

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 09/02/2026	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 302 ALCORN DRIVE , CORINTH, Mississippi, 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	
M0000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations (CI MS #3109701, CI MS #3108425, and CI MS #3183184) at the facility from 8/31/2026 through 9/2/2026. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and M0500 was cited for CI MS #3109701 and M0100 for CI MS #3108425. The facility was found to be in compliance with CI MS #3183184. The facility held a license for 95 beds and had a census of 78 at the time of the survey.		M0000				
M0500 SS = D	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as		M0500				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0500 SS = D	Continued from page 1 referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his	M0500					

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M0500 SS = D	Continued from page 2 personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest	M0500					

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M0500 SS = D	Continued from page 3 exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, resident interview, staff interviews, and facility policy review, the facility failed to ensure residents were treated with dignity and respect for one (1) of four (4) residents reviewed (Resident #7). Findings Include: Record review of facility policy titled "Nursing Facility Resident Rights" dated 3/6/2026 revealed, "...Facilities are required to protect and promote these rights for every resident....to be treated with dignity, courtesy, and respect." During an interview on 8/31/2026 at 12:27 PM, Resident #7 recalled an incident involving Certified Nursing Assistant (CNA) #3 in the smoking area and stated that CNA #3 was "inappropriate" and angry. During a telephone interview on 8/31/2026 at 1:59 PM, Licensed Practical Nurse (LPN) #1 stated that on 7/23/2026, Resident #4 reported witnessing CNA #3 speaking "ugly" to Resident #7 and stated CNA #3 called the resident "disgusting and gross." LPN #1 stated she learned CNA #3 had come to the facility to bring his wife, CNA #2, a shirt and approached Resident #7 while he was at the facility. LPN #1 stated she reported the incident to the Administrator and Social Worker. During telephone interview on 8/31/2026 at 2:07 PM, LPN #2 stated that on 7/23/2026, she was at her medication cart when Resident #7 stopped at the cart. She stated that she had asked Resident #7 if he was okay, and the resident laughed and continued down the hallway. LPN #2 also stated that she observed CNA #3 come to the facility to bring CNA #2 a shirt. LPN #2 further stated CNA #2 told her that CNA #3 "went off on him," referring to Resident #7. LPN #2 stated she reported CNA #2's statements to the Administrator. During an interview on 8/31/2026 at 3:05 PM, the Administrator stated that on 7/23/2026, LPN #1 notified him that Resident #4 reported witnessing CNA #3 approach Resident #7 in the smoking area and called the resident "disgusting." The Administrator stated that after arriving at the facility, he interviewed Resident #7 and Resident #4 and confirmed the interaction that CNA #3 had with Resident #7. The Administrator stated he and the	M0500					

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M0500 SS = D	Continued from page 4 Director of Nursing (DON) later met with CNA #3 regarding the incident. The Administrator stated CNA #3 confirmed that he had confronted Resident #7 and called him "disgusting." The Administrator stated CNA #3 declined to provide a written statement and indicated he was no longer interested in working at the facility. During an interview on 9/1/2026 at 11:05 AM, the DON stated that on 7/23/2026, she and the Administrator interviewed CNA #3 regarding his interaction with Resident #7. The DON stated CNA #3 confirmed that he approached the resident and told him to stop staring at his wife because he was making her uncomfortable and that was the reason she wanted to quit. The DON stated CNA #3 further confirmed, "I did tell him he was disgusting." The DON stated she also interviewed Resident #7, who confirmed CNA #3 called him "disgusting." During a follow up interview on 9/1/2026 at 1:24 PM, Resident #7 confirmed CNA #3 approached him in the smoking area, told him he had been inappropriate with CNA #3's wife and was the reason she wanted to quit, and called him "disgusting." Resident #7 identified Resident #4 as a witness to the incident and confirmed the interaction upset him. During a telephone interview on 9/1/2026 at 2:28 PM, CNA #3 stated that on 7/23/2026, he came to the facility to bring his wife, CNA #2, a shirt and approached Resident #7. CNA #3 confirmed he called Resident #7 "disgusting" and stated, "Yes, I did and I stand by that." When asked if he told Resident #7 that he was the reason CNA #2 wanted to quit, CNA #3 responded, "Yes, I sure did!" When asked if he believed his approach to Resident #7 was appropriate, CNA #3 stated, "I do." Record review of "Admission Record" revealed that Resident #7 was admitted to the facility on 9/9/2024 with diagnoses of Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/31/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 12, indicating that Resident #7 was moderately cognitively impaired.			M0500			

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M0100	45.2.15 Licensed Practical Nurse Licensed Practical Nurse. The term "licensed practical nurse" shall mean a person who is currently licensed by the Mississippi Board of Nursing as a Licensed Practical Nurse. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on record review, interview and facility policy review, the facility failed to ensure professional nursing staff maintained a current and active nursing license for one (1) of 27 nursing staff reviewed for licensure (Licensed Practical Nurse #3). Findings include: Record review of facility policy titled "Guidelines for Credentialing Staff," revised 10/2022, revealed, "a. Nurses will be verified through the Board of Nursing. If the nurse cannot be easily identified from the results returned, they will be required to provide their driver's license, copy of nurse license, or letter received from the Board of Nursing...4. Review all licenses and certifications monthly communicating upcoming expiration dates with the associate..." Record review of "QuickConfirm License Verification Report" for Licensed Practical Nurse (LPN) #3 revealed the nurse's Montana license expired on 12/31/2025 and Mississippi license was issued on 8/3/2026. Record review of employee timecards revealed LPN #3 continued to work as a Licensed Practical Nurse after the expiration of the nursing license from 1/1/2026 through 7/14/2026. During this period, LPN #3 worked 97 shifts without an active nursing license. Record review of Progress Notes, Medication Administration Records (MARs), and Treatment Administration Records (TARs) from January 2026 through July 2026 revealed LPN #3 performed and documented nursing duties after her Montana nursing license expired on 12/31/2025. LPN #3 documented administering medications and providing treatments during the period she did not have an active nursing license in the state of Mississippi. During an interview on 9/1/2026 at 10:28 AM, the Administrator stated that he interviewed LPN #3 in September 2025 and attempted to verify her nursing license through the Board of Nursing website. The Administrator stated LPN #3 had a Montana nursing	M0100					

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M0100	Continued from page 6 license with an expiration date of 12/31/2025, but he was unable to locate LPN #3 on the Mississippi Board of Nursing website. The Administrator stated he found a nursing license with a similar name, showed the license information to LPN #3, and she told him it was her license. The Administrator stated he accepted LPN #3's statement without further verification and stated, "it's my fault." The Administrator acknowledged the facility failed to verify that LPN #3 maintained an active nursing license and that she should not have been permitted to work as a nurse without an active nursing license. During an interview on 9/1/2026 at 10:43 AM, the Director of Nursing (DON) stated she was not involved in the initial interview or hiring process for LPN #3. The DON stated LPN #3 was introduced to her during orientation, and she asked the Administrator if LPN #3's nursing license had been verified. The DON stated the Administrator told her it had been verified. The DON stated the Staff Development Coordinator (SDC) was responsible for checking nursing licenses by 12/31 of each year to ensure they remained current. The DON stated the facility had been relying on the license information used when LPN #3 was hired, which was later determined not to belong to LPN #3. The DON stated that in July 2026, she instructed the SDC, who was responsible for tracking staff licenses, to review the licensure binder and ensure all licenses were current. The DON stated the SDC later notified her that she could not locate an active nursing license for LPN #3. The DON stated she initially provided the SDC with license information for LPN #3 under a previous last name that had been used when LPN #3 was hired. The DON stated she later reviewed the information and questioned whether it was correct. She searched for LPN #3 through Nursys and discovered that the National Council of State Boards of Nursing (NCSBN) identification numbers did not match. The DON stated she then contacted the Mississippi Board of Nursing and was informed that LPN #3 had applied for a Mississippi nursing license but had not submitted requested information. The DON stated that the Board of Nursing also informed her that they had not heard from LPN #3 since November 2025. During an interview on 9/1/2026 at 11:26 AM, the SDC stated she was responsible for monitoring staff nursing licenses. The SDC confirmed she did not verify LPN #3's nursing license in December 2025 because she was new to the position at that time and did not realize she was required to complete the licensure check. The SDC acknowledged that she should have verified LPN #3's nursing license to			M0100			

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M0100	Continued from page 7 ensure it remained current. During an interview on 9/2/2026 at 12:34 PM, the Human Resources (HR) Manager stated she does not typically verify nursing licenses. She stated the Administrator or DON verifies the nursing license during the interview process and provides her with a copy to upload into their personnel file. The HR Manager stated that if she does not receive a copy, she asks the Administrator or DON for it. She further stated that she does not verify or upload renewed nursing licenses each year. During an interview on 9/2/2026 at 2:34 PM, LPN #3 stated she did not realize her Montana license had expired. She stated there were issues with her school sending transcripts to the Mississippi Board of Nursing. She stated, "It's my fault, I didn't keep on top of it." She also stated, "Had I realized it had expired; I wouldn't have worked." During a subsequent interview on 9/2/2026 at 6:30 PM, the DON confirmed LPN #3 should not have been permitted to work as a nurse with an expired nursing license. The DON further confirmed the facility was responsible for ensuring nursing licenses were maintained and remained current.			M0100			