Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHABILITATION AND HEALTHCARE CENTER	**302 ALCORN DRIVE , CORINTH, Mississippi, 38834**

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M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #2800190) at the facility from 4/06/26 through 4/09/26. CI MS #2800190 was investigated for Activities of Daily Living and Bowel/Bladder Incontinence; there were two citations related to this complaint, M610 and M620. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M610, M620, M715, and M815. The facility had a census of 80 and was licensed for 95 beds.	M0000		
M0610	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents who were dependent on staff for hair care and shampooing received the necessary hygiene services to maintain personal cleanliness and grooming	M0610		

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

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M0610	Continued from page 1 for two (2) of eight (8) residents reviewed for activities of daily living (ADL) care during the initial pool. Resident #10 and #40 Findings Include: Review of the facility policy titled “Activities of Daily Living (ADL), Supporting” revised 3/18, revealed under, “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...” Resident 10 An observation of Resident #10 on 4/06/26 at 6:32 PM, and again on 4/07/2026 at 3:38 PM revealed the resident lying in bed with his hair oily, matted, and tangled. Resident #10 had a foul odor, and his room had a foul odor. An observation and interview with Certified Nursing Assistant (CNA) #2 on 4/08/26 at 9:25 AM confirmed Resident #10's hair was unclean and he had an odor. She stated that she was not on shift the previous day when he had his last shower, and it's necessary for an aide to assist him with soap and shampoo because he will just stand in the shower and let the water splash him. An observation and interview with the Administrator on 4/08/26 at 11:35 AM confirmed Resident #10' s hair had not been washed and was unclean. He stated it is the expectation of the facility for the staff to assist residents in showering and shampooing their hair if resident is unable to. Record review of the “Admission Record” revealed the facility admitted Resident #10 on 7/02/2025 with medical diagnoses that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/25/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 1, which indicated Resident #10 was severely cognitively impaired. Resident #40 An observation of Resident #40 on 4/6/26 at 7:29 PM and again on 4/7/2026 at 8:18 AM revealed the resident lying in bed with her hair uncombed, matted, and tangled. The scalp had visible yellowish, dry, flaky buildup to the entire front scalp area, consistent with lack of washing.	M0610		

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M0610	Continued from page 2 An observation and interview with Licensed Practical Nurse (LPN) #2 on 4/8/26 at 8:04 AM confirmed Resident #40 had visible hair residue and buildup. She revealed the resident's scheduled bath days were Monday, Wednesday, and Friday and stated that hair shampooing was considered part of bathing and should be completed on those days by the aide to ensure cleanliness. An observation and interview with the Administrator on 4/8/26 at 8:14 AM confirmed Resident #40's hair had not been washed and was unclean. He stated his expectation was for the resident to be clean and that her hair should be washed with bathing on scheduled bath days. Record review of the "Admission Record" revealed the facility admitted Resident #40 on 11/5/21 with medical diagnoses that included Unspecified Dementia, Muscle Weakness, and Need for Assistance with Personal Care. Record review of the MDS with an ARD of 2/12/26 revealed under section C, a BIMS summary score of 3, which indicated Resident #40 was severely cognitively impaired.	M0610		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure proper perineal care practices to prevent the spread of bacteria for one (1) of two (2) residents observed for perineal care. Resident #45 Findings Include: Review of the facility policy titled "Perineal Care" revised 4/16/24, revealed under, "Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition."	M0620		

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M0620	Continued from page 3 During an observation of perineal care for Resident #45 on 4/8/26 at 11:15 AM, Certified Nurse Aide (CNA) #2 performed care and, after cleansing the front perineal area, turned the resident onto her side. CNA 2 then re-dipped previously used washcloths into the water basin and used them to cleanse the back perineal area. The aide stated prior to exiting the room that she realized the practice was incorrect. On 4/8/26 at 11:40 AM, an interview with CNA #2 confirmed she reused washcloths while providing care to Resident #45 because she was out of clean supplies. She confirmed she should have stopped to retrieve extra supplies and that providing improper perineal care increased the resident's risk for spread of bacteria and urinary tract infection. During an interview with the Director of Nursing on 4/9/26 at 2:41 PM, she revealed the aide should have obtained additional clean washcloths to prevent the spread of germs during perineal care. Record review of the "Admission Record" revealed the facility admitted Resident #45 on 1/24/23 with medical diagnoses that included Epilepsy and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #45 was moderately cognitively impaired. Further review revealed under section H, the resident was always incontinent of bowel and bladder.	M0620		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Pattern Based on observation, staff interview, and facility policy review, the facility failed to ensure medications were properly labeled and stored in	M0715		

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M0715	Continued from page 4 accordance with accepted standards of practice for two (2) of three (3) medication carts observed. Specifically, the facility failed to ensure multi-dose vials were dated upon opening and discarded within the required timeframe. (Residents #4, # 7, #36, #40, #69, and #90) Findings include: Review of the facility policy titled “Medication Labeling and Storage,” with a review date of February 2023, revealed, “…Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days…” During an observation of A-Hall medication cart #1 on 4/8/2026 at 2:47 PM with Licensed Practical Nurse (LPN) #2, Resident #4’s opened multi-dose vial of Olopatadine HCl Ophthalmic Solution 0.1% had an open date of 2/27/2026; Resident #7’s opened multi-dose vial of Latanoprost Ophthalmic Solution 0.005% had an open date of 2/26/2026; Resident #36’s multi-dose vial of Lantus Subcutaneous Solution 100 unit/milliliter was observed opened without an open date, and Resident #36’s opened multi-dose vial of Artificial Tears Ophthalmic Solution 1.4% had an open date of 2/1/2026; Resident #40’s opened multi-dose vial of Timolol Maleate Solution 0.5% had no open date; and Resident #69’s opened multi-dose vial of Artificial Tears Ophthalmic Solution had an open date of 2/15/2026. LPN #2 stated, “I think insulin is good for 30 days.” She further stated insulin could lose effectiveness over time and referenced pharmacy guidelines. Additionally, she stated other multi-dose vials were good for 30 days after opening. During an observation of B-Hall medication cart #2 on 4/8/2026 at 3:03 PM with LPN #4, Resident #90’s opened multi-dose vial of Latanoprost Ophthalmic Solution 0.005% was observed without an open date. During an interview on 4/8/2026 at 3:11 PM, the Assistant Director of Nursing (ADON) confirmed all multi-dose vials should have an open date. She stated insulin is only good for 28 days after opening and that other multi-dose medications, such as eye drops, are typically good for 30 days after opening. Record review of the "Admission Record" indicated that the facility admitted Resident #4 on 12/19/2025 with a medical diagnosis that included Heart Failure. Record review of Resident #4’s Order Summary Report dated 4/9/26, revealed an active order for Olopatadine HCl Ophthalmic Solution 0.1% with order date	M0715		

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M0715	Continued from page 5 12/19/2025. Record review of the "Admission Record" indicated that the facility admitted Resident #7 on 7/20/2009 with a medical diagnosis that included Alzheimer's Disease with late onset. Record review of Resident #7 's Order Summary Report dated 4/9/26, revealed an active order for Latanoprost Ophthalmic Solution 0.005% with order date 8/13/2024. Record review of the "Admission Record" indicated that the facility admitted Resident #36 on 5/28/2021 with a medical diagnosis that included Type 2 Diabetes Mellitus without complications. Record review of Resident #36's Order Summary Report dated 4/9/26, revealed an active order for Lantus Subcutaneous Solution 100 unit/milliliter with order date 9/10/2025 and Artificial Tears Ophthalmic Solution 1.4% with order date 7/26/2024. Record review of the "Admission Record" indicated that the facility admitted Resident #40 on 11/5/2021 with a medical diagnosis that included Unspecified Protein-Calorie Malnutrition. Record review of Resident #40's Order Summary Report dated 4/9/26, revealed an active order for Timolol Maleate Solution 0.5% with order date 11/21/2021. Record review of the "Admission Record" indicated that the facility admitted Resident #69 on 1/29/2024 with a medical diagnosis that included Huntington's Disease. Record review of Resident #69's Order Summary Report dated 4/9/26, revealed an active order for Artificial Tears Ophthalmic Solution with order date 2/10/2026. Record review of the "Admission Record" indicated that the facility admitted Resident #90 on 4/7/2026 with a medical diagnosis that included Traumatic Subdural Hemorrhage with loss of consciousness of unspecified duration, subsequent encounter. Record review of Resident #90's Order Summary Report dated 4/9/26, revealed an active order for Latanoprost Ophthalmic Solution 0.005% with order date 4/7/2026.	M0715		
M0815	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.	M0815		

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M0815	Continued from page 6 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Widespread Based on observation, record review, interview and facility policy review, the facility failed to store and serve foods in a sanitary manner and maintain a clean dietary department for two (2) of four (4) days of survey. Findings include: Record review of facility policy titled, "Environment," dated 06/2025, stated, "All food preparation areas, food services, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation." Record review of policy titled, "Food Storage: Cold Foods," dated 02/2026, stated, "Freezer temperatures will be maintained as a temperature of 0 degrees or below." Observation on 04/06/2026 at 6:20 PM revealed on initial tour of the dietary department that a large amount of food debris and spilled liquids was observed on the floors throughout the dietary department. Along with discarded silverware, discarded pieces of paper, packs of butter, packs of jelly, dried pieces of pasta, shredded cheese and lettuce were observed on the floors in the dietary department. The floor in the dietary department was extremely sticky and the whole area was very unkept. During this observation on 04/06/26, it was noted that a large amount of grease and food build up was on the glass of the steam table backsplash. Observation revealed a gallon size plastic bag dated 02/24/26 with around 20 breadsticks, on a cart beside a blender. Observation revealed "Freezer 2" had a temperature of 48 degrees Fahrenheit (F) with thawed biscuits, rolls, and breaded chicken strips inside the freezer that were mushy to the touch and not frozen. A clean dish rack in the dish room was observed to have dirty gloves laying on the dish rack with the clean dishes, discarded salt and pepper packets and a large amount of food debris on the bottom rack of the clean dish rack. Interview on 04/06/26 at 6:25 PM with Dietary Employee #1 confirmed that she had been there since early that morning and that usually they try to clean up after each meal, but they have not cleaned the dietary area	M0815		

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M0815	Continued from page 7 today. Interview and observation with the Dietary Manager (DM) on 04/06/26 at 6:38 PM confirmed that the breadsticks should have been discarded and that they were over a month old. The DM confirmed the temperature in the freezer was 48 degrees F and she stated, "We had a freezer break down about a week ago and we moved the items to this freezer (Freezer 2), but I thought it was working." The DM confirmed that the dietary department was unkempt and needed to be cleaned and swept. She confirmed the large amount of food debris on the floor, the floor having large amounts of grease build up and sticky and agreed that the dietary department needed to be cleaned. DM confirmed that this rack should be clean and the dirty gloves and food debris should not be on the clean dish rack. Observation of the food tray line and interview with the DM on 04/08/26 at 12:15 PM it was observed during food tray line assembly that Dietary Employee #2 had soiled gloves on and touched the dinner rolls with the soiled gloves when assembling the lunch trays. The DM confirmed that dietary employees should not touch food with dirty gloves.	M0815		