 7/20/2023, Audits began for visual observation that Nursing Assistants are not working independently for four (4) weeks and monthly for three (3) months. Audits will be taken to Quality Assurance monthly beginning 8/15/2023 for three (3) months to identify that Activities of Daily Living are being performed without any issues. | |

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| M 610 | Continued From page 7 | M 610 | | |

supposed to always be with her when taking care of residents, but they were not. This NA confirmed that Resident #2's hair was unbrushed and matted up and confirmed that Resident #2 had a mild body odor. NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her.

On 07/18/23 at 10:30 AM, an interview with CNA #1, revealed that there was supposed to be a Certified Nursing Assistant working alongside Nursing Assistants until they received their certification. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was matted and unbrushed. CNA #1 revealed that Resident #2 was frequently resistant to care and often slapped them back with her hands blocking them from giving the care she needed. CNA #1 also revealed that the NA should always ask for help with residents.

On 07/18/23 at 10:35 AM, an interview with the NA revealed that this resident was often resistant to care. She confirmed that her hair was messy but when they tried to brush it, resident would lift her hands up to stop them from brushing it. This NA revealed that she should have asked for help with Resident #2 and not given her a bed bath without a Certified Nursing Assistant present.

On 07/18/23 at 10:45 AM, an interview with Administrator (ADM), revealed that the Nursing Assistants who had not received their certification were required to be overseen by Certified Nursing Assistants (CNAs) or Licensed Practical Nurses (LPNs). ADM stated, "They were supposed to work together." Administrator revealed that Nursing Assistant (NA) had passed the written certification test; but had failed her first skills test

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and was rescheduled to take it again.

On 07/18/23 at 11:15 AM, an interview with Registered Nurse (RN) #1 in Resident #2's room, revealed that she was working on A-Hall this shift. She confirmed that Resident #2 had disheveled, matted hair, and a mild body odor. RN #1 stated, "It doesn't appear that she had a bath yesterday based on the smell."

An interview on 07/19/23 at 9:45 AM, with Director of Nursing (DON), revealed that the Nursing Assistants (NAs) were supposed to be supervised by Certified Nursing Assistants (CNAs) and she confirmed that the NA was not supposed to be giving Resident #2 a bed bath by herself since her needs were documented for two persons assist. She confirmed that there was no way the resident could be thoroughly cleaned if she completed the bed-bath by herself. The DON revealed that this would require two people to turn and really get her clean.

On 07/20/23 at 4:15 PM, an interview with Licensed Practical Nurse (LPN) #3, revealed that the Nursing Aides who have not passed the CNA program could pass out ice, change bed linens, make beds; but were not supposed to give baths or showers to residents without a CNA or Nurse present.

Record review of Resident #2's "Documentation Survey Report" under "Tasks: Interventions and Tasks" in Electronic Medical Record (EMR) documented that she received a bed bath on 07/17/23 completed by Nursing Assistant. It was also documented under Activities of Daily Living (ADL)-Bathing the numbers four (4) and two (2) which represented the following: 4-Total Dependence and 2-Two-person physical assist.

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| M 610 | Continued From page 9<br><br>Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, and Need for Assistance with Personal Care.<br><br>Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/2023 under Section C documented a Brief Interview for Mental Status (BIMS) Score of 99 which indicated resident was unable to complete the interview. | M 610 | | |
| M 815 | 45.29.1 Safe Food Handling Procedures<br><br>Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interviews, and facility policy review, the facility failed to ensure cooking equipment was clean as evidenced by the deep fryer and oven being dirty for one (1) of two (2) kitchen tours.<br><br>Findings include:<br><br>Review of the facility policy titled, "Equipment" revised 9/2017, revealed "Policy Statement: All foodservice equipment will be clean, sanitary, and | M 815 | M 0815<br>Food Procurement, Store/Prepare/Serve-Sanitary<br><br>1. On 7/20/2023, The fryer and oven were both cleaned per Dietary District Manager in Training.<br>2. The facility determined that each of the 81 residents could be affected.<br>3. In-service on 7/20/2023, per Dietary District Manager in training that cleaning is weekly on kitchen equipment and the appropriate steps to cleaning appliances.<br>4. Effective 7/24/2023, Dietary Manager | 8/25/23 |

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| M 815 | Continued From page 10<br>in proper working order ...1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials ... 2. All staff members will be properly trained in the cleaning and maintenance of all equipment... 3. All food contact equipment will be cleaned and sanitized after every use.<br><br>State Agent (SA) entered the kitchen on 7/18/23 at 9:00 AM and toured with the District Manager in training and the Dietary Manager (DM) an observation of the deep fryer revealed black oil and a crumb-like substance floating on the oil and thick crumb build-up along the sides of the fryer. The District Manager in training revealed that's on the to-do list for tonight. The DM revealed the oil in the fryer is supposed to be changed weekly and the fryer is wiped down daily after each use. He confirmed that the fryer was dirty, and the oil hadn't been changed in a while. He confirmed that the outside of the fryer had not been wiped down after preparation of meals in a while due to the large buildup of food particles. An observation of the oven revealed a build-up of dark debris particles covering the bottom of the oven. The DM confirmed the oven was dirty and needed to be cleaned and he wasn't sure when it was last cleaned. He confirmed we don't really use the oven much, but it still needs to be cleaned. The DM revealed the kitchen equipment is supposed to be clean to prevent any possible cross-contamination and confirmed the fryer and oven were not clean and that could be a fire hazard.<br><br>An interview on 7/18/23 at 9:15 AM Dietary Worker #1 revealed the fryer is supposed to be kept clean and wiped down and the oil is supposed to be changed on Friday, she revealed that she didn't do it this past Friday because she | M 815 | and Infection Preventionist will conduct audits on kitchen sanitation weekly for four (4) weekly and monthly for three (3) months. On August 15, 2023, findings will be reviewed per Quality Assurance for three (3) months. | |

| 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 _____ | C 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CORNERSTONE REHABILITATION AND HEALTHCARI | 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 815 | Continued From page 11<br>was off work, and she has been the only one changing it. She revealed that the oil was old and black and there were thick food particles in the oil and the insides of the fryer and the along the side of the fryer.<br><br>An interview on 7/18/23 at 9:25 AM the DM revealed he is responsible for ensuring the fryer and the oven is cleaned along with all kitchen equipment and he will make sure this gets cleaned right away.<br><br>An interview on 7/19/23 at 3:50 PM the District Manager in training revealed, I know what the problem was regarding the fryer being dirty, she revealed she asked the staff yesterday if they knew how to properly clean the fryer and no one knew. State Agent inquired if there were instructions on how to clean the fryer, the District Manager in training revealed, we don't have instructions, but every manager should know and train the employees and this had not been done. | M 815 | | |