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 04/15/2024

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) MS #24344 at the facility on 04/15/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated allegations related to residents being left wet for extended periods and cited F656 and F677 related to the complaint. The census at the time of the survey was 77 and they held a license for 95 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		5/20/24

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

Electronically Signed | 05/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure a comprehensive care plan was implemented when a Certified Nursing Assistant (CNA) did not check a resident every two hours for incontinence episodes for one (1) of three (3) residents reviewed. Resident #1. Findings Include: Record review of the facility policy, "Care Plans, Comprehensive Person-Centered" with reviewed date of January 2023 revealed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and	F 656	Preparation and submission of this plan of correction by Cornerstone Rehabilitation and Healthcare Center, Corinth, MS does not constitute an admission of agreement by the provider of the truth, or the facts alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is submitted and prepared solely pursuant to the requirements under the federal and state laws. F656 Development/Implement Comprehensive Care Plan 1. Resident # 1 is dependent on staff to	

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F 656	Continued From page 2 functional needs is developed and implemented for each resident..." Record review of Resident #1's Care Plan with an initiation date of 03/19/24, revealed " Focus: "I am incontinent of bladder ...Interventions/Tasks ...Check every two (2) hours and as required for incontinence...." On 04/15/24 at 10:50 AM, an observation revealed Resident #1 lying in his bed on his left side and there was a mild odor of urine noted in the room. His sheet was pulled down with his incontinent brief exposed. The brief was saggy and appeared to be wet. On 04/15/24 at 11:20 AM, an observation revealed Licensed Practical Nurse (LPN) #1 performed wound care to Resident #1's right trochanter. LPN #1 pulled down Resident #1's incontinent brief to prepare for wound care and she confirmed that his incontinent brief was soaked with urine. Resident #1 revealed that he had not been changed since before breakfast. She revealed that the CNAs were supposed to make rounds on the residents every two hours. On 04/15/24 at 11:25 AM, an interview with CNA #1 confirmed that Resident #1 had not been changed since the last shift left at 7 AM that morning. On 04/15/24 at 11:45 AM, an interview with Assistant Director of Nursing (ADON), revealed CNAs were supposed to round on residents every two hours and if the resident refused care, they were supposed to report this to the nurse. The ADON confirmed Resident #1 should be checked at least every two hours.	F 656	provide incontinent care every 2 hours according to the Resident□s Care Plan. The Nursing Assistant revealed that she failed to check resident #1 for incontinent episodes in a timely manner. The Nursing Assistant was educated on 4/15/2024 that she is to provide incontinent care as directed in the resident's plan of care by Director of Nurses. ADL (Activities of Daily Living) care was performed immediately by wound care nurse and Certified Nursing Assistant (CNA). 2. The facility determined that each of the 77 residents could be affected. 3. On 4/15/2024 current nursing staff was in-serviced by the Director of Nursing and Assistant Director of Nursing on appropriate Incontinent Care to be performed and its frequency as related to the Residents□ Plan of Care. Nursing staff were in-serviced that each Resident has a person-centered Care Plan, which is followed to care for the Resident. If any changes are noted to the Resident Care Plan report it immediately to the Supervisor so the Care Plan can be updated. 4. On 4/16/2024, incontinent checks started and will be conducted by Medical Records Nurse and Wound Care Nurse, on incontinent residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure substantial compliance that Activity of Daily Living and incontinent	

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F 656	Continued From page 3 On 04/15/24 at 2:00 PM, an interview with Minimum Data Set (MDS) Nurse, revealed that the purpose of the care plan was to identify the care that each resident needed so the staff would know essentially how to take care of the resident. She revealed that the care plan identified the problems and the conditions of the residents and put individualized interventions in place to follow for each resident. The MDS Nurse also revealed "all residents should be checked on at least every two hours whether they were asleep or not and if they refused to be changed, they should be care planned for that as well." The MDS Nurse confirmed that if a resident was not checked on every two hours, the care plan was not followed.	F 656	care on residents is being followed according to Care Plan by staff. Check log will be reviewed daily by Interdisciplinary (IDT) team and monthly in the Quality Assurance (QA) meeting on 5/16/2024 and continue for three (3) months.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure Activities of Daily Living (ADL) care was completed on a dependent resident when a Certified Nursing Assistant (CNA) did not check a resident every two hours for incontinent episodes and the resident was left wet for an undetermined amount of time for one (1) of three (3) residents reviewed. Resident #1. Findings Include: Record review of the facility policy titled "Activities	F 677	F 677 ADL Care Provided for Dependent Residents 1. The facility failed to ensure Activities of Daily Living (ADL) care was completed on a dependent resident, Resident #1, when a Certified Nursing Assistant (CNA) did not check the resident every two hours for incontinent episodes and the resident was left wet for an undetermined amount of time. On 4/15/24 Wound Nurse and Certified Nursing Assistant(CNA) performed incontinent on Resident #1.	5/20/24

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F 677	Continued From page 4 of Daily Living (ADLs), Supporting" revised March 2018 revealed, "... 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." During an observation on 04/15/24 at 10:50 AM, revealed Resident #1 lying in bed and there was a mild odor noted. His bed sheet was pulled down with his incontinent brief exposed and it was sagging and appeared to be wet. During an observation and interview on 04/15/24 at 11:20 AM, revealed Licensed Practical Nurse (LPN) #1 gather supplies and perform wound care to Resident #1's right trochanter. There was a mild odor noted when LPN #1 unfastened the resident's incontinent brief. LPN #1 confirmed the mild odor, and stated, "It smells like urine." LPN #1 pulled down Resident #1's incontinent brief to prepare for wound care and she confirmed that his brief was soaked with urine. Resident #1 stated that he had "not been changed since before breakfast." During an interview on 04/15/24 at 11:25 AM, CNA #1 confirmed Resident #1 was assigned to her and she had not changed him yet because he was sleeping. CNA #1 confirmed that he had not been changed since the last shift left at 7 AM that morning. She revealed that she didn't get him up because he didn't like to be woken up. During an interview on 04/15/24 at 11:45 AM, the Assistant Director of Nursing (ADON), revealed that CNAs were supposed to round on residents every two hours and if the resident refused care, they were supposed to report this to the nurse.	F 677	On 4/15/2024, the Director of Nurses and Assistant Director of Nurses in-serviced current Nursing Staff on ADL (Activity of Daily Living) care according to the plan of care. 2. Each of the 77 residents in the facility has the potential to be affected in receiving Activity of Daily Living Care. 3. On 4/15/2024 current nursing staff were in-serviced by the Director of Nurses and Assistant Director of Nurses on completion with documentation of ADL (Activity of Daily Living). 4. Beginning 4/16/2024, random Incontinent checks on incontinent residents to be performed by Medical Records Nurse and Wound Care Nurse three (3) days a week, on ten (10) residents for eight (8) weeks, then once monthly for three (3) months. IDT (Interdisciplinary Team) will review daily for accuracy and will discuss in Monthly Quality Assurance (QA) meeting on 5/16/24 and continue for three (3) months.	

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F 677	Continued From page 5	F 677		

She revealed that leaving a resident wet for extended periods could cause the wounds to get worse and could cause infection. The ADON revealed that Resident #1 was normally up and "on the move" but he still should be checked at least every two hours. She revealed that even if residents were sleeping, they were required to check and see if they needed to be changed. She revealed that it was unacceptable for a CNA to leave a resident for hours without checking on them and changing their brief. She revealed that they would educate and in-service about this. She stated, "They can't not change them." She revealed that it was unacceptable for a CNA to leave a resident over four hours without checking on them and changing their brief.

During an interview on 04/15/24 at 11:55 AM, the Director of Nursing (DON) revealed "CNAs are required to check on residents every two hours that are incontinent and see if they needed changing." She revealed that CNA #1 should have rounded on Resident #1 and changed him even if he was asleep.

During an interview on 04/15/24 at 3:09 PM, CNA #2 revealed that they were supposed to round on all residents every two hours and change them whether they were asleep or not because residents could be at risk for skin breakdown.

Record review of Resident #1's Admission Record revealed that he was admitted on 04/13/22 and had diagnoses that included Huntington's Disease, Spina Bifida, Stage 3 Pressure Ulcer of Right Hip, and Need for Assistance with Personal Care.

Record review of Resident #1's Minimum Data

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F 677	Continued From page 6 Set (MDS) with an Assessment Reference Date (ARD) of 03/16/24, Section C revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated he had moderate cognitive deficits.	F 677		